

Mojave Crest Assurance Company

*Vista Access PPO: Small Group Commercial*

*Group ID: 238714*

## 2026 Evidence of Coverage and Plan Document

Dear Mojave Crest Assurance Company Member:

Thank you for choosing Mojave Crest Assurance Company to provide your health care benefits. We look forward to ensuring a positive experience and your continued satisfaction with the services we provide.

This is your new Mojave Crest Assurance Company Evidence of Coverage.

If your Group has requested that we make it available, you can choose to access this document online through Mojave Crest Assurance Company's secure website at [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp). You can also elect to have a hard copy of this Evidence of Coverage mailed to you. Please call the telephone number on the back of your Member identification card to request a copy.

We look forward to serving you. Contact us at [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp) 24 hours a day, seven days a week for information about our plans, your benefits and more. You can even submit questions to us through the website, or contact us at 1-888-893-1572. Our Customer Contact Center is available from 8:00 a.m. to 6:00 p.m., Monday through Friday, except holidays. You'll find the number to call on the back of your Member ID card.

This document is the most up-to-date version. To avoid confusion, please discard any versions you may have previously received.

Thank you for choosing Mojave Crest Assurance Company.

## About This Booklet

Please read the following information so you will know from whom or what group of providers health care may be obtained.

This Evidence of Coverage constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

See the "Notice of Privacy Practices" under "Miscellaneous Provisions" for information regarding your right to request confidential communications.

### Method of Provider Reimbursement

Mojave Crest Assurance Company pays Participating Providers on a fee-for-service basis, according to an agreed Contracted Rate. You may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on your Mojave Crest Assurance Company ID card.

### Use of Special Words

Special words used in this Evidence of Coverage (EOC) to explain your Plan have their first letter capitalized and appear in the "Definitions" section.

In addition, the following words are used frequently:

- “You” or “Your” refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been enrolled.
- “Employee” has the same meaning as the word “you” above.
- “We” or “Our” or “Us” refers to Mojave Crest Assurance Company.
- “Subscriber” means the primary Member, generally an Employee of a Group.
- “Group” is the business entity (usually an employer) that contracts with Mojave Crest Assurance Company to provide this coverage to you.
- “Plan” and “Evidence of Coverage” “EOC” have similar meanings. You may think of these as meaning your Mojave Crest Assurance Company benefits.
- “Preferred Provider Organization Plan” or “PPO” means a Preferred Provider Organization (PPO) plan. In a PPO plan, you have the flexibility to choose the providers you see. You can receive care from In-Network Providers or Out-of-Network Providers.
- “Preferred Provider,” “Participating Physician,” or “In-Network Provider” means the provider who has agreed to participate in Mojave Crest Assurance Company’s Preferred Provider Organization (“PPO”) to provide Covered Benefits, as explained in this EOC, and accept a special Contracted Rate, called the Contracted Rate, as payment in full. Your share of costs is based on this Contracted Rate.
- “Out-of-Network Provider,” or “Nonparticipating Providers” means the provider who is not part of the Mojave Crest Assurance Company’s Preferred Provider Organization Network (“PPO Network”). Out-of-Network Providers do not have a contract with Mojave Crest Assurance Company to accept Mojave Crest Assurance Company’s Maximum Allowable Amount (MAA) as payment in full for Covered Benefits. Except for Emergency Care (and services received at a Participating Hospital under certain conditions), you will pay more for Covered Benefits from an Out-of-Network Provider.
- “Tier” or “Level” refers to a benefit option offered in your Mojave Crest Assurance Company PPO Plan benefits.
- “In-Network Tier,” or “In-Network Benefit Level” refers to the benefit option in which you receive Covered Benefits from Preferred Providers.
- “Out-of-Network Tier” or “Out-of-Network Benefit Level” refers to the benefit option in which you receive Covered Benefits from Out-of-Network Providers.
- “Cost-Sharing” refers to your share of costs for Covered Benefits under this Plan. This term includes Deductibles, Coinsurance, and Copayments which are determined from Covered Expenses. You are responsible for any charges that are not Covered Expenses.

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## **Introduction To Mojave Crest Assurance Company Page 1**

### **Introduction To Mojave Crest Assurance Company**

The benefits described under this Evidence of Coverage do not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, and are not subject to any pre-existing condition or exclusion period.

Welcome to the Preferred Provider Organization (“PPO”) Plan, a product of Mojave Crest Assurance Company, a health care service plan regulated by the Nevada Department of Managed Health Care. Mojave Crest Assurance Company PPO provides two (2) coverage options: the flexibility of a Preferred Provider Organization network (“PPO Network”) through the in-network benefit level and the traditional indemnity arrangement through the out-of network benefit level.

This Plan covers care from In-Network Providers and Out-of-Network Providers. You do not need a referral. However, some services do require Prior Authorization (or treatment review). This Evidence of Coverage (EOC) will explain the benefits that are available to you under this Plan.

**IMPORTANT NOTE: WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF POCKET EXPENSE.** This is because the cost sharing for the out-of-network benefit is typically higher

than for the in-network benefit. Plus, you are responsible for the difference between the amount the Out of-Network Provider bills and the Maximum Allowable Amount (MAA). See “Your Financial Responsibility” later in this section for more details.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your Evidence of Coverage and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic or the Customer Contact Center at 1-888-893-1572 to ensure that you can obtain the Health Care Services that you need.

Please read this entire Evidence of Coverage so you will understand how your benefits work.

#### How to Obtain Care – In-Network

Under the in-network benefit level, you receive medical care from a Preferred Provider listed in the Mojave Crest Assurance Company PPO Network Directory. Simply call the Preferred Provider to schedule an appointment. Refer to “Timely Access to Care – Preferred Providers” later in this section for more details about scheduling an appointment with Preferred Providers.

To receive care related to Mental Health or Substance Use Disorders from a Preferred Provider, contact Mojave Crest Assurance Company by calling the phone number as shown on your Mojave Crest Assurance Company ID card. Mojave Crest Assurance Company will help you identify a nearby Participating Mental Health Professional and with whom you can schedule an appointment.

To obtain a copy of the Mojave Crest Assurance Company PPO Network Directory, please contact the Customer Contact Center at the telephone number on your Mojave Crest Assurance Company ID card or visit the Mojave Crest Assurance Company website at

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[www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp). The provider directory allows you to find information on network providers including names, addresses, telephone numbers, specialties, and more.

Preferred Providers have agreed to accept the Contracted Rate as payment in full. Your share of cost is based on the Contracted Rate. When you use a Mojave Crest Assurance Company Care Provider, you are not responsible for any amounts billed in excess of the Contracted Rate.

The PPO Network is subject to change. It is your obligation to be sure that the provider you choose is a Preferred Provider with a Mojave Crest Assurance Company agreement in effect. **IMPORTANT NOTE:** Please be aware that it is your responsibility and in your best financial interest to verify that the health care providers treating you are Preferred Providers, including:

- The Hospital or other facility where care will be given. After verifying that the Hospital or the facility is a Preferred Provider, you should not assume all providers at that Hospital or facility are also Preferred Providers; if you receive services from an Out-of-Network Provider at that Hospital or facility, refer to “How to Obtain Care – Out-of-Network” below for information on how those services are paid.
- The provider you select, or to whom you are referred, are a Preferred Provider at the specific location at which you will receive care. Some providers participate at one location, but not at others.

Preferred Providers may refer Members to Out-of-Network Providers. If you receive care from an Out of-Network Provider, even if the referral to that provider is from a Preferred Provider, then services are covered at the out-of-network benefit level. It is your obligation to confirm if the provider, to whom you are referred, is a Preferred Provider or an Out-of-Network Provider. To verify if the provider is a Preferred Provider, check the Mojave Crest Assurance Company PPO Network Directory, contact the Customer Contact Center at the telephone number on your Mojave Crest Assurance Company ID card or visit the Mojave Crest Assurance Company website at [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp). You are responsible for the cost share of the benefit level (that is, Preferred Provider or Out-of-Network Provider) that applies to the provider.

Some of the Covered Expenses under the in-network benefit level are subject to a requirement of Prior Authorization, or treatment review, in order for full benefits to be available to you. Please refer to the “Prior Authorization Requirement” section in this Evidence of Coverage for additional information.

#### Specialists and Referral Care

In the event that you desire to see a Specialist, find the Specialist you wish to see in the Mojave Crest Assurance Company PPO Network Directory and schedule an appointment.

#### Covered Benefits that are not Available through a Preferred Provider

Mojave Crest Assurance Company may authorize Covered Benefits from an out-of-network Specialist or ancillary provider when the Member cannot obtain Medically Necessary care from a Preferred Provider because either: (1) Mojave Crest Assurance Company does not have the provider type in its network; or (2) Mojave Crest Assurance Company does not contract with the provider type within a reasonable distance from the Member’s residence and an Out-of-Network Provider of that type is within such reasonable distance. When Mojave Crest Assurance Company authorizes such care, Covered Benefits from the Out-of-Network Provider will be paid at the in-network level of benefit. The Member will pay the cost sharing as shown under the “Preferred Provider” tier in the “Schedule of Benefits” section of this EOC.

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### **The Continued Participation Of Any One Physician, Hospital Or Other Provider Cannot Be Guaranteed.**

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY, OR MAKE IT A COVERED SERVICE.

#### How to Obtain Care – Out-of-Network

Under the out-of-network benefit level, you may receive medical care from any licensed Out-of Network Provider. Out-of-Network Providers have not agreed to participate in the Mojave Crest Assurance Company PPO Network. Therefore, you lose the protection of Contracted Rates and must also submit claims for benefits. You will not be reimbursed for any amounts in excess of the Maximum Allowable Amount. Please refer to the “Maximum Allowable Amount (MAA) for Out-of-Network Providers” section of this Evidence of Coverage for more details on how we determine MAA.

Some of the Covered Expenses under the out-of-network benefit level are subject to a requirement of Prior Authorization, or treatment review, in order for full benefits to be available to you. Please refer to the “Prior Authorization Requirement” section in this Evidence of Coverage for additional information.

#### Specialists and Referral Care

In the event you desire to see a particular Specialist that is not listed in the Mojave Crest Assurance Company PPO Network Directory, you can obtain services from an out-of-network Physician. Simply schedule an appointment with the provider. Services will be reimbursed to you based on the Maximum Allowable Amount and your benefits, once you submit the claims to Mojave Crest Assurance Company.

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY, OR MAKE IT A COVERED SERVICE.

#### Your Financial Responsibility

##### Preferred Providers

Covered Benefits from Preferred Providers are paid at the in-network benefit level. The maximum amount of Covered Expenses for a service or supply provided by a Preferred Provider is the lesser of the billed charge or the Contracted Rate. You will not be responsible for any amount billed in excess of the Contracted Rate. However, you are

responsible for any applicable Deductible, Copayments or Coinsurance payment. You are always responsible for services or supplies not covered by this Plan.

#### Out-of-Network Providers

Covered Benefits from Out-of-Network Providers are paid at the out-of-network benefit level. Your share of cost is based on the Maximum Allowable Amount. For more information on how we determine the Maximum Allowable Amount, refer to the "Maximum Allowable Amount (MAA) for Out-of Network Providers" section of this Evidence of Coverage. You are responsible for any applicable

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Deductible, Copayments or Coinsurance payment, and any amounts billed in excess of the Maximum Allowable Amount. THEREFORE, WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE.

You are completely financially responsible for care that this Plan does not cover. Additionally, the Out of-Network Provider may request that you pay the billed charges when the service is rendered. In this case, you are responsible for paying the full cost and for submitting a claim to Mojave Crest Assurance Company for a determination of what portion of the billed charges is reimbursable to you.

#### Covered Benefits from an Out-of-Network Provider at an In-Network Facility

When Nonemergent Services are provided by an Out-of-Network Provider:

Nonemergent services provided by an Out-of-Network Provider at a Preferred Provider facility will be payable at the in network benefit level, with the same cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount); the cost sharing and Deductible will accrue to the in-network Out-of-Pocket Maximum.

However, the Out-of-Network Provider may bill or collect from you the difference between a provider's billed charge and the Maximum Allowable Amount in addition to any applicable out-of-network Deductible(s), Copayments and/or Coinsurance, only when you consent in writing at least 24 hours in advance of care. In order to be valid, that consent must meet all of the following requirements: (1) it must be in a document that is separate from the document used to obtain the consent for any other part of the care or procedure, (2) the Out-of-Network Provider has given you a written estimate of the total out-of-pocket cost of care, (3) the consent has advised you that you may elect to seek care from a Preferred Provider or may contact Mojave Crest Assurance Company to arrange to receive care from a Preferred Provider, (4) that any costs that you incur as a result of your use of the out-of-network benefit level shall be in addition to the in-network cost-sharing amounts and may not count toward the in-network annual Out of-Pocket Maximum or an in-network Deductible, if any, and (5) the consent and

estimate shall be provided to you in languages other than English under certain circumstances.

For information regarding Mojave Crest Assurance Company's payment for out-of-network nonemergent services, please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this Evidence of Coverage.

When Emergency Services and Care are provided by an Out-of-Network Provider: When Covered Benefits are received in connection with Emergency Services and Care, you will pay the Preferred Provider level of cost-sharing, regardless of whether the provider is a Preferred Provider or an Out-of Network Provider, and without balance billing. Balance billing is the difference between an Out-of Network Provider's billed charge and the Maximum Allowable Amount. When you receive Emergency Care from an Out-of-Network Provider, your payment of the cost-sharing will accrue toward the Deductible (if applicable) and the Out-of-Pocket Maximum for Preferred Providers.

For information regarding Mojave Crest Assurance Company's payment for out-of-network Emergency Care, please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this Evidence of Coverage.

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### **Deductible**

For certain services and supplies under this Plan, a Deductible may apply which must be satisfied before these services and supplies are payable by Mojave Crest Assurance Company. Such services and supplies are only covered to the extent that Covered Expenses exceed the Deductible. You will be notified by us of your Deductible accumulation for each month in which benefits were used. You will also be notified when you have reached your Deductible amount for the Calendar Year. You can also obtain an update on your Deductible accumulation by calling the Customer Contact Center at the telephone number on your ID card. Refer to the "Schedule of Benefits" section for specific information on Deductible(s).

### **Nonauthorization Penalties**

Some Covered Expenses under this Plan require Prior Authorization. Nonauthorization penalties apply to Covered Benefits that require Prior Authorization but Prior Authorization is not obtained. Refer to the "Schedule of Benefits" and "Prior Authorization Requirement" sections for specific information.

Prior Authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply.

### **Questions**

Call Mojave Crest Assurance Company's Customer Contact Center with questions about this Plan at the number shown on your Mojave Crest Assurance Company ID card.

#### Timely Access to Care – Preferred Providers

The Nevada Department of Managed Health Care (DMHC) has issued regulations (Nevada Code of Regulations, Title 28, Section 1300.67.2.2) with requirements for timely access to nonemergency Health Care Services. Mojave Crest Assurance Company's in-network providers agree to provide timely access to care.

Please contact Mojave Crest Assurance Company at the number shown on your Mojave Crest Assurance Company ID card, 7 days per week, 24 hours per day to access triage or screening services. Mojave Crest Assurance Company provides access to covered Health Care Services in a timely manner.

Please see the "Language Assistance Services" section and the "Notice of Language Services" section for information regarding the availability of no cost interpreter services.

### Definitions Related To Timely Access To Care

Triage or Screening is the evaluation of a Member's health concerns and symptoms by talking to a doctor, nurse, or other qualified health care professional to determine the Member's urgent need for care.

Triage or Screening Waiting Time is the time it takes to speak by telephone with a doctor, nurse, or other qualified health care professional who is trained to screen or triage a Member who may need care, and will not exceed 30 minutes.

Business Day is every official working day of the week. Typically, a business day is Monday through Friday, and does not include weekends or holidays.

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##### Scheduling Appointments with an In-Network Physician

When you need to see your Physician, call their office for an appointment. Please call ahead as soon as possible. When you make an appointment, identify yourself as a Mojave Crest Assurance Company Member, and tell them when you would like to see your doctor. They will make every effort to schedule an appointment at a time convenient for you. If you need to cancel an appointment, notify your Physician as soon as possible.

This is a general idea of how many business days, as defined above, that you may need to wait to see a Participating Provider. Wait times depend on your condition and the type of care you need. You should get an appointment to see a Participating Provider.

