HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Health Plan of Nevada, Inc. has been awarded an accreditation status of Accredited from the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to measuring the quality of America's health care. Accreditation is for the Commercial HMO and Commercial POS product lines in Nevada.

PATRICIA D TOWLER
NV

PLAN BENEFIT INFORMATION

PUBLIC EMPLOYEES' BENEFITS PROGRAM
10000330 A001
04232024

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card or plan documents.
You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201
We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card or plan documents.

English:
You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card or plan documents.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card or plan documents.

Español (Spanish)
Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan o los documentos de su plan.

Tagalog (Tagalog)
May karapatan kang makakuha ng tulong at impormasyon sa sinasalita mong wika nang libre. Upang humiling ng interpreter, tawagan ang toll-free na numero ng telepono para sa miyembro na nakalista sa iyong ID card sa planong pangkalusugan o sa mga dokumento ng plano.

繁體中文 (Chinese)
您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡或計劃文件上的免付費會員電話號碼。

한국어 (Korean)
귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드 혹은 플랜 문서에 기재된 무료 회원 전화번호로 **전화하십시오.**

Tiếng Việt (Vietnamese)
Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID hoặc trên các tài liệu chương trình bảo hiểm y tế của quý vị.

አማርኛ (Amharic)
በምትፈልጉት ቋንቋ እርዳታና መረጃ የማግኘት መብት አለዎት። አስተርጓሚ ለመጠየቅ፣ በጤና ካርድዎ ወይም የጤና ሰነዶች የተዘረዘረውን የማያስከፍል ቴሌፎን ይደውሉ። ጥያቄዎች ካሉዎት፣ አባክዎ ያስታውቁኝ። አመሰግናለሁ! አናሂ

ภาษาไทย (Thai)
คุณมีสิทธิ์ขอความช่วยเหลือหรือขอข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายใด ๆ เมื่อต้องการล่าม กรุณาโทรฟรีมาที่หมายเลขโทรศัพท์สำหรับสมาชิกที่อยู่บนบัตรแผนสุขภาพหรือเอกสารแผนสุขภาพของคุณ

日本語 (Japanese)
ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードまたはプランの資料に記載されているメンバー用のフリーダイヤルまでお電話ください。

العربيـــــة (Arabic)
لديك الحق في الحصول على المساعدة والمعلومات بلغتك وبدون تكلفة. لطلب مترجم، اتصل بالرقم المجاني المدرج على بطاقة عضويتك في البرنامج الصحي أو وثائق البرنامج.

Русский (Russian)
Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты или документах о вашем плане.

Français (French)
Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé ou dans la documentation relative à votre régime.

فارسی **(Persian)**
ی‌بـرا .دی‌کـن افـتـی‌در گـان‌ی‌را صـورت بـه خودتـان زبـان بـه را اطلاعات و یـی‌راهنما تـا دی‌هست بـرخوردار حق ن‌ی‌ا از شما طرحتـان بـه مـربوط اسـناد ای سـلامت طرح یـی‌شناسـا کـارت در موجود گـان‌ی‌را تلفـن شماره بـا ،ی‌شـفاه مـترجم درخواست دی‌ری‌بـگ تمـاس.

Gagana fa'a Sāmoa (Samoan)
E iai lau aia tatau e maua ai faamatalaga i lau gagana e aunoa ma se totogi. Ina ia talosaga mo se tasi e faaliliu, telefoni mai le numera o le telefoni e le totogia o lisi atu i lau pepa ID o le peleni tausoifua maloloina poo pepa mo le peleni.

Deutsch (German)
Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte oder in den Versicherungspapieren.

Ilokano (Ilocano)
Addaan ka ti karbengan a maala iti daytoy nga tulong ken impormasion para ti lenguahem nga awan ti bayadna. Tapno agkiddaw iti maysa nga tagapataros, awagan iti toll-free nga numero ti telepono para kadagiti kameng nga nakalista ayan iti ID card mo para ti plano iti salun-at mo wenno ayan dagiti dokumento ti planom.

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HEALTH PLAN OF NEVADA
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Reference Guide

Thank you for being our member. We're experienced, dedicated and here for you.

Enclosed is your health plan benefit packet. It includes your evidence of coverage, benefit schedule, and applicable riders and endorsements. These documents explain your benefits in detail. They also outline the health plan's obligations to you. We encourage you to read all materials carefully, because the more you know about us, the better we can serve you.

Keep track of your health plan information the easy way - together in one place.

The MyHPN app makes it easy to manage and access your important health insurance information on the go. Use this convenient service to:

- Find out who is on record as your primary care provider (PCP).
- Talk with an advice nurse 24/7.
- Access virtual visits 24/7. No appointment needed.
- Search for a doctor, specialist, facility or lab.
- View and email your health plan ID card.
- Save your health plan ID card to your Apple wallet.
- See your copay, deductible, and out-of-pocket expenses, if applicable.
- Check the status of a claim, prior authorization or referral.
- Access your health records.
- Update your contact information and address.
- Save your password with Touch ID or Face ID.

To get started, search for **MyHPN** in your app store. Download the app and sign in with your Optum ID. First-time users will need to create an account. We use Optum ID to help protect the security of your personal information. Your personal medical information is confidential and is only available to you and your provider.

Visit **HealthPlanofNevada.com** and sign in to our online member center to access your plan documents, select or change your primary care provider (PCP), pay your premium (if applicable), watch health education videos and more.

How to reach us:

Mobile App
Get the **MyHPN** app.

Online Member Center
Visit **HealthPlanofNevada.com** and sign in.

Walk-In Customer Service
2720 N. Tenaya Way, Las Vegas, NV 89128

Member Services
Call toll-free **1-800-777-1840**, TTY **711**,
Monday through Friday, 8 a.m. to 5 p.m.

HPN Claims
P.O. Box 15645
Las Vegas, NV 89114-5645

24/7 Advice Nurse
Call toll-free **1-800-288-2264**, TTY **711**.

24/7 Virtual Visits
Visit **NowClinic.com** or get the NowClinic app.

Health Education and Wellness
Call toll-free **1-800-720-7253**, TTY **711**,
Monday through Friday, 8 a.m. to 5 p.m.

Behavioral Healthcare Options
Visit **bhoptions.com** or call toll-free **1-800-873-2246**, TTY **711**,
Monday through Friday, 8 a.m. to 5 p.m.

Southwest Medical
Visit **smalv.com** or call **702-877-5199.**

Health Plan of Nevada
A UnitedHealthcare Company

P.O. Box 15645 • Las Vegas, Nevada 89114-5645

Notice to Members

This is to provide notice as required under recent federal law

(the Women´s Health and Cancer Rights Act, effective October 21, 1998).

Under this health plan, coverage will be provided to a member who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

1. reconstruction of the breast on which a mastectomy has been performed;

2. surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. prostheses; and

4. treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the covered patient, and will be subject to the same terms and conditions of your evidence of coverage, including any required copayments, annual deductibles or coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of
mastectomies and corresponding reconstructive
surgery, please contact the Member Services number on the back of your ID card.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call **toll-free 1-800-777-1840**, TTY 711. We are available Monday through Friday, 8 a.m. to 5 p.m. PT.

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-777-1840 (TTY: 711)

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-777-1840 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-777-1840 (TTY: 711).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-777-1840（TTY：711）。

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-777-1840 (TTY: 711)번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-777-1840 (TTY: 711).

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-777-1840 (መስማት ለተሳናቸው: 711).

ภาษาไทย (Thai)
เรียน: ถาคุณพดู ภาษาไทยคุณสามารถใชบ้ รกิ ารชว่ยเหลอืทางภาษาไดฟ้ รี โทร 1-800-777-1840 (TTY: 711).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-777-1840（TTY:711）まで、お電話にてご連絡ください。

العربية (Arabic)

مقر بلصنا .نامجلما بلطا رفاوتت ةيوغللا تدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ: ظوحلم **1-800-777-1840**
(رقم هاتف الصم والبكم: 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-777-1840 (телетайп: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-777-1840 (ATS : 711).

Persian
توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-800-777-1840 تماس بگیرید.(TTY: 711)

Gagana fa'a Sāmoa (Samoan)
MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-777-1840 (TTY: 711)

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-777-1840 (TTY: 711).

Ilokano (Ilocano)
PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-777-1840 (TTY: 711).

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-800-777-1840 (TTY: 711).

ધ્યાન આપો: જો તમે ગુજરાતી **(Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.
કૃપા કરી 1-800-777-1840 પર કોલ કરો.

Notice of Non-Discrimination

We[1] do not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call **toll-free 1-800-777-1840**, TTY 711. We are available Monday through Friday, 8 a.m. to 5 p.m. PT.

You can also file a complaint with the U.S. Dept. of Health and Human services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "We" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Medical Information Privacy Notice

Effective January 1, 2024

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, **HealthPlanofNevada.com**. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees’ information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or

wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with,

state workers compensation laws that govern job-related injuries or illness.

- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary
  (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any

time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

  You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your website, **HealthPlanofNevada.com**.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, **please call the toll-free member phone number on your health plan ID card or you may contact Member Services at 1-800-777-1840 (TTY 711).**
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  Health Plan of Nevada
  Member Services – Privacy Unit
  P.O. Box 15645
  Las Vegas, NV 89114-5645

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD – Individual Practice Association, Inc.; Medica Health Plans of Florida, Inc.; Medica Healthcare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Peoples Health, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Financial Information Privacy Notice

THIS NOTICE SAYS HOW YOUR FINANCIAL INFORMATION MAY BE USED AND SHARED. REVIEW IT CAREFULLY.