- Nonurgent appointments with a Participating Provider: within 10 business days of request for an appointment.
- Urgent care appointment with a Participating Provider: within 48 hours of request for an appointment.

- Routine check-up/physical exam: within 30 business days of request for an appointment.

Your Participating Physician may decide that it is okay to wait longer for an appointment as long as it does not harm your health.

#### Scheduling Appointments with Your Participating Mental Health Professional

When you need to see your designated Participating Mental Health Professional, call their office for an appointment. When you call for an appointment, identify yourself as covered through Mojave Crest Assurance Company, and tell them when you would like to see your provider. They will make every effort to schedule an appointment at a time convenient for you. If you need to cancel an appointment, notify your provider as soon as possible.

This is a general idea of how many business days, as defined above, that you may need to wait to see a Participating Mental Health Professional:

- Urgent care appointment with non-Physician behavioral Health Care Provider or behavioral health care Physician (psychiatrist) that does not require Prior Authorization: within 48 hours of request
- Urgent care appointment with non-Physician behavioral Health Care Provider or behavioral health care Physician (psychiatrist) that requires Prior Authorization: within 96 hours of request
- Nonurgent appointment with behavioral Health Care Physician (psychiatrist): within 15 business days of request
- Nonurgent appointment with non-Physician behavioral Health Care Provider: within 10 business days of request
- Nonurgent follow-up appointment with non-Physician mental Health Care Provider (NPMH): within 10 business days of request
- Non-Life-Threatening behavioral health emergency: within 6 hours of request for an appointment.

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- Life-Threatening behavioral health emergencies: require immediate intervention and treatment.

Your Participating Mental Health Professional may decide that it is okay to wait longer for an appointment as long as it does not harm your health.

#### Scheduling Appointments with an In-Network Specialist for Medical and Surgical Services

When you need to see a Specialist, call their office for an appointment. Please call ahead as soon as possible. When you make an appointment, identify yourself as a Mojave Crest Assurance Company PPO Member, and tell them when you would like to

see the Specialist. The Specialist's office will do their best to make your appointment at a time that works best for you.

This is a general idea of how many business days, as defined above, that you may need to wait to see the Specialist. Wait times for an appointment depend on your condition and the type of care you need. You should get an appointment to see the Specialist:

- Nonurgent appointments with Specialists: within 15 business days of request for an appointment
- Urgent care appointment: with a Specialist or other type of provider that needs approval in advance – within 96 hours of request for an appointment
- Urgent care appointment: with a Specialist or other type of provider that does not need approval in advance – within 48 hours of request for an appointment

#### Scheduling Appointments for In-Network Ancillary Services

Sometimes your doctor will tell you that you need ancillary services such as lab, x-ray, therapy, and medical devices, for treatment or to find out more about your health condition.

Here is a general idea of how many business days, as defined above, that you may need to wait for the appointment:

- Ancillary service appointment: within 15 business days of request for an appointment.

#### Canceling or Missing Your Appointments

If you cannot go to your appointment, call the doctor's office right away. If you miss your appointment, call right away to reschedule your appointment. By canceling or rescheduling your appointment, you let someone else be seen by the doctor.

#### Triage and/or Screening/24-Hour Nurse Advice Line

As a Mojave Crest Assurance Company Member, you have access to triage or screening services, 24 hours per day, 7 days per week. When you are sick or need urgent behavioral health care and cannot reach your doctor, like on the weekend or when the office is closed, you can call Mojave Crest Assurance Company's Customer Contact Center or the 24-hour Nurse Advice Line at the number shown on your Mojave Crest Assurance Company ID card, and select the Triage and/or Screening option to these services. You will be connected to a health care professional (such as a doctor, nurse, or other provider, depending on your needs) who will be able to help you and answer your questions. You can also call 988, the national suicide and mental health crisis hotline system.

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If you have a Life- Threatening emergency, call "911" or go immediately to the closest emergency room. Use "911" only for true emergencies.

## Transition of Care for New Members

You may request continued care from a provider, including a Hospital that does not contract with Health Net if, at the time of enrollment with Mojave Crest Assurance Company, you were receiving care from such a provider for any of the following conditions:

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from your Effective Date of coverage under this Plan;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal Mental Health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- A newborn up to 36 months of age not to exceed twelve months from your Effective Date of coverage under this Plan;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by your prior health plan as part of a documented course of treatment.

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see the “Definitions” section.

Mojave Crest Assurance Company may provide coverage for completion of services from such a provider, subject to applicable Copayments or Coinsurance and any exclusions and limitations of this Plan at the in-network benefit level. You must request the coverage within 60 days of your Group’s effective date unless you can show that it was not reasonably possible to make the request within 60 days of the Group’s effective date and you make the request as soon as reasonably possible. The Out-of-Network Provider must be willing to accept the same contract terms applicable to providers currently contracted with Mojave Crest Assurance Company, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Mojave Crest Assurance Company is not obligated to provide coverage with that provider at the in-network benefit level.

To request continued care, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care, or request a copy of the Continuity of Care Request Form or of our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Mojave Crest Assurance Company ID card.

## Introduction To Mojave Crest Assurance Company Page 9

Emergency and Urgently Needed Care through Your PPO Plan

## **What To Do When You Need Medical Or Mental Health Or Substance Use Disorder Care Immediately**

In serious emergency situations: Call “911” or go to the nearest Hospital.

If your situation is not so severe: Call your Physician or if you cannot call them or you need medical or mental health care right away, go to the nearest medical center or Hospital. You can also call 988, the national suicide and mental health crisis hotline system.

If you are not sure whether you have an emergency or require urgent care please contact Mojave Crest Assurance Company at the number shown on your Mojave Crest Assurance Company ID card. As a Mojave Crest Assurance Company Member, you have access to triage or screening services, 24 hours per day, 7 days per week.

Emergency Services and Care is covered and does not require Prior Authorization. Emergency Services and Care is covered at the in-network benefit level regardless of whether the services are performed by a Preferred Provider or an Out-of-Network Provider.

Urgently Needed Care is covered and does not require Prior Authorization. Urgently Needed Care is covered at the benefit level that applies to the provider of service. Always present your Mojave Crest Assurance Company PPO ID card to the Health Care Provider regardless of where you are. It will help them understand the type of coverage you have and they may be able to assist you in contacting your Physician.

State Hospital Treatment: Services in a state Hospital are limited to treatment or confinement as the result of an Emergency Services and Care or Urgently Needed Care as defined in the “Definitions” section

After your medical problem (including Mental Health or Substance Use Disorder) no longer requires Urgently Needed Care or ceases to be an emergency and your condition is stable, any additional care you receive is considered Follow-Up Care.

Follow-Up Care services performed by an Out-of-Network Provider are covered as described earlier in this section under “How to Obtain Care – Out-of-Network.”

Follow-Up Care after Emergency Services and Care at a Hospital: If, once your Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized, and your treating Health Care Provider at the Hospital believes that you require additional Medically Necessary Hospital services, the Hospital must contact Mojave Crest Assurance Company to obtain timely Prior Authorization or you will be subject to the nonauthorization penalty. If you want to be transferred from an Out-of-Network Hospital to a Preferred Provider Hospital, and Mojave Crest Assurance Company determines that you may be safely transferred, Mojave Crest Assurance Company will arrange for the transfer and for the care to continue at the Preferred Provider Hospital

Please refer to the “Definitions” section for definitions of Emergency Services and Care, Emergency Medical Condition, Psychiatric Emergency Medical Condition and Urgently Needed Care.

## **Prescription Drugs**

If you purchase a covered Prescription Drug for a medical Emergency Services and Care or Urgently Needed Care from a Nonparticipating Pharmacy, this Plan will reimburse you for the retail cost of the drug less any required Copayment or Coinsurance shown in the “Schedule of Benefits” section. You may have to pay for the Prescription Drug when it is dispensed.

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To be reimbursed, you must file a claim with Mojave Crest Assurance Company. Call our Customer Contact Center at the telephone number on your Mojave Crest Assurance Company ID card or visit our website at [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp) to obtain claim forms and information.

Note(s):

The “Prescription Drugs/Outpatient Prescription Drugs” exclusion in” in the “Exclusions and Limitations” section and the requirements of the Formulary also apply.

## **Schedule Of Benefits Page 11**

### **Schedule Of Benefits**

The following schedule shows the applicable Deductible(s), Copayments or Coinsurance for Covered Benefits under this Plan. There is a limit to the amount of Copayments or Coinsurance you must pay in a Calendar Year. Refer to the “Out-of-Pocket Maximum” section for more information.

**In-Network:** When you receive care or services from a Preferred Provider, you will be responsible for the applicable Deductible(s), Copayments or a percentage of the Contracted Rate (Coinsurance) as stated after each benefit listed below under the heading “Preferred Provider.”

**Out-of-Network:** Except for Emergency Services Care, when you receive care or services from an Out-of-Network Provider, you will be responsible for the applicable Deductible(s), Copayments or a percentage of the Maximum Allowable Amount (Coinsurance) as stated after each benefit listed below under the heading “Out-of-Network Provider.” (There are additional exceptions as stated in

the “Introduction to Mojave Crest Assurance Company” section.) You will also be responsible for any charges the Out-of Network Provider bills in excess of the Maximum

Allowable Amount. For more details about the Maximum Allowable Amount, refer to the “Maximum Allowable Amount (MAA) for Out-of Network Providers” section of this Evidence of Coverage.

Some Covered Benefits require Prior Authorization or your benefits will be reduced as shown under “Nonauthorization Penalties” in this schedule. Please see the “Prior Authorization Requirement” section for further details.

Covered Benefits for medical conditions and Mental Health and Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Benefits delivered in-person. Telehealth Services will be covered only when performed by a Preferred Provider. Please refer to the “Telehealth Services” definition in the “Definitions” section for more information.

See “COVID-19 Outpatient Services” in the “Covered Benefits” section for additional coverage information about diagnostic and screening testing, therapeutics, and vaccinations for COVID-19 and its variants.

#### Calendar Year Deductible

Each Calendar Year, you must meet the Deductible amount below before Covered Expenses for medical services or supplies can be paid by Mojave Crest Assurance Company. Certain services are not subject to the Calendar Year Deductible and are indicated as “Deductible waived” or “Calendar Year Deductible waived” in this “Schedule of Benefits” section. The Calendar Year Deductible does not apply to Preventive Care Services through Preferred Providers.

#### Preferred Provider Out-of-Network Provider

Calendar Year Deductible,

per Member ..... Not applicable .....\$200

Calendar Year Deductible,

per family ..... Not applicable .....\$600

Note(s):

- Once the family Deductible is met, no further Calendar Year Deductible is required for any member of the family during the remainder of that Calendar Year.

#### Page 12 Schedule of Benefits

- Any amount applied toward the Calendar Year Deductible for Covered Benefits received from a Preferred Provider will not apply toward the Calendar Year Deductible for Out-of Network Providers. In addition, any amount applied toward the Calendar Year Deductible for Covered Benefits received from an Out-of-Network Provider will not apply toward the Calendar Year Deductible for Preferred Providers.
- Covered Expenses incurred under Preferred Providers or Out-of-Network Providers in the last three months of a Calendar Year, used to satisfy the medical Deductible(s)

for that Calendar Year, may also be used to satisfy the medical Deductible(s) for the following Calendar Year.

- Only Covered Expenses will be applied to the satisfaction of the Calendar Year Deductible. The following does not apply to the Calendar Year Deductible:
  - o Any nonauthorization penalties incurred by you for receiving nonauthorized services, o Expenses incurred under the Prescription Drug benefit.

#### Nonauthorization Penalties

Some Covered Expenses require Prior Authorization. Nonauthorization penalties apply to Covered Benefits that require Prior Authorization but Prior Authorization is not obtained. For a list of services which require Prior Authorization, please see the “Prior Authorization Requirement” section. The Coinsurance percentage applicable to the coverage of nonauthorized services is based on the amount determined to be a Covered Expense, not a percentage of the billed charges.

#### Preferred Provider Out-of-Network Provider

#### Medically Necessary

services for which Prior

Authorization was

required but not obtained..... 50% .....50%  
Note(s):

- Prior Authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply.
- The nonauthorization penalty listed above will apply before the Coinsurance is reduced to the amount shown. The nonauthorization penalty will not exceed the cost of the benefit to Mojave Crest Assurance Company.
- You will be responsible for an additional amount of Coinsurance based on the amount of the nonauthorization penalty.
- For a list of services which require Prior Authorization, please see the “Prior Authorization Requirement” section. The Coinsurance percentage applicable to the coverage of nonauthorized services is based on the amount determined to be a Covered Expense, not a percentage of the billed charges.

## Schedule Of Benefits Page 13

### Copayments and Coinsurance (Including any Additional Benefit Deductibles)

After you meet the Calendar Year Deductible amount described above, you remain responsible for paying the applicable additional benefit Deductibles, Copayments or Coinsurance described below until you satisfy the Out-of-Pocket Maximum. Certain

benefits are not subject to the Calendar Year Deductible and are indicated as “Deductible waived” or “Calendar Year Deductible waived” in this “Schedule of Benefits” section.

When a covered service or supply is subject to a Copayment and a Coinsurance, the Copayment will apply first, then the Coinsurance percentage payable by the Member will be calculated from the Covered Expense amount less the Copayment amount.

UNLESS OTHERWISE NOTED, ALL BENEFIT MAXIMUMS WILL BE COMBINED FOR COVERED BENEFITS PROVIDED BY PREFERRED PROVIDERS AND OUT-OF-NETWORK PROVIDERS.

Services obtained in an Emergency Room or Urgent Care Center (Medical care other than Mental Health and Substance Use Disorder services)

Preferred Provider Out-of-Network Provider\*

or

Emergency Care

Emergency room (facility

and professional

services)..... 20% .....20%

(Deductible waived)

Urgent care center (facility

and professional

services)..... 20% .....20%

(Deductible waived)

Note(s):

Refer to “Ambulance Services” below for emergency medical transportation Copayment or Coinsurance.

\* The cost-sharing amounts shown for Out-of-Network Providers will only apply to services that do not meet the criteria of Emergency Services and Care as defined in the “Definitions” section of this Evidence of Coverage. Emergency Services and Care is covered under your Preferred Provider level of benefits even when such services are from an Out-of-Network Provider and will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider’s billed charge and the Maximum Allowable Amount). For information regarding Mojave Crest Assurance Company’s payment for out-of network Emergency Services and Care, please refer to the “Maximum Allowable Amount (MAA) for Out-of-Network Providers” section of the Evidence of Coverage.

Services obtained in an Emergency Room or Urgent Care Center (Mental Health or Substance Use Disorder services)

Preferred Provider Out-of-Network Provider\*

or

Emergency Care

Emergency room (facility

and professional

services)..... 20% .....20%  
(Deductible waived)

Urgent care center (facility

and professional

services)..... \$0 .....20%  
(Deductible waived)

Note(s):

Refer to “Ambulance Services” below for emergency medical transportation Copayment or Coinsurance.

\* The cost-sharing amounts shown for Out-of-Network Providers will only apply to services that do not meet the criteria of Emergency Services and Care as defined in the “Definitions” section of this Evidence of Coverage. Emergency Services and Care is covered under your Preferred Provider level of benefits even when such services are from an Out-of-Network Provider and will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider’s billed charge and the Maximum Allowable Amount). For information regarding Mojave Crest Assurance Company’s payment for out-of network Emergency Services and Care, please refer to the “Maximum Allowable Amount (MAA) for Out-of-Network Providers” section of the Evidence of Coverage.

Ambulance Services (Medical care other than Mental Health or Substance Use Disorder services)

Preferred Provider Out-of-Network Provider

or

Emergency Care

Ground ambulance ..... 20%  
.....20% (Deductible waived)

Air ambulance ..... 20%  
.....20% (Deductible waived)

Note(s):

Prior Authorization for nonemergency ground or air ambulance transport is required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" if Prior Authorization is required but not obtained.

For more information on ambulance services coverage, refer to the "Ambulance Services" portions of the "Covered Benefits" section and "Exclusions and Limitations" section.

## Schedule Of Benefits Page 15

Covered services provided by an out-of-network ground or air ambulance provider will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount).