Effective January 1, 2024

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please **call the toll-free member phone number on your plan ID card** or call Member Services at **1-800-777-1840 (TTY/RTT 711)**.

The full Notices of Privacy Practices are posted on your plan website, **HealthPlanofNevada.com**.

[3] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the sixth page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Health Allies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women's and Children's Health, LLC; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. The Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice.

NOTICE OF PROTECTION PROVIDED BY NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Effective On or Before July 1, 2022

This notice provides a **brief summary** regarding the protections provided to policyholders by the Nevada Life and Health Insurance Guaranty Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies and health maintenance organizations licensed in Nevada to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is limited and is *not* a substitute for consumers' care in selecting insurers. **Your policy or contract may not be covered, and if covered, there are substantial coverage limitations and exclusions. Further, coverage is dependent on continued residence in Nevada.** Below is a brief summary of the coverages, exclusions, and limits provided by the Association. This summary does not cover all provisions of the law, and the law may change.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in Nevada at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in Nevada.

Amounts of Coverage

For any one life, per company, the coverage protections provided by the Association shall not exceed:

- **Life Insurance**
  - Death benefits: $300,000
  - Cash surrender or withdrawal values: $100,000

- **Annuities and Structured Settlement Annuities**
  - Present value of annuity benefits and structured settlement annuities, including cash surrenders or withdrawal values: $250,000
  - Participants in a government retirement plan covered by an unallocated annuity as described by NRS 686.C.035: $250,000.

- **Health Insurance**
  - Disability Income and long-term care insurance, including net cash surrender values: $300,000
  - Health Benefit Plan: $500,000
  - Health insurance, other than disability income, long-term care insurance or Health Benefit Plan: $100,000

Please note that the maximum protection provided by the Association to an individual for all life insurance, annuities, and structured settlement annuities with one insurer is $300,000; or for all life insurance, annuities, structured settlement annuities, and benefits for health benefit plans with one insurer, $500,000, regardless of the number of policies or contracts covering the individual.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The following policies and persons are examples of those excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Nevada when it issued the policy or contract
- A policy or contract issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or an organization that is only licensed to issue charitable gift annuities
- Persons provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual except for annuities owned by a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields exceed an average rate

NOTICES

Member insurers or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. The member insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance or coverage offered by a health maintenance organization. You may file a complaint with the Nevada Insurance Commissioner if you believe any provision of the Nevada Life and Health Insurance Guarantee Association law has been violated. To learn more about coverage provided by the Association, please visit the Association's website at www.nvlifega.org, or contact either of the following:

Nevada Life and Health Insurance
Guaranty Association
2377 Gold Meadow Way, Suite 100
Gold River, CA 95670

Nevada Division Insurance
Department of Business and Industry
1818 E. College Pkwy., Suite 103
Carson City, NV 89706

When selecting an insurer, you should not rely on Association coverage. If there is any inconsistency between this notice and Nevada law, Nevada law will control.

PREVENTIVE HEALTH CARE GUIDELINES

These guidelines are based on the recommendations by the United States Preventive Services Task Force (USPSTF), the Centers for Disease Control and Prevention (CDC), the American Academy of Family Practitioners (AAFP), and the American Academy of Pediatrics (AAP)/Bright Futures.

Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life
A UnitedHealthcare Company

Introduction

Health Plan of Nevada and Sierra Health and Life suggest that health plan members get certain screening tests, exams and shots to stay healthy. This document gives our health plan members and doctors in the health plan's network guidelines about when and how often to get preventive care. This advice is not designed to take the place of your doctor's judgement about your own health care needs.

Please talk with your doctor about any questions or concerns. Your doctor may make changes to these guidelines based on your own needs. Please refer to your health plan's Evidence of Coverage and plan documents for details about the coverage and costs to you for these preventive services.