Ambulance Services (Mental Health and Substance Use Disorder services)

Preferred Provider Out-of-Network Provider\*

or

Emergency Care

Ground ambulance ..... 20%  
.....20% (Deductible waived)

Air ambulance ..... 20%  
.....20% (Deductible waived)

Note(s):

Prior Authorization for nonemergency ground or air ambulance transport is required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" if Prior Authorization is required but not obtained.

For more information on ambulance services coverage, refer to the "Ambulance Services" portions of the "Covered Benefits" section and "Exclusions and Limitations" section.

Covered Benefits provided by an out-of-network ground or air ambulance provider will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount).

Office Visits

Preferred Provider Out-of-Network Provider

Visit to Physician, Physician

Assistant or Nurse

Practitioner ..... \$20.....40%

Specialist consultation.....

\$20.....40% Physician visit to Member's

home ..... 20% .....40%

Specialist visit to Member's

home ..... 20% .....40%

Annual nonpreventive

routine physical

examination (age 17 and

older)\* ..... \$20.....40%

Combined Calendar

Year maximum payable

by Mojave Crest Assurance Company.....

\$250.....\$250

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Vision examination (for

diagnosis or treatment,

including refractive eye

examinations) by an

ophthalmologist (birth

through age 16)..... \$20.....40%

Vision examination (for

diagnosis or treatment,

including refractive eye

examinations) by all

other providers including

optometrists (birth

through age 16)..... \$20.....40%

Hearing examination for

hearing loss by an

otolaryngologist (birth

through age 16)..... \$20.....40%

Hearing examination for

hearing loss by all other

providers including

audiologists (birth

through age 16)..... \$20.....40%

Telehealth consultation

through the Select

Telehealth Services

Provider\*\* ..... \$0..... Not

Covered Note(s):

\* For nonpreventive purpose, such as taken to obtain employment or administered at the request of a third party, such as a school, camp or sports organization. For annual preventive physical examinations, see "Preventive Care Services" below.

\*\* The designated Select Telehealth Services Provider for this Plan is listed on your Mojave Crest Assurance Company ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

Preventive Care Services

Preferred Provider Out-of-Network Provider

Preventive Care Services.....

\$0.....40% Note(s):

- Covered services include, but are not limited to, annual preventive physical examinations, immunizations, screening and diagnosis of prostate cancer, well-woman examinations, preventive services for pregnancy, other women's preventive services as supported by the Health Resources and Services Administration (HRSA), breastfeeding support and supplies (including one breast pump per pregnancy), and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of the "Covered Benefits" section for details.

## Schedule Of Benefits Page 17

If you receive any other covered services in addition to Preventive Care Services during the same visit, you will also pay the applicable Copayment or Coinsurance for those services.

- Cervical cancer and human papillomavirus (HPV) screenings, and preventive colonoscopies will be covered at no cost.

## Hospital Visits by Physician

### Preferred Provider Out-of-Network Provider

Physician visit to Hospital or

Skilled Nursing Facility ..... 20% .....40%

Note(s):

The above Copayment or Coinsurance applies to professional services only. Care that is rendered in a Hospital or Skilled Nursing Facility is also subject to the applicable facility Copayment or Coinsurance. Look under the “Inpatient Hospital Services” and “Skilled Nursing Facility Services” headings to determine any additional Copayments or Coinsurance that may apply.

## Allergy, Immunizations and Injections

### Preferred Provider Out-of-Network Provider

Allergy testing .....

\$20.....40% Allergy injection services

(serum not included)..... \$20.....40%

Allergy serum..... 20%

.....40% Injections (Office-based

medications –

administration (per dose)..... \$20.....40%

Office-based injectable\*

medications - injected

substance (per dose) \* ..... \$20.....40%

Note(s):

- Immunizations that are part of Preventive Care Services are covered under “Preventive Care Services” in this section.
- Injections for the treatment of Infertility are described below in the “Infertility Services” section.

\* Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician’s office. If you need to have the provider administer the Specialty Drug, you will need to obtain the Specialty Drug through our contracted specialty pharmacy vendor and bring it with you to the provider office. Alternatively, you can coordinate delivery of the Specialty Drug directly to the provider office through our contracted specialty pharmacy vendor. Please refer to the “Prescription Drugs” portion of this “Schedule of Benefits” section for the applicable Copayment or Coinsurance.

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Rehabilitation and Habilitation Therapy

Preferred Provider Out-of-Network Provider

Physical therapy, speech

therapy, occupational

therapy, habilitation

therapy, cardiac

rehabilitation therapy

and pulmonary

rehabilitation therapy..... 20% .....40%

Combined visits per

Calendar Year..... 20.....20

Note(s):

- These services will be covered when Medically Necessary.
- Coverage for physical, occupational and speech rehabilitation and habilitation therapy services is subject to certain limitations as described under the heading “Rehabilitation and Habilitation Therapy” portion of the “Exclusions and Limitations” section.
- Benefits for up to 12 additional visits for physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy may be covered if Prior Authorized as Medically Necessary for rehabilitation services following neurological and orthopedic surgery, cerebral/cardiovascular accident, third degree burns, head trauma and spinal cord injury. All visit maximums will be combined for Covered Benefits provided by Preferred Providers and Out-of-Network Providers. Medically Necessary rehabilitative services following post-mastectomy lymphedema syndrome are not subject to such visit limitations. In addition, Medically Necessary rehabilitative or habilitative services for autism or pervasive developmental disorder are not subject to such visit limitations.

The coverage described above in the preceding paragraph, in relation to Medically Necessary rehabilitative services for post-mastectomy lymphedema syndrome, complies with requirements under the Women's Health and Cancer Rights Act of 1998. In compliance with the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

- Prior Authorization may be required. Please refer to the “Prior Authorization Requirement” section for details. Payment of benefits will be reduced as set forth

under “Nonauthorization Penalties” in this section if Prior Authorization is required but not obtained.

#### Care for Conditions of Pregnancy

##### Preferred Provider Out-of-Network Provider

Prenatal office visit.....  
\$0.....40% Postnatal office visit.....  
20% .....40% Specialist consultation  
regarding pregnancy..... \$20.....40%

## Schedule Of Benefits Page 19

#### Newborn care office visit

(birth through 30 days)..... \$20.....40%

#### Physician visit to the mother

or newborn at a Hospital ..... 20% .....40%

#### Normal delivery, including

cesarean section,

prenatal and postnatal

care (other than office

visits)..... 20% .....40%

#### Circumcision of newborn

(birth through 30 days)\* ..... 20% .....40%

#### Note(s):

- The above Copayments and Coinsurances apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment or Coinsurance. Look under the “Inpatient Hospital Services” and “Outpatient Facility Services” headings to determine any additional Copayments or Coinsurance that may apply. Genetic testing is covered as a laboratory service as shown under the “Other Professional Services” heading below. Genetic testing through the Nevada Prenatal Screening (PNS) Program at PNS-contracted labs, and follow-up services provided through PNS-contracted labs and other PNS-contracted providers are covered in full.
- Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank is covered as shown under “Prostheses” in the “Medical Supplies” section below.
- Termination of pregnancy and related services are covered in full. Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full under

Preferred Providers and the Calendar Year Deductible does not apply. See “Preventive Care Services” above. If other non-Preventive Care Services are received during the same office visit, the above Copayment or Coinsurance will apply for the non-Preventive Care Services. Refer to “Preventive Care Services” and “Pregnancy” in the “Covered Benefits” section.

- Prior Authorization may be required. Please refer to the “Prior Authorization Requirement” section for details. Payment of benefits will be reduced as set forth under “Nonauthorization Penalties” in this “Schedule of Benefits” section if Prior Authorization is required but not obtained.

\* Circumcisions for Members age 31 days or older are covered when Medically Necessary under “Outpatient Surgery.” Refer to the “Outpatient Facility Services” section for applicable Copayments or Coinsurance.

#### Family Planning

##### Preferred Provider Out-of-Network Provider

Sterilization of female .....  
\$0.....40% Sterilization of male  
..... \$0.....40%

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##### Note(s):

- The above Copayments and Coinsurances apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment or Coinsurance. Look under the “Inpatient Hospital Services” and “Outpatient Facility Services” headings to determine any additional Copayments or Coinsurance that may apply.
- Sterilization of females and contraception methods and counseling, as supported by HRSA guidelines, are covered under “Preventive Care Services” in this section.
- Prior Authorization may be required. Please refer to the “Prior Authorization Requirement” section for details. Payment of benefits will be reduced as set forth under “Nonauthorization Penalties” in this “Schedule of Benefits” section if Prior Authorization is required but not obtained.

#### Infertility Services

##### Preferred Provider Out-of-Network Provider

##### Infertility services (all

services that diagnose,

evaluate or treat

infertility) .....See note below\* ..... See note below\* Note(s):

- Infertility services (which include GIFT, IVF and ZIFT (limited to 3 completed oocyte retrieval cycles per lifetime) and all Covered Benefits that prepare the Member to receive this procedure) are covered only for the Mojave Crest Assurance Company Member.
- Injections for Infertility are covered only when provided in connection with services that are covered by this Plan.
- Refer to the “Infertility Services” and “Fertility Preservation” provisions in the “Covered Benefits” section for additional information.
- Prior Authorization may be required. Please refer to the “Prior Authorization Requirement” section for details. Payment of benefits will be reduced as set forth under “Nonauthorization Penalties” in this “Schedule of Benefits” section if Prior Authorization is required but not obtained.
- Applicable Deductible or Copayment or Coinsurance requirements apply to any services and supplies required for Infertility services. For example, if the Infertility service requires an office visit, then the office visit Copayment will apply.

#### Other Professional Services

##### Preferred Provider Out-of-Network Provider

Surgery or assistance at

surgery

Performed in an office or

outpatient facility..... 20% .....40%

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Surgery or assistance at

surgery

Performed in an inpatient

setting ..... 20% .....40%

Administration of

anesthetics

Performed in an office or

outpatient facility..... 20% .....40%

Administration of

anesthetics

Performed in an inpatient

|                           |     |                   |
|---------------------------|-----|-------------------|
| setting .....             | 20% | 40%               |
| Chemotherapy .....        | 20% |                   |
| .....                     | 40% | Radiation therapy |
| Performed in an           |     |                   |
| outpatient setting .....  | 20% | 40%               |
| Radiation therapy         |     |                   |
| Performed in an inpatient |     |                   |
| setting .....             | 20% | 40%               |
| Laboratory services in a  |     |                   |
| Physician's office or     |     |                   |
| outpatient facility.....  | 20% | 40%               |
| Laboratory services in an |     |                   |
| inpatient setting .....   | 20% | 40%               |
| Diagnostic imaging        |     |                   |
| (including x-ray)         |     |                   |
| services in a Physician's |     |                   |
| office or outpatient      |     |                   |
| facility.....             | 20% | 40%               |
| Diagnostic imaging        |     |                   |
| (including x-ray)         |     |                   |
| services in an inpatient  |     |                   |
| setting .....             | 20% | 40%               |
| Complex radiology (CT,    |     |                   |

## Spect, Mri, Muga

|                              |     |                          |
|------------------------------|-----|--------------------------|
| and PET).....                | 20% | 40%                      |
| Medical social services..... | 20% |                          |
| .....                        | 40% | Patient education*       |
| \$0.....                     | 40% | Nuclear medicine (use of |
| radioactive materials)       |     |                          |
| Performed in an              |     |                          |
| outpatient setting .....     | 20% | 40%                      |
| Nuclear medicine (use of     |     |                          |
| radioactive materials)       |     |                          |

Performed in an inpatient

setting ..... 20% .....40%

Renal dialysis ..... 20%

.....40%

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Organ, tissue or stem cell

transplants.....See note below\*\* ..... Not

Covered Infusion therapy

In an office or outpatient

setting ..... 20% .....40%

Infusion therapy

In a home setting ..... 20% .....40%

Note(s):

- The above Copayments or Coinsurance apply to professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable facility Copayment or Coinsurance. Look under the “Inpatient Hospital Services” and “Outpatient Facility Services” headings to determine any additional Copayments or Coinsurance that may apply.
- Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.
- Prior Authorization may be required. Please refer to the “Prior Authorization Requirement” section for details. Payment of benefits will be reduced as set forth under “Nonauthorization Penalties” in this “Schedule of Benefits” section if Prior Authorization is required but not obtained.

\* Covered health education counseling for weight management and smoking cessation, including programs provided online and counseling over the phone, are covered as preventive care through Preferred Providers and have no cost sharing; however, if other medical services are provided at the same time that are not solely for the purpose of covered preventive care, the appropriate related Copayment or Coinsurance will apply.

\*\* Applicable Deductible or Copayment or Coinsurance requirements apply to any services and supplies required for organ, tissue, or stem cell transplants. For example, if the transplant requires an office visit, then the office visit Copayment or Coinsurance will apply.

Medical Supplies

Preferred Provider Out-of-Network Provider

Durable Medical Equipment,

|                             |     |     |
|-----------------------------|-----|-----|
| nebulizers, including       |     |     |
| face masks and tubing*      | 20% | 40% |
| Orthotics (such as bracing, |     |     |
| supports and casts)         | 20% | 40% |
| Diabetic equipment,         |     |     |
| including diabetic          |     |     |
| footwear**                  | 20% | 40% |
| Corrective Footwear (for    |     |     |
| treatment of conditions     |     |     |
| not related to diabetes)    | 20% | 40% |
| Prostheses (internal or     |     |     |
| external)***                | 20% | 40% |

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Blood or blood products

except for drugs used to

treat hemophilia,

including blood factors..... 20% .....40%

Drugs used to treat

hemophilia, including

blood factors\*\*\*\* \$20.....\$20

(Deductible waived)

Note(s):

- Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under “Preventive Care Services” in this section. For additional information, please refer to the “Preventive Care Services” provision in this “Covered Benefits” section.
- If the retail charge for the medical supply is less than the applicable Copayment, you will only pay the retail charge.
- Prior Authorization may be required. Please refer to the “Prior Authorization Requirement” section for details. Payment of benefits will be reduced as set forth under “Nonauthorization Penalties” in this “Schedule of Benefits” section if Prior Authorization is required but not obtained.

\* Durable Medical Equipment is covered when Medically Necessary and acquired or supplied by a Mojave Crest Assurance Company designated contracted vendor for Durable Medical Equipment. Preferred Providers that are not designated by Mojave

Crest Assurance Company as a contracted vendor for Durable Medical Equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. For information about Mojave Crest Assurance Company's designated contracted vendors for Durable Medical Equipment, please contact the Customer Contact Center at the telephone number on your Mojave Crest Assurance Company ID card.

\*\* Corrective Footwear for the management and treatment of diabetes are covered under "Diabetic Equipment" as Medically Necessary. For a complete list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in the "Covered Benefits" section.

\*\*\*Includes coverage for Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank. Prostheses also include coverage of ostomy and urological supplies. See "Ostomy and Urological Supplies" portion of "Covered Services and Supplies."

\*\*\*\*Drugs for the treatment of hemophilia, including blood factors, are also covered under the Prescription Drug benefit.

#### Home Health Care Services

##### Preferred Provider Out-of-Network Provider

Home health visit ..... 20%  
.....40% Note(s):

- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

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##### Hospice Services

##### Preferred Provider Out-of-Network Provider

Hospice care ..... 20%  
.....40% Note(s):

- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

##### Acupuncture and Chiropractic Services

##### Preferred Provider Out-of-Network Provider

##### Acupuncture Deductible

(applies each Calendar

Year Combined with

chiropractic services

Deductible ..... \$200.....\$200

Acupuncture ..... 20%

.....40% Combined Calendar

Year maximum.....15 visits ..... 15 visits

Chiropractic Deductible

(applies each Calendar

Year Combined with

chiropractic services

Deductible ..... \$200.....\$200

Chiropractic services..... 20%

.....40% Combined Calendar

Year maximum.....15 visits ..... 15 visits

Note(s):

- Covered chiropractic appliances are covered in full to a Calendar Year maximum of \$50.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.
- Up to 15 Medically Necessary office visits to a Contracted Chiropractor during a Calendar Year are covered (combined with office visits to the Contracted Acupuncturist).

Inpatient Hospital Services

Preferred Provider Out-of-Network Provider

Unlimited days of care in a

semi-private room or

Special Care Unit

including ancillary

(additional) services ..... \$250 plus 20%.....\$250 plus  
40%

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Note(s):

- The above cost-sharing amounts apply to facility services only. Care that is rendered in a Hospital is also subject to the professional services Copayments or Coinsurance. Look under the "Hospital Visits by Physician," "Care for Conditions of Pregnancy" and "Other Professional Services" headings to determine any additional Copayments or Coinsurance that may apply.
- The above cost-sharing amounts apply to the hospitalization of an adult, pediatric or newborn patient. For an inpatient stay for the delivery of a newborn, the newborn will not be subject to a separate Deductible and Copayment or Coinsurance for inpatient Hospital services unless the newborn patient requires admission to a Special Care Unit or requires a length of stay greater than 48 hours for vaginal delivery or 96 hours for caesarean section.
- The Preferred Provider Deductible and Coinsurance will apply if you are admitted to a Hospital directly from an emergency room or urgent care center. You will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amounts) for the inpatient stay by an Out-of-Network Provider.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.
- Services for bariatric surgery and organ, tissue and stem cell transplants by Out-of-Network Providers are not covered.

### Outpatient Facility Services

#### Preferred Provider Out-of-Network Provider

#### Outpatient surgery (Hospital

charges only, except for

Infertility services) ..... \$0.....40%

#### Outpatient surgery

#### (Outpatient Surgical

Center charges only,

except for Infertility

services)..... \$0.....40%

#### Outpatient services (other

than surgery, except for

Infertility services) ..... \$0.....40%

Note(s):

- The above cost-sharing amounts apply to facility services only. Care that is rendered in an outpatient surgery setting is also subject to the professional services Copayments or Coinsurance. Look under the “Care for Conditions of Pregnancy,” “Family Planning” and “Other Professional Services” headings to determine any additional Copayments or Coinsurance that may apply.

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- Other professional services performed in the outpatient department of a Hospital, such as a visit to a Physician (office visit), laboratory and x-ray services or physical therapy are subject to the same Copayment or Coinsurance that is required when these services are performed at your Physician’s office. Look under the headings for the various services such as office visits, rehabilitation and other professional services to determine any additional Copayment or Coinsurance payments that may apply.
- Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the “Preventive Care Services” section above. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment or Coinsurance applicable for outpatient facility services.
- Prior Authorization may be required. Please refer to the “Prior Authorization Requirement” section for details. Payment of benefits will be reduced as set forth under “Nonauthorization Penalties” in this “Schedule of Benefits” section if Prior Authorization is required but not obtained.

#### Skilled Nursing Facility Services

##### Preferred Provider Out-of-Network Provider

Room and board in a semi

private room with

ancillary (additional)

services..... \$250 plus 20%.....\$250 plus 40% Note(s):

- Prior Authorization is required. Please refer to the “Prior Authorization Requirement” section for details. Payment of benefits will be reduced as set forth under “Nonauthorization Penalties” in this section if Prior Authorization is required but not obtained.

#### Mental Health and Substance Use Disorders

##### Mental Health Preferred Provider Out-of-Network Provider Outpatient office

visit/professional

consultation  
(psychological  
evaluation or therapeutic  
session in an office  
setting, including  
medication management  
and drug therapy  
monitoring)..... \$0.....\$0  
(Deductible waived)

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Outpatient services other  
than office  
visit/professional  
consultation including  
(psychological and  
neuropsychological  
testing, other outpatient  
procedures, intensive  
outpatient care program,  
day treatment, partial  
hospitalization and  
therapeutic session in a  
home setting for  
pervasive developmental  
disorder or autism per  
provider per day and  
other outpatient services  
including, but not limited  
to, laboratory services or  
rehabilitation when

provided for a Mental  
Health or Substance Use  
Disorder condition)\* ..... \$0.....\$0  
(Deductible waived)

Mental health professional  
visit to Members home  
(at the discretion of the  
mental health  
professional)..... \$0.....\$0  
(Deductible waived)

Mental health professional  
visit to Hospital,  
behavioral health facility  
or Residential Treatment  
Center ..... 20% .....20%  
(Deductible waived)

Inpatient services at a  
Hospital, behavioral  
health facility or  
Residential Treatment  
Center ..... 20% .....20%  
(Deductible waived)

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Substance Use Disorder Preferred Provider Out-of-Network Provider Outpatient office  
visit/professional  
consultation  
(psychological  
evaluation or therapeutic  
session in an office  
setting, including  
medication management  
and drug therapy

monitoring)..... \$0.....\$0  
(Deductible waived)

Outpatient services other

than office

visit/professional

consultation (including

psychological and

neuropsychological

testing, other outpatient

procedures, intensive

outpatient care program,

day treatment, day

treatment , partial

hospitalization and other

outpatient services

including, but not limited

to, laboratory services or

rehabilitation when

provided for a Mental

Health or Substance Use

Disorder condition)\*) ..... \$0.....\$0  
(Deductible waived)

Mental health professional

visit to Members home

(at the discretion of the

mental health

professional)..... \$0.....\$0  
(Deductible waived)

Mental health professional

visit to Hospital,

behavioral health facility

or Residential Treatment

Center ..... 20% .....20%  
(Deductible waived)

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Inpatient services at a

Hospital, behavioral

health facility or

Residential Treatment

Center ..... 20% .....20%  
(Deductible waived)

Detoxification at a Hospital,

Participating Behavioral

Health Facility or

Residential Treatment

Center ..... 20% .....20%  
(Deductible waived)

Note(s):

- The applicable Copayment or Coinsurance for outpatient services is required for each visit.
- Prior Authorization may be required. Please refer to the “Prior Authorization Requirement” section for details. Payment of benefits will be reduced as set forth under “Nonauthorization Penalties” in this “Schedule of Benefits” section if Prior Authorization is required but not obtained.

\* Medically Necessary services for Mental Health or Substance Use Disorders are not subject to the visit limitations shown elsewhere in this “Schedule of Benefits” section.

## Prescription Drugs

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed, and whether the drug was dispensed by a Participating Pharmacy or a Nonparticipating Pharmacy as defined in the “Definitions” section Also refer to Notes below for clarification regarding Deductible, Copayment, Coinsurance, and any applicable Coinsurance maximum or benefit maximums.

For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to the “Prescription Drugs” portion of the “Covered Benefits” section and the

Prescription Drugs/Outpatient Prescription Drugs” exclusion in the “Exclusions and Limitations” sections.

Copayment and Coinsurance

Retail Pharmacy

(up to a 30-day supply) Participating Pharmacy Nonparticipating Pharmacy Tier 1 Drugs include most

Generic Drugs and low

cost preferred Brand

Name Drugs ..... \$10.....\$10 plus  
50%

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Tier 2 Drugs include

nonpreferred Generic

Drugs, preferred Brand

Name Drugs and any

other drugs

recommended by the

Pharmacy and

Therapeutics Committee

based on safety, efficacy,

and cost..... \$25.....\$25 plus

50% Tier 3 Drugs include

nonpreferred Brand

Name Drugs or drugs

that are recommended by

the Pharmacy and

Therapeutics Committee

based on safety, efficacy,

and cost, or that

generally have a

preferred and often less

costly therapeutic

|                                                                                        |                       |           |
|----------------------------------------------------------------------------------------|-----------------------|-----------|
| alternative at a lower tier.....                                                       | \$35.....             | \$55 plus |
| 50% Infertility drugs (including                                                       |                       |           |
| injectable drugs) .....                                                                | See note below* ..... | See note  |
| below* Weight loss drugs for the                                                       |                       |           |
| treatment of obesity                                                                   |                       |           |
| (including injectable                                                                  |                       |           |
| drugs).....                                                                            | 50% .....             | 50%       |
| Preventive drugs and                                                                   |                       |           |
| contraceptives.....                                                                    | \$0.....              | \$0       |
| Specialty Drugs (up to a 30 day supply) Specialty Pharmacy Vendor Except as listed     |                       |           |
| below, all Specialty Drugs are subject to the applicable Tier 1, 2 or 3 Drug Copayment |                       |           |
| shown above under "Retail Pharmacy."                                                   |                       |           |
| Self-injectable drugs and drugs for the treatment of hemophilia,                       |                       |           |
| including blood factors, per                                                           |                       |           |
| prescription.....                                                                      |                       | \$20      |
| Maintenance Drugs through the Mail Order                                               |                       |           |
| Program (up to a 90 day supply) Mail Order Program Tier 1 Drugs include most Generic   |                       |           |
| Drugs and low-cost preferred                                                           |                       |           |
| Brand Name                                                                             |                       |           |
| Drugs.....                                                                             |                       | \$20 Tier |
| 2 Drugs include nonpreferred Generic Drugs, preferred                                  |                       |           |
| Brand Name Drugs and any other drugs recommended by                                    |                       |           |
| the Pharmacy and Therapeutics Committee                                                |                       |           |
| based on safety, efficacy, and cost                                                    |                       |           |
| .....                                                                                  |                       | \$50      |

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Tier 3 Drugs include nonpreferred Brand Name Drugs or  
drugs that are recommended by the Pharmacy  
and Therapeutics Committee based on safety, efficacy,  
and cost, or that generally have a preferred and often  
less costly therapeutic alternative at a lower  
tier.....\$70 Preventive drugs and  
contraceptives.....\$0

Note(s):

- You will be charged the Copayment or Coinsurance for each Prescription Drug Order. The Coinsurance listed above is based on the Prescription Drug Covered Expense.
- Prescription Drugs will have a Copayment and Coinsurance maximum of \$250 for an individual prescription of up to a 30-day supply. However, up to a 30-day supply of insulin obtained through a Participating Pharmacy will have a cost share maximum of \$35., or the applicable Tier 1, 2 or 3 Copayment or Coinsurance shown above under "Retail Pharmacy," whichever is less.
- Percentage Copayments will be based on the lesser of Mojave Crest Assurance Company's contracted pharmacy rate or the pharmacy's cost of the prescription for covered Prescription Drugs.
- Orally administered anti-cancer drugs will have a Copayment and Coinsurance maximum of \$200 for an individual prescription of up to a 30-day supply and \$600 for an individual prescription of up to a 90-day supply.
- If the pharmacy's cost of the prescription is less than the applicable Copayment or Coinsurance, you will pay the pharmacy's cost of the prescription and it will accrue to the Deductible and Out-of-Pocket Maximum.
- Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name Drugs that have generic equivalents only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Mojave Crest Assurance Company at the Copayment or Coinsurance for Tier 3 Drugs. Covered Brand Name Drugs are subject to the applicable Prescription Drug Deductible and Copayment or Coinsurance for Tier 2 Drugs or Tier 3 Drugs.

A Physician must obtain Mojave Crest Assurance Company's Prior Authorization for coverage of Brand Name Drugs that have generic equivalents.

\* Infertility drugs are subject to the applicable Tier 1, 2 or 3 or Specialty Drug Tier Copayment shown above under "Retail Pharmacy."

Prior Authorization:

- Prior Authorization may be required. Refer to the "Prescription Drugs" portion of "Covered Benefits" for a description of Prior Authorization requirements or visit our website at [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp) to obtain a list of drugs that require Prior Authorization.

Copayment Exception(s):

- If the pharmacy's or the mail order administrator's cost of the prescription is less than the applicable Copayment, you will only pay the pharmacy's cost of the prescription or the mail order administrator's cost of the prescription.

#### Preventive Drugs and Contraceptives:

- Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration and recommended by the United States Preventive Services Task Force (USPSTF) are covered at no cost to the Member. Please see the “Preventive Drugs and Contraceptives” provision in the “Prescription Drugs” portion of the “Covered Services and Supplies” section for additional details. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications.
- Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Mojave Crest Assurance Company, then the Brand Name Drug will be dispensed at no charge.
- Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.

#### Mail Order:

- Up to a 90-consecutive-calendar-day supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment or Coinsurance. However, when the retail Copayment is a percentage, the mail order Copayment is the same percentage of the cost to Mojave Crest Assurance Company as the retail Copayment.
- Maintenance Drugs on the Mojave Crest Assurance Company Maintenance Drug List may also be obtained at a CVS retail pharmacy under the mail order program benefits.

#### Diabetic Supplies:

- Diabetic supplies (blood glucose testing strips, lancets, disposable needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be “broken” (i.e., opened in order to dispense the product in quantities other than those packaged).

When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your Physician has prescribed for up to a 30-day period.

#### Specialty Drugs:

- Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. Specialty Drugs are identified in the Mojave Crest Assurance Company Formulary with “SP,” require Prior Authorization from Mojave Crest Assurance

Company and may be required to be dispensed through the specialty pharmacy vendor to be covered. Specialty Drugs are not available through mail order.

Out-of-Pocket Maximum Page 33

## Out-Of-Pocket Maximum

The Out-of-Pocket Maximum (OOPM) amounts below are the maximum amounts you must pay for covered services during a particular Calendar Year, except as described in “Exceptions to OOPM” below.

Once the total amount of all Deductibles, Copayment and Coinsurance you pay for covered services and supplies under this Evidence of Coverage in any one Calendar Year equals the “Out-of-Pocket Maximum” amount, no payment for covered services and benefits may be imposed on any Member, except as described in “Exceptions to OOPM” below.

The OOPM amounts for the medical benefits are:

Preferred Provider Out-of-Network Provider

|                      |             |        |
|----------------------|-------------|--------|
| Individual OOPM..... | \$1500..... |        |
| \$1500 Family        |             |        |
| OOPM.....            | \$4500..... | \$4500 |

The OOPM amounts for the Prescription Drug benefits are:

Participating Pharmacy Non Participating Pharmacy

|                      |             |        |
|----------------------|-------------|--------|
| Individual OOPM..... | \$2000..... |        |
| \$2000 Family        |             |        |
| OOPM.....            | \$4000..... | \$4000 |

### Exceptions to OOPM

Only Covered Expenses will be applied to OOPM. The following expenses will not be counted, nor will these expenses be paid at 100% after the OOPM is reached.

- Out-of-pocket costs for Prescription Drugs exceeding Prescription Drug benefit coverage as described in the “Retail Pharmacies and the Mail Order Program” provision of the “Prescription Drugs” subsection of the “Covered Services and Supplies” section.

You are required to continue to pay these Deductible(s); Coinsurance and Copayments listed in the bullets above after the Preferred Provider and Out-of-Network Provider OOPM has been reached. In addition, you will continue to pay any charges billed by an Out-of-Network Provider in excess of the Maximum Allowable Amount or Prescription Drug Covered Expense.

Note(s):

All Specialty Drugs will be applied to the Pharmacy OOPM.

#### How the OOPM Works

- Any Deductible, Copayments or Coinsurance paid for the services of a Preferred Provider will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Deductible, Copayments or Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Copayments or Coinsurance paid for out-of-network Emergency Services and Care (including emergency medical transportation, emergency Hospital care) and urgent care received outside the United States will be applied to the Out-of-Pocket Maximum for Preferred Providers.

#### Page 34 Out-of-Pocket Maximum

- If an individual Member pays amounts for Covered Benefits in a Calendar Year that equal the per Member OOPM amount shown above for an individual Member, no further payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments, Coinsurance and Calendar Year Deductible (s) until either (a) the aggregate of such Copayments and Coinsurance; and Calendar Year Deductible (s) paid by the family reaches the family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for covered services and supplies paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services.
- Only amounts that are applied to the individual Member's OOPM amount may be applied to the family's OOPM amount. Any amount you pay for covered services and supplies for yourself that would otherwise apply to your individual OOPM but exceeds the above stated OOPM amount for one Member will be refunded to you by Mojave Crest Assurance Company, and will not apply toward your family's OOPM. Individual Members cannot contribute more than their individual OOPM amount to the family OOPM.

You will be notified by us of your OOPM accumulation for each month in which benefits were used. You will also be notified when you have reached your OOPM amount for the Calendar Year. You can also obtain an update on your OOPM accumulation by calling the Customer Contact Center at the telephone number on your ID card. Please keep a copy of all receipts and canceled checks for costs for Covered Benefits as proof of payments made.

#### Eligibility, Enrollment and Termination Page 35 ELIGIBILITY, ENROLLMENT AND TERMINATION

##### Who is Eligible for Coverage

The Covered Benefits of this Plan are available to eligible employees (Subscribers) of a Group that is based in the Service Area, as long as they live in the continental United States; are full-time paid on a salary/hourly basis (not 1099, commissioned or substitute); and are nonseasonal employees working the minimum number of hours per week as specified in the Group Application; and meet any additional eligibility requirements of the Group and mutually agreed upon by Mojave Crest Assurance Company:

Covered Benefits of this Plan are also available to the following Family Members of the Subscriber who meet any eligibility requirements of the Group or as mutually agreed upon with Mojave Crest Assurance Company:

- Spouse: The Subscriber's lawful spouse as defined by Nevada law. (The term "spouse" also includes the Subscriber's Domestic Partner as defined in the "Definitions" section.)
- Children: The children of the Subscriber or their spouse (including legally adopted children, stepchildren and wards, as defined in the following provision).
- Wards: Children for whom the Subscriber or their spouse is a court-appointed guardian.

Children of the Subscriber or spouse who are the subject of a Medical Child Support Order, according to state or federal law, are eligible.

#### Age Limit for Children

Each child is eligible until the age of 26 (the limiting age).

#### Disabled Child

Children who reach age 26 are eligible to continue coverage if all of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the Subscriber for support and maintenance.

If you are enrolling a disabled child for new coverage, you must provide Mojave Crest Assurance Company with proof of incapacity and dependency within 60 days of the date you receive a request for such information about the dependent child from Mojave Crest Assurance Company. The child must have been continuously covered as a dependent of the Subscriber or spouse under a previous group health plan at the time the child reached the age limit.

Mojave Crest Assurance Company must provide you notice at least 90 days prior to the date your enrolled child reaches the age limit at which the dependent child's coverage will terminate. You must provide Mojave Crest Assurance Company with proof of your child's incapacity and dependency within 60 days of the date you receive such notice

from Mojave Crest Assurance Company in order to continue coverage for a disabled child past the age limit.

You must provide the proof of incapacity and dependency at no cost to Mojave Crest Assurance Company.

#### Page 36 Eligibility, Enrollment and Termination

Mojave Crest Assurance Company may require proof of continuing incapacity and dependency. If so, Mojave Crest Assurance Company will follow these guidelines:

- Within the first two years following the child's reaching the age limit, you may be asked to provide proof as may be required by Mojave Crest Assurance Company.

After this two-year period, Mojave Crest Assurance Company may require proof no more frequently than once a year.

A disabled child may remain covered by this Plan for as long as they remain incapacitated and continue to meet the eligibility criteria described above.

#### How to Enroll for Coverage

Notify the Group that you want to enroll an eligible person. The Group will send the request to Mojave Crest Assurance Company according to current procedures.

#### Employee

Eligible employees must enroll within 30 days of the date they first become eligible for this Plan. Eligible Family Members may also be enrolled at this time (see "Who Is Eligible for Coverage" above in this section).

If enrollment of the eligible employee or eligible Family Members does not occur within this time period, enrollment may be carried out as stated below in the "Late Enrollment Rule" provision of this section.

The employee may enroll on the earlier of the following dates:

- When this Plan takes effect, if the employee is eligible on that date; or
  - When any waiting or probationary period required by the Group has been completed
- Eligible employees who enroll in this Plan are called Subscribers.

#### Newly Acquired Dependents

You are entitled to enroll newly acquired dependents as follows:

**Spouse:** If you are the Subscriber and you marry while you are covered by this Plan, you may enroll your new spouse (and your spouse's eligible children) within 30 days of the date of marriage. Coverage begins on the first day of the calendar month following the date the application for coverage is received.

**Domestic Partner:** If you are the Subscriber and you enter into a domestic partnership while you are covered by this Plan, you may enroll your new Domestic Partner (and their

eligible children) within 30 days of the date a Declaration of Domestic Partnership is filed with the Secretary of State or other recognized state or local agency, or within 30 days of the formation of the domestic partnership according to your Group's eligibility rules.

Coverage begins on the first day of the calendar month following the date the application for coverage is received.

**Newborn Child:** A child newly born to the Subscriber or their spouse will automatically be covered for 31 days (including the date of birth). If you do not enroll the newborn within 31 days (including the date of birth), they are covered for only the 31 days starting on and including the day of birth.

#### Eligibility, Enrollment and Termination Page 37

**Adopted Child:** A newly adopted child or a child who is being adopted, becomes eligible on the date the appropriate legal authority grants the Subscriber or their spouse, in writing, the right to control the child's health care.

Coverage begins automatically and will continue for 30 days from the date of eligibility. You must enroll the child before the 30th day for coverage to continue beyond the first 30 days.

Mojave Crest Assurance Company will require written proof of the right to control the child's health care when you enroll them.

**Legal Ward (Guardianship):** If the Subscriber or spouse becomes the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. The child must be enrolled within 30 days of the effective date of the guardianship. Coverage will begin on the first day of the month after Mojave Crest Assurance Company receives the enrollment request.

Mojave Crest Assurance Company will require proof that the Subscriber or spouse is the court-appointed legal guardian.

#### In Hospital on Your Effective Date

If you are confined in a Hospital or Skilled Nursing Facility on the Effective Date of coverage, this Plan will cover the remainder of that confinement only if you inform Mojave Crest Assurance Company's Customer Contact Center upon your Effective Date about the confinement.

Mojave Crest Assurance Company will consult with your attending Physician and may transfer you to a participating facility when medically appropriate.

#### Totally Disabled on Your Effective Date

Generally, under the federal Health Insurance Portability and Accountability Act, Mojave Crest Assurance Company cannot deny you benefits due to the fact that you are totally disabled on your Effective Date. However, if upon your Effective Date you are totally disabled and pursuant to state law you are entitled to an extension of benefits from your

prior group health plan, benefits of this Plan will be coordinated with benefits payable by your prior group health plan, so that not more than 100% of Covered Expenses are provided for services rendered to treat the disabling condition under both plans.

For the purposes of coordinating benefits under this Evidence of Coverage, if you are entitled to an extension of benefits from your prior group health plan, and state law permits such arrangements, your prior group health plan shall be considered the primary plan (paying benefits first) and benefits payable under this Evidence of Coverage shall be considered the secondary plan (paying any excess Covered Expenses), up to 100% of total Covered Expenses.

#### Late Enrollment Rule

Mojave Crest Assurance Company's late enrollment rule requires that if an individual does not enroll within 30 days of becoming eligible for coverage, they must wait until the next Open Enrollment Period to enroll. (Time limits for enrolling are explained in the "Employee" or "Newly Acquired Dependents" provisions above.)

The term "form" within this section may include electronic enrollment forms or enrollment over the phone. Electronic enrollment forms or phone enrollments are deemed signed when you use your employer's enrollment system to make or confirm changes to your benefit enrollment.

#### Page 38 Eligibility, Enrollment and Termination

You may have decided not to enroll upon first becoming eligible. At that time, your Group should have given you a form to review and sign. It would have contained information to let you know that there are circumstances when you will not be considered a late enrollee.

If you later change your mind and decide to enroll, Mojave Crest Assurance Company can impose its late enrollment rule. This means that individuals identified on the form you signed will not be allowed to enroll before the next Open Enrollment Period. However, there are exceptions to this rule.

#### Exceptions to Late Enrollment Rule

If any of the circumstances below are true, the late enrollment rule will not apply to you.

1. 1. You Did Not Receive a Form to Sign or a Signed Form Cannot Be Produced If you chose not to enroll when you were first eligible, the late enrollment rule will not apply to you if:
  - You never received from your Group or signed a form explaining the consequences of your decision; or
  - The signed form exists but cannot be produced as evidence of your informed decision.

2. 2. You Do Not Enroll Because of Other Coverage and Later the Other Coverage Is Lost If you declined coverage in this Plan and you stated on the form that the reason you were not enrolling was because of coverage through another group health plan and coverage is or will be lost for any of the following reasons, the late enrollment rule will not apply to you.
- The subscriber of the other plan has ceased being covered by that other plan (except for either failure to pay premium contributions or a “for cause” termination such as fraud or misrepresentation of an important fact).
  - Loss of coverage because of termination of employment or reduction in the number of hours of employment.
  - Loss of coverage through an HMO or other individual arrangement because an individual ceases to reside, live or work in the Service Area.
  - Loss of coverage through an HMO or other arrangement in the group market because an individual ceases to reside, live or work in the Service Area,, and no other benefit package is available to the individual.
  - The other plan is terminated and not replaced with other group coverage.
  - The other Group stops making contributions toward employee's or dependent's coverage.
  - When the individual's plan ceases to offer any benefits to the class of similarly situated individuals that includes the individual.
  - The other subscriber or employee dies.
  - The subscriber and spouse are divorced or legally separated and this causes loss of the other group coverage.
  - Loss of coverage because of cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan).
  - The other coverage was federal COBRA or Nevada COBRA and the period of coverage ends.

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#### 3. 3. You Lose Eligibility from a Medi-Cal Plan

If you become ineligible and lose coverage under Medi-Cal, you and/or your dependent(s) will be eligible to enroll in this Plan upon submitting a completed application form within 60 days of losing such coverage. If you and/or your dependent(s) wait longer than 60 days to enroll, you and/or your dependent(s) may not enroll until the next Open Enrollment period.

#### 4. 4. Multiple Health Plans

If you are enrolled as a dependent in a health plan (not Mojave Crest Assurance Company) and the subscriber, during open enrollment, chooses a different plan (such as moving from an HMO plan to a fee-for-service plan) and you do not wish to continue to

be covered by it, you will not be considered a late enrollee should you decide to enroll in this Plan.

## 5. 5. Court Orders

If a court orders the Subscriber to provide coverage for a spouse (a current spouse, not a former spouse) or orders the Subscriber or enrolled spouse to provide coverage for a minor child through Mojave Crest Assurance Company, that spouse or child will not be treated as a late enrollee.

If the exceptions in 2 or 4 above apply, you must enroll within 30 days of the loss of coverage. If you wait longer than 30 days to enroll, you will be a late enrollee and you may not enroll until the next Open Enrollment Period. A court ordered dependent may be added without any regard to open enrollment restrictions.

### Special Enrollment Rule for Newly Acquired Dependents

If an employee gains new dependents due to childbirth, adoption or marriage the following rules apply.

#### If the Employee is Enrolled in this Plan

If you are covered by this Plan as a Subscriber, you can enroll your new dependent if you request enrollment within 30 days after childbirth, marriage, adoption or placement for adoption. In addition, a court ordered dependent may be added without any regard to open enrollment restrictions.

More information about enrolling new dependents and their Effective Date of coverage is available above under the heading "How to Enroll for Coverage" and the subheading "Newly Acquired Dependents."

#### If the Employee Declined Enrollment in this Plan

If you previously declined enrollment in this Plan because of other group coverage and you gain a new dependent due to childbirth, marriage, adoption or placement for adoption, you can enroll yourself and the dependent within 30 days of childbirth, marriage, adoption or placement for adoption.

If you gain a new dependent due to a court order and you did not previously enroll in this Plan, you may enroll yourself and your court ordered dependent(s) without any regard to open enrollment restrictions.

In addition, any other family members who are eligible for coverage may enroll at the same time as you and the new dependent. You no longer have to wait for the next Open Enrollment Period and whether or not you are covered by another group plan has no effect on this right.

If you do not enroll yourself, the new dependent and any other family members within 30 days of acquiring the new dependent, you will have to wait until the next Open Enrollment Period to do so.

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The Effective Date of coverage for you and all family members who enroll within 30 days of childbirth, marriage, adoption or placement for adoption will be the same as for the new dependent.

- In the case of childbirth, the Effective Date will be the moment of birth.
- For marriage or domestic partnership, the Effective Date will be the first of the month following the date the application for coverage is received.
- Regarding adoption, the Effective Date will be the date the birth parent or appropriate legal authority grants the employee or their spouse, in writing, the right to control the child's health care.
- In the case of a Medical Child Support Order, the Effective Date will be the date the Group is notified of the court order.

Note: When you (the employee) are not enrolled in this Plan and you wish to have coverage for a newborn or adopted child who is ill, please contact your Group as soon as possible and ask that you (the employee) and the newborn or adopted child be enrolled. An employee must be enrolled in order for their eligible dependent to be enrolled.

While you have 30 days within which to enroll the child, until you and your child are formally enrolled and recorded as Members in our computer system, we cannot verify coverage to any inquiring medical provider.

### Special Reinstatement Rule for Reservists Returning From Active Duty

Reservists ordered to active duty on or after January 1, 2007, who were covered under this Plan at the time they were ordered to active duty and their eligible dependents will be reinstated without waiting periods or exclusion of coverage for pre-existing conditions. A reservist means a member of the U.S.

Military Reserve or Nevada National Guard called to active duty pursuant to Public Law 107-243 or Presidential Order No. 13239. Please notify the Group when you return to employment if you want to reinstate your coverage under the Plan.

### Special Reinstatement Rule Under USERRA

USERRA, a federal law, provides service members returning from a period of uniformed service who meet certain criteria with reemployment rights, including the right to reinstate their coverage without pre-existing exclusions or waiting periods, subject to certain restrictions. Please check with your Group to determine if you are eligible.

### When Coverage Ends

You must notify the Group of changes that will affect your eligibility. The Group will send the appropriate request to Mojave Crest Assurance Company according to current procedures. Mojave Crest Assurance Company is not obligated to notify you that you are no longer eligible or that your coverage has been terminated.

#### All Group Members

All Members of a Group become ineligible for coverage under this Plan at the same time if the Group Service Agreement (between the Group and Mojave Crest Assurance Company) is terminated, including for termination due to nonpayment of subscription charges by the Group, as described below in the "Termination for Nonpayment of Subscription Charges" provision.

#### Termination for Nonpayment of Subscription Charges

If the Group fails to pay the required subscription charges when due, the Group Service Agreement could be canceled after a 30-day grace period.

When subscription charges are not paid by the due date, a Late Payment Notice is generated. The date of the Late Payment Notice is the first day of the 30-day grace period. The Notice will include the dollar amount due to Mojave Crest Assurance Company, the last day of paid coverage, and the start and last day of the grace period after which coverage will be cancelled if subscription charges are not paid. Coverage will continue during the grace period but the Member is responsible for unpaid subscription charges and any required Copayments, Coinsurance or Deductible amounts.

If Mojave Crest Assurance Company does not receive payment of the delinquent subscription charges from your employer within the 30-day grace period, Mojave Crest Assurance Company will mail a termination notice that will provide the following information: (a) that the Group Service Agreement has been cancelled for nonpayment of subscription charges; (b) the specific date and time when coverage is terminated for the Subscribers and all dependents; and (c) your right to submit a grievance.

If coverage through this Plan ends for reasons other than nonpayment of subscription charges, see the "Coverage Options Following Termination" section below for coverage options.

#### Termination for Loss of Eligibility

Individual Members become ineligible on the date any of the following occurs: • The Member no longer meets the eligibility requirements established by the Group and Mojave Crest Assurance Company.

This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:

6. 1. The date established by the order.
  7. 2. The date the order expired.
- The Member becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan.

- The Subscriber's marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for the Subscriber's enrolled spouse (now former spouse) and that spouse's enrolled dependents, who were related to the Subscriber only because of the marriage, will end.
- When the Member ceases to reside in the continental United States, coverage will be terminated effective on midnight of the last day of the month in which loss of eligibility occurred.

For any termination for loss of eligibility, a cancellation or nonrenewal notice will be sent at least 30 days prior to the termination which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice; (c) your right to

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submit a grievance; and (d) information regarding possible eligibility for reduced-cost coverage through the Nevada Health Benefit Exchange or no-cost coverage through Medi-Cal. Once coverage is terminated, Mojave Crest Assurance Company will send a termination notice which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice; and (c) your right to submit a grievance.

The Subscriber and all their Family Members will become ineligible for coverage at the same time if the Subscriber loses eligibility for this Plan.

#### Termination for Cause

Mojave Crest Assurance Company has the right to terminate your coverage from this Plan for good cause, as set forth below. Your coverage may be terminated with a 30-day written notice if you commit any act or practice, which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, including:

- Misrepresenting eligibility information about yourself or a dependent;
- Presenting an invalid prescription or Physician order;
- Misusing a Mojave Crest Assurance Company Member ID card (or letting someone else use it); or
- Failing to notify us of changes in family status that may affect your eligibility or benefits. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

For any termination for cause, a cancellation or nonrenewal notice will be sent at least 30 days prior to the termination which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice; (c) your right to submit a grievance; and (d) information regarding possible eligibility for reduced-cost coverage through the Nevada Health Benefit Exchange or no-

cost coverage through Medi-Cal. Once coverage is terminated, Mojave Crest Assurance Company will send a termination notice which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice; and (c) your right to submit a grievance.

#### How to Appeal Your Termination

You have the right to file a complaint if you believe that your coverage is improperly terminated or not renewed. A complaint is also called a grievance or an appeal. Refer to the “Grievance Procedures” provision in the “General Provisions” section for information about how to appeal Mojave Crest Assurance Company's decision to terminate your coverage.

If your coverage is terminated based on any reason other than for nonpayment of subscription charges and your coverage is still in effect when you submit your complaint, Mojave Crest Assurance Company will continue your coverage under this Plan until the review process is completed, subject to Mojave Crest Assurance Company's receipt of the applicable subscription charges. You must also continue to pay any applicable Deductible, Coinsurance and Copayments for any services and supplies received while your coverage is continued during the review process.

If your coverage has already ended when you submit your request for review, Mojave Crest Assurance Company is not required to continue coverage. However, you may still request a review of Mojave Crest Assurance Company's decision to terminate your coverage by following the complaint process described in the “Grievance Procedures” provision in the

#### Eligibility, Enrollment and Termination Page 43

“General Provisions” section. If your complaint is decided in your favor, Mojave Crest Assurance Company will reinstate your coverage back to the date of the termination.

Mojave Crest Assurance Company will conduct a fair investigation of the facts before any termination for any of the above reasons is carried out. Your health status or requirements for Health Care Services will not determine eligibility for coverage. If you believe that coverage was terminated because of health status or the need for health services, you may request a review of the termination by the Director of the Nevada Department of Managed Health Care.

#### Coverage Options Following Termination

If coverage through this Plan ends as a result of the Group's nonpayment of subscription charges, see “All Group Members” portion of “When Coverage Ends” in this section for coverage options following termination. If coverage through this Plan ends for reasons other than the Group's nonpayment of subscription charges, the terminated Member may be eligible for additional coverage.

- **COBRA Continuation Coverage:** Many Groups are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For most Groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside Nevada. Please check with your Group to determine if you and your covered dependents

are eligible.

- **NV-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in Nevada, you may be eligible for additional continuation coverage under state NV-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue Group coverage under this Evidence of Coverage through NV-COBRA for up to 36 months from the date that federal COBRA coverage began.

**Mojave Crest Assurance Company Will Offer NV-COBRA to Members:** Mojave Crest Assurance Company will send Members whose federal COBRA coverage is ending information on NV-COBRA rights and obligations along with the necessary premium information, enrollment forms, and instructions to formally choose NV-COBRA Continuation Coverage. This information will be sent by U.S. mail with the notice of pending termination of federal COBRA.

**Choosing NV-COBRA:** If an eligible Member wishes to choose NV-COBRA Continuation Coverage, they must deliver the completed enrollment form (described immediately above) to Mojave Crest Assurance Company by first class mail, personal delivery, express mail, or private courier company. The address appears on the back cover of this Evidence of Coverage.

The Member must deliver the enrollment form to Mojave Crest Assurance Company within 60 days of the later of (1) the Member's termination date for COBRA coverage or (2) the date they were sent a notice from Health Net that they may qualify for NV-COBRA Continuation.

**Payment for NV-COBRA:** The Member must pay Mojave Crest Assurance Company 110% of the applicable group rate charged for employees and their dependents.

The Member must submit the first payment within 45 days of delivering the completed enrollment form to Mojave Crest Assurance Company in accordance with the terms and conditions of the health Plan contract. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and NV-COBRA Continuation Coverage. The Member's first payment

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must be delivered to Mojave Crest Assurance Company by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private

courier company. If the payment covering the period from the last day of prior coverage to the present is not received within 45 days of providing the enrollment form to Mojave Crest Assurance Company, the Member's NV-COBRA election is not effective and no coverage is provided.

All subsequent payments must be made on the first day of each month. If the payment is late, the Member will be allowed a grace period of 30 days. Fifteen days from the due date (the first of the month), Mojave Crest Assurance Company will send a letter warning that coverage will terminate 15 days from the date on the letter. If the Member fails to make the payment within 15 days of the notice of termination, enrollment will be canceled by Mojave Crest Assurance Company. If the Member makes the payment before the termination date, coverage will be continued with no break in coverage. Amounts received after the termination date will be refunded to the Member by Mojave Crest Assurance Company within 20 business days.

**Employer Replaces Previous Plan:** There are two ways the Member may be eligible for Cal COBRA Continuation Coverage if the employer replaces the previous plan:

8. 1. If the Member had chosen NV-COBRA Continuation Coverage through a previous plan provided by their current employer and replaced by this Plan because the previous policy was terminated, or
9. 2. If the Member selects this Plan at the time of the employer's open enrollment.

The Member may choose to continue to be covered by this Plan for the balance of the period that they could have continued to be covered by the prior group plan. In order to continue NV-COBRA coverage under the new plan, the Member must request enrollment and pay the required premium within 30 days of receiving notice of the termination of the prior plan. If the Member fails to request enrollment and pay the premium within the 30-day period, NV-COBRA continuation coverage will terminate.

**Employer Replaces this Plan:** If the agreement between Mojave Crest Assurance Company and the employer terminates, coverage with Mojave Crest Assurance Company will end. However, if the employer obtains coverage from another insurer or HMO, the Member may choose to continue to be covered by that new plan for the balance of the period that they could have continued to be covered by the Mojave Crest Assurance Company plan.

**When Does NV-COBRA Continuation Coverage End?** When a qualified beneficiary has chosen NV-COBRA Continuation Coverage, coverage will end due to any of the following reasons:

10. 1. You have been covered for 36 months from your original COBRA effective date (under this or any other plan).\*
11. 2. The Member becomes entitled to Medicare; that is, enrolls in the Medicare program. 3. The Member moves outside Nevada.

12. 4. The Member fails to pay the correct premium amount on the first day of each month as described above under “Payment for NV-COBRA.”

13. 5. The date your Group’s agreement with Mojave Crest Assurance Company terminates. (See “Employer Replaces this Plan.”)

6. The Member becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan.

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If the Member becomes covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, coverage through this Plan will continue. Coordination of benefits will apply, and NV-COBRA plan will be the primary plan.

\* The COBRA effective date is the date the Member first became covered under COBRA continuation coverage.

- USERRA Coverage: Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your Group to determine if you are eligible.
- Extension of Benefits: Described below in the subsection titled “Extension of Benefits.” Extension of Benefits

#### When Benefits May Be Extended

Benefits may be extended beyond the date coverage would ordinarily end if you lose your Mojave Crest Assurance Company coverage because the Group Service Agreement is discontinued and you are totally disabled at that time.

When benefits are extended, you will not be required to pay subscription charges. However, the Deductible, Copayments and Coinsurance payments shown in the “Schedule of Benefits” section will continue to apply.

Benefits will only be extended for the condition that caused you to become totally disabled. Benefits will not be extended for other medical conditions.

Benefits will not be extended if coverage was terminated for cause as stated in the “Individual Members - Termination for Cause” provision of this “Eligibility, Enrollment and Termination” section.

“Totally disabled” has a different meaning for different Family Members.

- For the Subscriber it means that because of an illness or injury, the Subscriber is unable to engage in employment or occupation for which they are or become

qualified by reason of education, training or experience; furthermore, the Subscriber must not be employed for wage or profit.

- For a Family Member it means that because of an illness or injury, that person is prevented from performing substantially all regular and customary activities usual for a person of their age and family status.

#### How to Obtain an Extension

If your coverage ended because the Group Service Agreement between Mojave Crest Assurance Company and the Group was terminated and you are totally disabled and want to continue to have extended benefits, you must send a written request to Mojave Crest Assurance Company within 90 days of the date the Agreement terminates. The request must include written certification by the Member's Physician that the Member is totally disabled.

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If benefits are extended because of total disability, provide Mojave Crest Assurance Company with proof of total disability at least once every 90 days during the extension. The Member must ensure that Mojave Crest Assurance Company receives this proof before the end of each 90-day period.

#### When the Extension Ends

The Extension of Benefits will end on the earliest of the following dates:

- On the date the Member is no longer totally disabled;
- On the date the Member becomes covered by a replacement health policy or plan obtained by the Group and this coverage has no limitation for the disabling condition;
- On the date that available benefits are exhausted; or
- On the last day of the 12-month period following the date the extension began.

#### Prior Authorization Requirement Page 47

### **Prior Authorization Requirement**

Some of the Covered Expenses under this Plan are subject to a requirement of Prior Authorization, or treatment review, before services are received, in order for the nonauthorization penalty to not apply.

Prior Authorizations are performed by Mojave Crest Assurance Company or an authorized designee. The telephone number which you can use to obtain Prior Authorization is listed on your Mojave Crest Assurance Company ID card. If you are outside Nevada, require medical care or treatment, and use a provider from the supplemental network, Prior Authorizations will be performed by the supplemental network. For additional information, see "Out-of State Providers" in the "Miscellaneous Provisions" section. For additional information regarding Prior Authorization

requirements for Mental Health or Substance Use Disorders, see the “Mental Health or Substance Use Disorder Benefits” portion of “Covered Services and Supplies.”

Services provided as the result of an emergency are covered at the in-network benefit level and do not require Prior Authorization.

We may revise the Prior Authorization list from time to time. Any such changes including additions and deletions from the Prior Authorization list will be communicated to Participating Providers and posted on the [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp) website.

Prior Authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply. However, Mojave Crest Assurance Company will not rescind or modify Prior Authorization after a provider renders Health Care Services in good faith and pursuant to the Prior Authorization, and will pay benefits under the Evidence of Coverage for the services authorized.

#### Services Requiring Prior Authorization

##### Inpatient admissions

Any type of facility, including but not limited to:

- Acute rehabilitation center
- Behavioral health facility
- Hospice
- Hospital
- Skilled Nursing Facility
- Substance abuse facility

##### Outpatient procedures, services or equipment

- Ablative techniques for treating Barrett’s esophagus and for treatment of primary and metastatic liver malignancies
- Acupuncture (after the initial consultation)
- Ambulance: nonemergency, air or ground ambulance services
- Bariatric procedures

#### Page 48 Prior Authorization Requirement

- Bronchial thermoplasty
- Capsule endoscopy
- Cardiovascular procedures
- Chiropractic care (after the initial consultation)
- Clinical trials
- Diagnostic procedures including:

##### 14. 1. Advanced imaging

- o Computerized Tomography (CT)
- o Computed Tomography Angiography (CTA)
- o Magnetic Resonance Angiography (MRA)
- o Magnetic Resonance Imaging (MRI)
- o Positron Emission Tomography (PET)

#### 15. 2. Cardiac imaging

- o Coronary Computed Tomography Angiography (CCTA)
- o Myocardial Perfusion Imaging (MPI)
- o Multigated Acquisition (MUGA) scan

#### 16. 3. Sleep studies (facility-based sleep testing)

- Durable Medical Equipment (DME)
- Ear, Nose and Throat (ENT) procedures
- Enhanced External Counterpulsation (EECP)
- Services Experimental or Investigational Services and new technologies.
- Gender affirming services
- Genetic testing (Prior Authorization is not required for biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer)
- Interventional Pain Management
- 
- Facet joint denervation, injection or block
- Epidural spine injections
- Sacroiliac (SI) joint injection
- 

o Spinal cord stimulator

o Sympathetic nerve block

#### Prior Authorization Requirement Page 49

- Mental Health or Substance Use Disorder services other than office visits including:
  1. Applied Behavioral Analysis (ABA) and other forms of Behavioral Health Treatment (BHT) for autism and pervasive developmental disorders

17. 2. Electroconvulsive Therapy (ECT)

18. 3. Half-day partial hospitalization

19. 4. Intensive Outpatient Program (IOP)

20. 5. Neuropsychological testing

6. Partial Hospital Program or Day Hospital (PHP)

7. Psychological testing

8. Transcranial Magnetic Stimulation (TMS)

- Musculoskeletal procedures
  - o Joint surgery
  - o Spine surgery
- Neuro cord stimulator
- Neuropsychological testing
- Orthognathic procedures (includes TMJ treatment)
- Orthotics (custom made)
- Pharmaceuticals

21. 1. Outpatient Prescription Drugs

o Most Specialty Drugs, including self-injectable drugs and hemophilia factors, must have Prior Authorization through the “Outpatient Prescription Drugs” benefit and may need to be dispensed through the specialty pharmacy vendor. Please refer to the Formulary to identify which drugs require Prior Authorization. Urgent or emergent drugs that are Medically Necessary to begin immediately may be obtained at a retail pharmacy.

o Other Prescription Drugs, as indicated in the Formulary, may require Prior Authorization. Refer to the Formulary to identify which Drugs require Prior Authorization.

22. 2. Certain Physician-administered drugs, including newly approved drugs, whether administered in a Physician office, freestanding infusion center, home infusion, Outpatient Surgical Center, outpatient dialysis center or outpatient Hospital. Refer to the Mojave Crest Assurance Company website, [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp), for a list of Physician-administered drugs that require Prior Authorization. Biosimilars are required in lieu of branded drugs, unless Medically Necessary.

- Proprietary laboratory analysis
- Prosthesis
- Quantitative drug testing
- Radiation therapy

Page 50 Prior Authorization Requirement

- Reconstructive and cosmetic surgery, services and supplies such as:

23. 1. Bone alteration or reshaping such as osteoplasty

24. 2. Breast reductions and augmentations except when following a mastectomy (includes gynecomastia and macromastia)

25. 3. Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
26. 4. Dermatology such as chemical exfoliation, electrolysis, dermabrasion, chemical peel, laser treatment, skin injection or implants
27. 5. Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
6. Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
7. Gynecologic or urology procedures such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy
8. Hair electrolysis, transplantation or laser removal
9. Lift such as arm, body, face, neck, thigh
10. Liposuction
11. Nasal surgery such as rhinoplasty or septoplasty
12. Otoplasty
13. Penile implant
14. Treatment of varicose veins
15. Vermilionectomy with mucosal advancement
  - Testosterone therapy
  - Therapy (includes home setting)
- o Occupational therapy
- o Physical therapy
- o Speech therapy
  - Transplant and related services; transplants must be performed through Mojave Crest Assurance Company's designated transplantation specialty network.
  - Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
  - Vestibuloplasty
  - Wound care

Mojave Crest Assurance Company will consider the medical necessity of your proposed treatment, your proposed level of care (inpatient or outpatient) and the duration of your proposed treatment.

In the event of an admission, a concurrent review will be performed. Confinement in excess of the number of days initially approved must be authorized by Mojave Crest Assurance Company.

Additional services not indicated in the above list may require Prior Authorization. Please consult the “Schedule of Benefits” section to see additional services that may require Prior Authorization.

#### Exceptions

- Mojave Crest Assurance Company does not require Prior Authorization for maternity care. However, please notify Health Net at the time of the first prenatal visit.
- Prior Authorization is not needed for the first 48 hours of inpatient Hospital services following a vaginal delivery, nor the first 96 hours following a cesarean section. However, please notify Health Net within 24 hours following birth or as soon as reasonably possible. Prior Authorization must be obtained if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.
- Prior Authorization is not required for the length of a Hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy).
- Other than Prescription Drugs, services provided pursuant to a CARE agreement or CARE plan approved by a court do not require Prior Authorization. See “Treatment Related to Judicial or Administrative Proceedings” in the “Covered services and supplies” section for more information.
- Prior Authorization by Mojave Crest Assurance Company may be required for certain drugs. Please refer to “Prior Authorization and Step Therapy Exception Process for Prescription Drugs” in the “Prescription Drugs” section. You may refer to our website at [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp) to review the drugs that require a Prior Authorization as noted in the Formulary.

#### Prior Authorization Procedure

Prior Authorization must be requested by you within the following periods:

- Five or more business days before the proposed elective admission date or the commencement of treatment, except when due to a medical emergency.
- 72 hours or sooner, taking into account the medical exigencies, for proposed elective services needed urgently.
- In the event of being admitted into a Hospital following outpatient emergency room or urgent care center services for Emergency Services Care; please notify the Plan of the inpatient admission within 24 hours or as soon as reasonably possible.
- Before admission to a Skilled Nursing Facility or Hospice Care program or before Home Health Care Services are scheduled to begin.

In order to obtain Prior Authorization, you or your Physician is responsible for contacting Health Net as shown on your Mojave Crest Assurance Company identification card

before receiving any service requiring Prior Authorization. If you receive any such service and do not follow the procedures set forth in the Prior Authorization section, your benefits are subject to the “Nonauthorization Penalty” as shown in the “Schedule of Benefits” section. However, for services that require notification only, the nonauthorization penalty will not apply.

#### Page 52 Prior Authorization Requirement

Mojave Crest Assurance Company will make its decision to approve, modify, or deny Prior Authorization within five (5) business days of receiving your or your Physician’s request and within 72 hours of receiving the request if you face an imminent and serious threat to your health.

Verbal Prior Authorization may be given for the service. Written Prior Authorization for inpatient services will be sent to the patient and the provider of service.

If Prior Authorization is denied for a covered service, Mojave Crest Assurance Company will send a written notice to the patient and to the provider of the service.

#### Effect on Benefits

If Prior Authorization is obtained and services are rendered within the scope of the Prior Authorization, benefits for Covered Expenses will be provided in accordance with the “Covered Services and Supplies” section of this EOC.

If Prior Authorization is not obtained, or services, supplies or expenses are received or incurred beyond the scope of Prior Authorization given, the payable percentage will be the reduced percentage as shown in the “Schedule of Benefits” section of this Evidence of Coverage. Also, an additional Deductible may be applied to Covered Expenses as shown in the “Schedule of Benefits” section.

#### Resolution of Disputes

In the event that you or your Physician should disagree with any Prior Authorization decision made, the following dispute resolution procedure must be followed:

- Either you or your Physician may contact Mojave Crest Assurance Company to request an appeal of our decision. Refer to the “Grievance and Appeals Process” provision in the “General Provisions” section for more details. Additional information may be requested or the treating Physician may be consulted in any reconsideration. A written reconsideration decision will be provided; and
- If you still remain dissatisfied with the reconsideration decision following review by Mojave Crest Assurance Company, you may request an independent review or go through the binding arbitration remedy set forth in the “Independent Medical Review of Grievances Involving a Disputed Health Care Service” and “Binding Arbitration” provisions of the “General Provisions” section of this EOC.

## Maximum Allowable Amount (Maa) For Out-Of-Network Providers

When you receive care from an Out-of-Network Provider, your share of cost is based on the Maximum Allowable Amount. You are responsible for any applicable Deductible, Copayments or Coinsurance payment, and any amounts billed in excess of MAA. You are completely financially responsible for care that this Plan does not cover.

MAA may be less than the amount the provider bills for services and supplies. Mojave Crest Assurance Company calculates MAA as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as set forth below. MAA is not the amount that Mojave Crest Assurance Company pays for a covered service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this Evidence of Coverage.

- Maximum Allowable Amount for Covered Benefits and supplies, excluding Emergency Services and Care and outpatient pharmaceuticals, received from an Out-of-Network Provider is a percentage of what Medicare would pay, known as the Medicare Allowable Amount, as defined in this Evidence of Coverage.

For illustration purposes only, Out-of-Network Provider: 70% Mojave Crest Assurance Company Payment, 30% Member Coinsurance:

Out-of-Network Provider's billed charge for extended office visit.....\$128.00 MAA allowable for extended office visit (example only; does not mean

that MAA always equals this amount).....\$102.40 Your Coinsurance is 30% of MAA:  $30\% \times \$102.40$  (assumes Deductible

has already been satisfied) .....\$30.72 You also are responsible for the difference between the billed charge

(\$128.00) and the MAA amount (\$102.40) .....\$25.60 Total amount of \$128.00 charge that is your responsibility.....\$56.32

The Maximum Allowable Amount for facility services, including but not limited to Hospital, Skilled Nursing Facility, and outpatient surgery, is determined by applying 150% of the Medicare Allowable Amount.

Maximum Allowable Amount for Physician and all other types of services and supplies is the lesser of the billed charge or 100% of the Medicare Allowable Amount.

In the event there is no Medicare Allowable Amount for a billed service or supply code:

a. Maximum Allowable Amount for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by

gapfilling methodology shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Benefits provided; (2) the 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology (3) 100% of the Medicare Allowable Amount for the same Covered Benefits under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for covered services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.

#### Page 54 Maximum Allowable Amount (MAA) for Out-of-Network Providers

b. Maximum Allowable Amount for facility services shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Benefits provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare Allowable Amount for the same Covered Benefits under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for covered services.

- Maximum Allowable Amount for Out-of-Network Emergency Services Care will be the greatest of: (1) the median of the amounts negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method Mojave Crest Assurance Company generally uses to determine payments for Out-of-Network providers, excluding any in-network Deductible, Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance. Emergency Services Care from an Out-of-Network Provider is subject to the applicable Deductible, Copayment and/or Coinsurance at the Preferred Provider benefit level. You are not responsible for any amount that exceeds MAA for Emergency Services Care.
- Maximum Allowable Amount for nonemergent services at an in-network health facility, at which, or as a result of which, you receive nonemergent Covered Benefits by an Out-of-Network Provider, the nonemergent services provided by an Out-of-Network Provider will be payable at the greater of the average Contracted Rate or 125% of the amount Medicare reimburses on a fee-for service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and Mojave Crest Assurance Company.
- Maximum Allowable Amount for covered outpatient pharmaceuticals (including but not limited to injectable medications) dispensed and administered to the patient, in

an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.

The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Covered Benefits" and "Exclusions and Limitations" sections for specific benefit limitations, maximums, Prior Authorization requirements and payment policies that limit the amount Mojave Crest Assurance Company pays for certain covered services and supplies. Mojave Crest Assurance Company uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, Mojave Crest Assurance Company also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event Mojave Crest Assurance Company contracts with a Third Party Network that has a contract with the Out-of-Network Provider, Health Net may, at its option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount. Alternatively, we may, at our option, refer a claim for out-of-network services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In either of these two circumstances, you will not be responsible for the difference between billed charges and the Maximum Allowable Amount. You will

#### Maximum Allowable Amount (MAA) for Out-of-Network Providers Page 55

be responsible for any applicable Deductible, Copayment and/or Coinsurance at the out-of-network benefit level.

NOTE: When the Centers for Medicare and Medicaid Services (CMS) adjusts the Medicare Allowable Amount, Mojave Crest Assurance Company will adjust, without notice, the Maximum Allowable Amount based on the CMS schedule currently in effect. Claims payment will be determined according to the schedule in effect at the time the charges are incurred.

Claims payment will also never exceed the amount the Out-of-Network Provider charges for the service or supply. You should contact the Customer Contact Center if you wish to confirm the Covered Expenses for any treatment or procedure you are considering.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help you further understand your potential financial responsibilities for out-of-network services and supplies please log on to [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp) or contact Mojave Crest Assurance Company Customer Service at the number on your Member identification card.

## Covered Services And Supplies

This Plan covers services or supplies provided from the Effective Date of coverage through midnight of the effective date of cancellation, except as specified in the “Extension of Benefits” portion of the “Eligibility, Enrollment and Termination” section. A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

In order for a service or supply to be covered, it must be Medically Necessary as defined in the “Definitions” section. Any covered service may require a Deductible, Copayment, Coinsurance payment or have a benefit limit. Refer to the “Schedule of Benefits” section for details.

In addition, certain Covered Benefits listed herein are subject to Prior Authorization, in many instances, prior to the expenses being incurred. If Prior Authorization is not obtained, the available benefits will be subject to the nonauthorization penalty shown in the “Schedule of Benefits” section. Please refer to the “Prior Authorization Requirement” section for further details.

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY, OR MAKE IT A COVERED SERVICE.

This Plan only covers services or supplies that are specified as Covered Benefits in this Evidence of Coverage, unless coverage is required by state or federal law.

Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury are not covered. However, the Plan does cover Medically Necessary services or supplies for medical conditions directly related to non-Covered Benefits when complications exceed routine Follow-Up Care (such as Life-Threatening complications of cosmetic surgery).

Certain limitations may apply.

It is extremely important to read this section and the “Exclusions and Limitations” section before you obtain services in order to know what Mojave Crest Assurance Company will and will not cover.

### Medical Services and Supplies

Please refer to the “Schedule of Benefits” section of this Evidence of Coverage to determine the benefits and cost-sharing that apply under each benefit level.

#### Office Visits

Office visits for services by a Physician are covered. Also covered are office visits for services by other health care professionals.

#### Preventive Care Services

The coverage described below shall be consistent with the requirements of the Affordable Care Act (ACA).

#### Covered Services and Supplies Page 57

Preventive Care Services are covered for children and adults, as directed by your Physician, based on the guidelines from the following resources:

- U.S. Preventive Services Task Force (USPSTF) Grade A & B recommendations (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>)
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (<http://www.cdc.gov/vaccines/schedules/index.html>)
- Guidelines for infants, children and adolescents as supported by the Health Resources and Services Administration (HRSA). These recommendations are referred to as Bright Futures. ([https://downloads.aap.org/AAP/PDF/periodicity\\_schedule.pdf](https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf))
- Guidelines for women's preventive health care as supported by the Health Resources and Services Administration (HRSA) ([www.hrsa.gov/womensguidelines/](http://www.hrsa.gov/womensguidelines/))

Your Physician will evaluate your health status (including, but not limited to, your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The list of Preventive Care Services is available through [www.healthcare.gov/preventive-care-benefits/](http://www.healthcare.gov/preventive-care-benefits/). Examples of Preventive Care Services include, but are not limited to:

- Periodic health evaluations
- Preventive vision and hearing screenings
- Blood pressure, diabetes, and cholesterol tests
- U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA) recommended cancer screenings, including cervical cancer screening (including human papillomavirus (HPV) screening), screening and diagnosis of prostate cancer (including prostate specific antigen testing and digital rectal examinations), breast cancer screening (mammograms, including three-dimensional (3D) mammography, also known as digital breast tomosynthesis), I. Additional breast imaging (e.g., MRI, ultrasound) and pathology evaluation is covered if additional imaging is indicated to complete the screening process.
- Human Immunodeficiency Virus (HIV) testing and screening;
- Pre-Exposure Prophylaxis (PrEP) medications for the prevention of HIV infection including related medical services - baseline and follow-up testing and ongoing monitoring (e.g., HIV testing, kidney function testing, serologic testing for hepatitis B and C virus, testing for other sexually transmitted infections, pregnancy testing when appropriate and adherence counseling)
- Developmental screenings to diagnose and assess potential developmental delays

- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, treating depression, prevention of sexually transmitted diseases and reducing alcohol use
- Routine immunizations to prevent diseases and infections, as recommended by the ACIP (e.g., chickenpox, measles, polio, meningitis, mumps, flu, pneumonia, shingles, or HPV)
- Vaccination for Acquired Immune Deficiency Disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies

#### Page 58 Covered Services and Supplies

- Anxiety screening for children, adolescents, and adults
- Regular well-baby and well-child visits
- Well-woman visits

Preventive Care Services for women also include screening for gestational diabetes (diabetes in pregnancy); sexually-transmitted infection counseling; Human Immunodeficiency Virus (HIV) counseling; FDA-approved contraception methods for women and contraceptive counseling; breastfeeding support, supplies and counseling; screening and counseling for intimate partner and domestic violence.

One breast pump and the necessary supplies to operate it (as prescribed by your Physician) will be covered for each pregnancy at no cost through Preferred Providers to the Member. This includes one retail-grade breast pump (either a manual pump or a standard electric pump) as prescribed by your Physician. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. You can find out how to obtain a breast pump by calling the Customer Contact Center at the phone number on your Mojave Crest Assurance Company ID card or visit our website at [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp).

Preventive Care Services are covered as shown in the “Schedule of Benefits” section.

#### COVID-19 Outpatient Services

COVID-19 diagnostic and screening testing, therapeutics, and vaccinations are: • Covered in full when provided by a Participating Pharmacy or through a Preferred Provider; or

- Covered at the applicable Member cost share when provided by a Nonparticipating Pharmacy or Out-of-Network Provider.

Preventive Care Services received through a Participating Pharmacy or Preferred Provider are covered in full and the Calendar Year Deductible does not apply. Preventive Care Services received through a Nonparticipating Pharmacy or Out-of-

Network Provider are covered at the applicable Member cost share after the Calendar Year Deductible has been met.

The Member cost shares above apply to these listed services only.

#### Surgical Services

Services by a surgeon, assistant surgeon, anesthetist or anesthesiologist are covered. Mojave Crest Assurance Company uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement. Mojave Crest Assurance Company uses Medicare guidelines to determine the circumstances under which claims for assistant surgeon services and co-surgeon and team surgeon services will be eligible for reimbursement, in accordance with Mojave Crest Assurance Company's normal claims filing requirements.

When adjudicating claims for Covered Benefits for the postoperative global period for surgical procedures, Mojave Crest Assurance Company applies Medicare's global surgery periods to the American Medical Association defined Surgical Package. The Surgical Package includes typical postoperative care. These criteria include consideration of the time period for recovery following surgery and the need for any subsequent services or procedures which are part of routine postoperative care.

#### Covered Services and Supplies Page 59

When multiple procedures are performed at the same time, Covered Expenses include the Contracted Rate or Maximum Allowable Amount (as applicable) for the first (or major) procedure and one-half the Contracted Rate or Maximum Allowable Amount for each additional procedure. Mojave Crest Assurance Company uses Medicare guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with Mojave Crest Assurance Company's normal claims filing requirements. No benefit is payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

Mojave Crest Assurance Company uses available Medicare guidelines to determine which services and procedures are eligible for payment separately or as part of a bundled package, including but not limited to, which items are separate professional or technical components of services and procedures. Mojave Crest Assurance Company also uses proprietary guidelines to identify potential billing errors.

Prior Authorization may be required for surgical services. Please refer to the "Prior Authorization Requirement" section for details.

#### Gender Affirming Surgery

Medically Necessary gender affirming services, including, but not limited to, mental health evaluation and treatment, pre-surgical and post-surgical hormone therapy, fertility

preservation, speech therapy, and surgical services (such as hysterectomy, ovariectomy, orchiectomy, genital surgery, breast surgery, mastectomy, and other reconstructive surgery), for the treatment of gender dysphoria or gender identity disorder are covered. Services not Medically Necessary for the treatment of gender dysphoria or gender identity disorder are not covered. Surgical services must be performed by a qualified provider in conjunction with gender affirming surgery or a documented gender affirming surgery treatment plan.

Reasonable travel, lodging and meal costs, as determined by Mojave Crest Assurance Company, for a Member to undergo an authorized gender affirming surgery are covered limited to a lifetime maximum of \$75,000. Travel and lodging are only available for the patient (companion not covered).

If you live 50 miles or more from the nearest authorized gender affirming surgery facility, you are eligible to receive travel expense reimbursement, including clinical work-up, diagnostic testing and preparatory procedures, when necessary for the safety of the Member and for the prior approved gender affirming surgery. All requests for travel expense reimbursement must be prior approved by Mojave Crest Assurance Company.

Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Member to and from the gender affirming surgery facility up to \$130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit).
- Hotel accommodations for the Member not to exceed \$100 per day for the pre-surgical work-up, pre surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed \$25 per day, up to two (2) days per trip for the pre-surgical work-up, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

The following items are specifically excluded and will not be reimbursed:

- Expenses for tobacco, alcohol, telephone, television, and recreation are specifically excluded.

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- Submission of adequate documentation including receipts is required to receive travel expense reimbursement from Mojave Crest Assurance Company.
- Certain services require Prior Authorization. Please refer to the "Prior Authorization Requirement" section for details.

#### Laboratory and Diagnostic Imaging (including X-ray) Services

Laboratory and diagnostic imaging (including x-ray) services and materials are covered as Medically Necessary.

Payment of benefits will be reduced as set forth in this EOC if Prior Authorization is not obtained for certain services. Please refer to the "Prior Authorization Requirement" section of this Evidence of Coverage for details.

#### Genetic Testing and Diagnostic Procedures

Genetic testing is covered when determined by Mojave Crest Assurance Company to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Biomarker testing is covered when determined by Mojave Crest Assurance Company to be Medically Necessary, including for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment decisions. However, Prior Authorization is not required for biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer.

Genetic testing will not be covered for nonmedical reasons or when a Member has no medical indication. For information regarding genetic testing and diagnostic procedures of a fetus, see the "Pregnancy" portion of the "Covered Services and Supplies" section.

#### Home Visit

Visits by a Physician to a Member's home are covered at the Physician's discretion in accordance with the rules and criteria set by Mojave Crest Assurance Company, and if the Physician concludes that the visit is medically and otherwise reasonably indicated.

#### Rehabilitation Therapy

Rehabilitation therapy services (physical, speech and occupational therapy) are covered when Medically Necessary, except under "Therapies" in the "Exclusions and Limitations" section.

Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a Plan contracted Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of their license, to treat physical conditions and Mental Health or Substance Use Disorders, or a Qualified Autism Service (QAS) Provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism. Coverage is subject to any required authorization from the Plan or the Member's Physician Group. The services must be based on a treatment plan authorized, as required by the Plan or the Member's Physician Group. Such services are not covered when medical documentation does not support the medical necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals. See the "General Provisions" section for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of medical necessity.

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Rehabilitation and habilitation therapy for physical impairments in Members with Mental Health or Substance Use Disorders, including pervasive developmental disorder and

autism that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation or habilitation therapy are met.

Aquatic therapy and other water therapy are not covered, except for aquatic therapy and other water therapy services that are part of a physical therapy treatment plan.

This Plan covers massage therapy only when such services are part of a physical therapy treatment plan. The services must be based on a treatment plan authorized, as required by Mojave Crest Assurance Company or your Physician Group.

Payment of benefits will be reduced as set forth in this EOC if Prior Authorization is not obtained. Please refer to the "Prior Authorization Requirement" section of this Evidence of Coverage for details.

#### Habilitative Services

Coverage for habilitative services and/or therapy is limited to Health Care Services and devices that help a person keep, learn, or improve skills and functioning for daily living, when provided by a Member Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of their license, to treat physical and mental health conditions, subject to any required Prior Authorization from Mojave Crest Assurance Company. The services must be based on a treatment plan authorized, as required by Mojave Crest Assurance Company and address the skills and abilities needed for functioning in interaction with an individual's environment.

Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under this Evidence of Coverage.

#### Cardiac Rehabilitation Therapy

Rehabilitation therapy services provided in connection with the treatment of heart disease is covered when Medically Necessary.

#### Pulmonary Rehabilitation Therapy

Rehabilitation therapy services provided in connection with the treatment of chronic respiratory impairment is covered when Medically Necessary.

#### Approved Clinical Trials

Routine patient care costs for items and services furnished in connection with participating in an Approved Clinical Trial are covered when Medically Necessary, authorized by Mojave Crest Assurance Company, and either the Member's treating Physician has recommended participation in the trial or the Member has provided medical and scientific information establishing eligibility for the Clinical Trial. Clinical Trial services performed by non-Participating Providers are covered only when the protocol

for the trial is not available through a Participating Provider within Nevada. Services rendered as part of a

Approved Clinical Trial may be provided by a Non-participating or Participating Provider subject to the reimbursement guidelines as specified in the law.

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“Life threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

“Routine patient care costs” are the costs associated with the requirements of Mojave Crest Assurance Company, including drugs, items, devices and services that would normally be covered under this Evidence of Coverage, if they were not provided in connection with an Approved clinical Trials program.

Please refer to “Independent Medical Review of Investigational or Experimental Therapies,” in the “General Provisions” section, as well as the “Medical Services and Supplies” portion of the “Covered Services and Supplies” section for additional information.

Please refer to the “Services and Supplies” portion of the “Exclusions and Limitations” section for more information.

#### Routine Physical Examinations

One routine physical examination (including psychological examinations or drug screening) per Calendar Year, requested by the Member without medical condition indications is covered. However, filling out forms related to the physical exam is not covered.

A routine examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking a Member’s general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp or sports organization.

Please refer to “Annual routine physical examination” in the “Schedule of Benefits” section for Copayment requirements. See “Preventive Care Services” in this “Covered Services and Supplies” section for information about coverage of examinations that are for preventive health purposes.

#### Routine Foot Care

Routine foot care including callus treatment, corn paring or excision, toenail trimming, massage of any type and treatment for fallen arches, flat or pronated feet are covered only when Medically Necessary for a diabetic condition or peripheral vascular disease. Additionally, treatment for cramping the feet, bunions and muscle trauma are covered only when Medically Necessary.

## Pregnancy

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures, alpha-fetoprotein testing and genetic testing of the fetus are also covered. Prenatal diagnostic procedures include services provided by the Nevada Prenatal Screening Program administered by the Nevada Department of Public Health and are covered at no cost to the Members. The Nevada Prenatal Screening Program is a statewide program offered by prenatal care providers to all pregnant individuals in Nevada. Prenatal screening uses a pregnant individual's blood samples to screen for certain birth defects in their fetus. Prenatal screenings must be performed at or through a PNS-contracted lab. Individuals with a fetus found to have an increased chance of one of those birth defects are offered genetic counseling and other follow-up services through state-contracted Prenatal Diagnosis Centers.

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Please refer to the "Schedule of Benefits" section, under the headings "Care for Conditions of Pregnancy" and "Inpatient Hospital Services" for Copayment and Coinsurance requirements.

Termination of pregnancy and related services, including initial consultation, diagnostic services and follow up care, are covered at no cost to the Member. Travel allowances for Members outside Nevada may be available; call the Customer Contact Center at the telephone number on your Mojave Crest Assurance Company ID card for additional information.

Coverage for pregnancy includes at least one Maternal Mental Health screening during pregnancy and another within the first six weeks postpartum. Additional screenings will be provided if your provider determines they are Medically Necessary.

As an alternative to a Hospital setting, birthing center services are covered when authorized by Health Net and provided by a Preferred Provider. A birthing center is a homelike facility accredited by the Commission for Accreditation of Birth Centers (CABC) that is equipped, staffed and operated to provide maternity-related care, including prenatal, labor, delivery and postpartum care. Services provided by other than a CABC-accredited designated center will not be covered.

A birth which takes place at home will only be covered when the criteria for Emergency Services and Care, as defined in this Evidence of Coverage, have been met.

Preventive services for pregnancy, as listed in the U.S. Preventive Services Task Force A&B recommendations and Health Resources and Services Administration's ("HRSA") Women's Preventive Service are covered as Preventive Care Services.

Mojave Crest Assurance Company offers a doula program for Members who are pregnant or were pregnant in the past year. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and nonmedical support for pregnant and

postpartum persons before, during, and after childbirth, including support for miscarriage, stillbirth, and termination of pregnancy. For more information, you can call the Customer Contact Center telephone number listed on your Mojave Crest Assurance Company ID card[ or visit our website at [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp).

When you give birth to a child in a Hospital, you are entitled to coverage of at least 48 hours of care following a vaginal delivery or at least 96 hours following a cesarean section delivery.

Your Physician will not be required to obtain Prior Authorization for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the Hospital and scheduled or elective cesarean sections will require Prior Authorization. Please notify Mojave Crest Assurance Company upon confirmation of pregnancy.

You may be discharged earlier only if you and your Physician agree to it.

If you are discharged earlier, your Physician may decide, at their discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed Health Care Provider whose scope of practice includes postpartum care and newborn care. Your Physician will not be required to obtain Prior Authorization for this visit.

The coverage described above meets requirements for Hospital length of stay under the Newborns' and Mothers' Health Protection Act of 1996, which states:

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However,

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federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Donor human milk is an alternative to breastfeeding or formula for infants and is of particular benefit to pre-term infants. Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank is covered. See "Prostheses" in the "Schedule of Benefits" section for Copayment or Coinsurance requirements.

#### Medical Social Services

Hospital discharge planning and social service counseling are covered. In some instances, a medical social service worker may refer you to providers or agencies for additional services. These services are covered only if not otherwise excluded under this Plan.

## Home Health Care Services

The services of a Home Health Care Agency in the Member's home are covered when provided by a registered nurse or licensed vocational nurse and/or licensed physical, occupational, speech therapist or respiratory therapist. These services are in the form of visits that may include, but are not limited to, skilled nursing services, medical social services, rehabilitation therapy (including physical, speech and occupational), pulmonary rehabilitation therapy and cardiac rehabilitation therapy.

Home Health Care Services must be ordered by your Physician, approved by Mojave Crest Assurance Company and provided under a treatment plan describing the length, type and frequency of the visits to be provided. The following conditions must be met in order to receive Home Health Care Services:

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Member is homebound because of illness or injury (this means that the Member is normally unable to leave home unassisted, and, when the Member does leave home, it must be to obtain medical care, or for short, infrequent nonmedical reasons such as a trip to get a haircut, or to attend religious services or adult day care);
- The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 4 hours in duration in every 24 hours; and
- The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Member's home.

Additionally, Home Infusion Therapy is also covered. A provider of infusion therapy must be a licensed pharmacy. Home nursing services are also provided to ensure proper patient education, training, and monitoring of the administration of prescribed home treatments. Home treatments may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. The patient does not need to be homebound to be eligible to receive Home Infusion Therapy. See the "Definitions" section.

Custodial Care services and Private Duty Nursing, as described in the "Definitions" section and any other types of services primarily for the comfort or convenience of the Member, are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include

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Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift care services) is not a Covered Benefit under this Plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See the "Definitions" section.

Payment of benefits will be subject to the nonauthorization penalty shown in the "Schedule of Benefits" section if Prior Authorization is not obtained for home-based physical, speech or occupational therapy.

## Outpatient Infusion Therapy

Outpatient infusion therapy used to administer covered drugs and other substances by injection or aerosol is covered when appropriate for the Member's illness, injury or condition and will be covered for the number of days necessary to treat the illness, injury or condition.

Infusion therapy includes: Total Parenteral Nutrition (TPN) (nutrition delivered through the vein); injected or intravenous antibiotic therapy; chemotherapy; injected or intravenous Pain management; intravenous hydration (substances given through the vein to maintain the patient's fluid and electrolyte balance, or to provide access to the vein); aerosol therapy (delivery of drugs or other Medically Necessary substances through an aerosol mist); and tocolytic therapy to stop premature labor.

Covered Benefits include professional services (including clinical pharmaceutical support) to order, prepare, compound, dispense, deliver, administer or monitor covered drugs or other covered substances used in infusion therapy.

Covered supplies include injectable Prescription Drugs or other substances which are approved by the Nevada Department of Public Health or the Food and Drug Administration for general use by the public. Other Medically Necessary supplies and Durable Medical Equipment necessary for infusion of covered drugs or substances are covered.

All services must be billed and performed by a provider licensed by the state. Up to a 30-day supply will be dispensed per delivery.

Infusion therapy benefits will not be covered in connection with the following:

- Infusion medication administered in an outpatient Hospital setting that can be administered in the home or a non-Hospital infusion suite setting;
- Nonprescription drugs or medications;
- Any drug labeled "Caution, limited by federal law to investigational use" or Investigational drugs not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;
- FDA-approved drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except for non-investigational FDA-approved drugs used for off-label indications when the conditions of state law have been met);
- Growth hormone treatment; or
- Supplies used by a Health Care Provider that are incidental to the administration of infusion therapy, including but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Payment of benefits will be reduced as set forth in this EOC if Prior Authorization is not obtained for certain services.

Certain drugs that are administered as part of outpatient infusion therapy require Prior Authorization. Refer to the Mojave Crest Assurance Company website, [www.mojavecrest.com/psbp](http://www.mojavecrest.com/psbp), for a list of services and infused drugs that require Prior Authorization.

#### Ambulance Services

All air and ground ambulance, and ambulance transport services provided as a result of a "911" emergency response system request for assistance will be covered when the criteria for Emergency Services and Care, as defined in this Evidence of Coverage, have been met.

Covered Benefits provided by an out-of-network ground or air ambulance provider will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount).

Paramedic, ambulance, or ambulance transport services are not covered in the following situations:

- If Mojave Crest Assurance Company determines that the ambulance or ambulance transport services were never performed; or
- If Mojave Crest Assurance Company determines that the criteria for Emergency Services and Care were not met, unless authorized by your Physician Group; or
- Upon findings of fraud, incorrect billings, that the provision of services that were not covered under the Plan, or that membership was invalid at the time services were delivered for the pending emergency claim.

Ambulance services that do not meet the criteria for Emergency Services and Care may require Prior Authorization. Please refer to the "Prior Authorization Requirement" section for more information.

Nonemergency ambulance services and psychiatric transport van services are covered when Medically Necessary and when your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide when the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Benefits.

Payment of benefits will be reduced as set forth in this EOC if Prior Authorization is not obtained for certain services.

#### Hospice Care

Hospice Care is available for Members diagnosed as terminally ill by a Physician. To be considered terminally ill, a Member must have been given a medical prognosis of one year or less to live.

Hospice Care includes Physician services, counseling, medications, other necessary services and supplies, and homemaker services. The Physician will develop a plan of care for a Member who elects Hospice Care.

In addition, up to five consecutive days of inpatient care for the Member may be authorized to provide relief for relatives or others caring for the Member.

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Payment of benefits will be subject to the nonauthorization penalty shown in the "Schedule of Benefits" section if Prior Authorization is not obtained for the care.

#### Durable Medical Equipment

Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches, standard curved handle or quad cane and supplies, dry pressure pad for a mattress, compression burn garments, IV pole, tracheostomy tube and supplies, enteral pump and supplies, bone stimulator, cervical traction (over door), phototherapy blankets for treatment of jaundice in newborns, bracing, supports, casts, nebulizers (including face masks and tubing), inhaler spacers, peak flow meters and Hospital beds, is covered. Durable Medical Equipment also includes Orthotics (such as bracing, supports and casts) that are custom made for the Member.

Equipment and medical supplies required for home hemodialysis and home peritoneal dialysis are covered after you receive appropriate training at a dialysis facility approved by Mojave Crest Assurance Company. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs.

Corrective Footwear (including specialized shoes, arch supports, and inserts) is covered when Medically Necessary and custom made for the Member.

Corrective Footwear for the management and treatment of diabetes-related medical conditions is covered under the "Diabetic Equipment" benefit as Medically Necessary.

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Mojave Crest Assurance Company will decide whether to repair or replace an item. Mojave Crest Assurance Company will also determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

In assessing Medical Necessity for Durable Medical Equipment (DME) coverage, Mojave Crest Assurance Company applies nationally recognized DME coverage guidelines such as those defined by InterQual (McKesson) and the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD).

Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for nonmedical use. Nebulizers (including face

masks and tubing), inhaler spacers, peak flow meters and Orthotics are not subject to such quantity limits.

This Plan does not cover the following items:

- Appliances or devices for comfort or convenience; or luxury equipment or features.
- Alteration of your residence to accommodate your physical or medical condition, including the installation of elevators.
- Air purifiers, air conditioners and humidifiers.
- Exercise equipment.
- Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
- Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools.

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- Orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Support appliances such as stockings, except as described in the “Prostheses” provision of the “Covered Services and Supplies” section, and over-the-counter support devices or Orthotics.
- Devices or Orthotics for improving athletic performance or sports-related activities. • Orthotics and Corrective Footwear, except as described above.
- Other Orthotics, including Corrective Footwear, not mentioned above, unless Medically Necessary and custom made for the Member. Corrective Footwear must also be permanently attached to an Orthotic device that meets coverage requirements under this Plan.

Prior Authorization may be required. Please refer to the “Prior Authorization Requirement” section for details.

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered as Preventive Care Services. For additional information, please refer to the “Preventive Care Services” provision in this “Covered Services and Supplies” section.

When applicable, coverage includes fitting and adjustment of covered equipment or devices.

#### Diabetic Equipment

Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including:

- Insulin pumps and all related necessary supplies
- Corrective Footwear to prevent or treat diabetes-related complications

- Specific brands of blood glucose monitors and blood glucose testing strips\* • Blood glucose monitors designed to assist the visually impaired
- Ketone urine testing strips\*
- Lancets and lancet puncture devices\*

Additionally, the following supplies are covered under the medical benefit as specified:

- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the “Prostheses” portion of this section).
- Glucagon is provided through the self-injectables benefit (see the “Immunizations and Injections” portion of this section).