Section 1: General Preventive Screening Tests and Exams for Children, Teens and Adults

Item	Gender		Adults	Newborns, Children and/or Teens	Comments About Screening Test, Counseling, Exam or Shot
	Male	Female			
Abdominal Aortic Aneurysm Screening Test	X	N/A	X	Adults only	This screening test is a one-time test for men between the ages of 65-75 years old who have smoked even if there are no symptoms.
Alcohol Abuse: Screening and Behavioral Counseling Intervention in Primary Care to Reduce Unhealthy Alcohol Use in Adults	X	X	X	Adults only	Screening for adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling to reduce alcohol misuse.
Autism Screening	X	X	N/A	X	A formal, standardized developmental screen is recommended during the 9 month and 30-month visit. A formal, standardized developmental screen is recommended during the 18-month visit, including formal autism screen. A formal, standardized autism screen is recommended during the 24-month visit.
Bacteriuria Screening	N/A	X	X	Adults only	Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12-16 weeks gestation or at the first prenatal visit, if later.
Breast Cancer Screening - Mammogram	N/A	X	X	Adults only	Screening is recommended every 2 years for women who are 50-74 years old and are at average risk for breast cancer. Women who are 40 to 49 years old should talk to their doctor about when to start and how often to get a mammogram.
Breast Genetic Counseling and Evaluation for BRCA Testing	N/A	X	X	Adults only	This screening is for women who have a family member with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

Item	Gender		Adults	Newborns, Children and/or Teens	Comments About Screening Test, Counseling, Exam or Shot
	Male	Female			
Breast Cancer - Chemoprevention	N/A	X	X	Adults only	USPSTF recommends that clinicians offer to prescribe risk-reducing medications to women who are at increased risk for breast cancer and at low risk for adverse medication effects.
Behavioral Counseling in Primary Care to Promote a Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Risk Factors	X	X	X	Adults only	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.
Cervical Cancer Screening - Pap Smear	N/A	X	X	Adults only	A cervical cancer screening is recommended for average risk women aged 21-65 years. For women aged 21-29 years, a cervical cancer screening using cervical cytology (Pap smear) is recommended every 3 years. Women aged 30-65 years should be screened with cytology and human papillomavirus testing every 5 years or cervical cytology alone every 3 years.
Chlamydia Infection Screening	N/A	X	X	X	This screening test is for all sexually active non-pregnant women aged 24 years and younger and older women at increased risk for infection. This applies to all sexually active adolescents and adult women, including pregnant women. Bright Futures recommends sexually transmitted infection screening be conducted if risk assessment is positive between ages 11-21 years.
Cholesterol Screening - Lipid Disorders Screening	X	X	X	Adults only	The USPSTF recommends that this screening test is for all adults without a history of cardiovascular disease (CVD) (i.e. symptomatic coronary artery disease or ischemic stroke) use a low to moderate dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1. They are aged 40-75 years; 2. They have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension or smoking); 3. They have a calculated 10 year risk of a cardiovascular event of 10% or greater.

Item	Gender		Adults	Newborns, Children and/or Teens	Comments About Screening Test, Counseling, Exam or Shot
	Male	Female			
					Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults aged 40-75 years. See Dyslipidemia Screening (Pediatric) for recommendations for children.
Colorectal Cancer Screening: Fecal Occult Blood Test (FOBT), Fecal ImmunochemicalTest (FIT), Sigmoidoscopy and Colonoscopy	X	X	X	Adults only	USPSTF recommends screening starting at age 45 years and continuing until age 75 years.
Contraceptive Methods (Including Sterilizations)	N/A	X	X	X	Adolescent and adult women have access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes. Contraceptive care should include contraceptive counseling, initiation of contraception use and follow-up care (e.g. management and evaluation as well as change of and removal or discontinuation of contraceptive method). The Women's Preventive Services Initiative recommends that the full range of U.S. Food and Drug Administration (FDA) approved contraceptive methods, effective family planning practices and sterilization procedures be available as part of contraceptive care. Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method.
Depression in Adults - Screening	X	X	X	Adults only	This screening is for the general adult population including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

Item	Gender		Adults	Newborns, Children and/or Teens	Comments About Screening Test, Counseling, Exam or Shot
	Male	Female			
Depression in Children and Adolescents - Screening	X	X	N/A	X	This screening is for adolescents between the ages of 12-18 years for major depressive disorder (MDD). Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Bright Futures Periodicity Schedule recommends depression screening begins at age 12.
Diabetes Screening	X	X	X	Adults only	The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions. USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
Dyslipidemia Screening - Pediatric	X	X	N/A	X	For children and adolescents 20 years or younger: The USPSTF found that the current evidence is insufficient to assess the balance of benefits and harms of screening for lipid disorders.
Fluoride Application in Primary Care	X	X	N/A	X	Recommended for children from birth through age 5 years. It is recommended that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. For high-risk children, consider application of fluoride varnish for caries prevention every 3-6 months between ages 6 months to 5 years.
Gonorrhea Screening	N/A	X	X	X	USPSTF recommends screening for gonorrhea in sexually active women aged 24 years and younger and in older women who are at increased risk for infection. Bright Futures recommends sexually transmitted infection screening be conducted if risk assessment is positive between ages 11-21 years.

Item	Gender		Adults	Newborns, Children and/or Teens	Comments About Screening Test, Counseling, Exam or Shot
	Male	Female			
Hearing Screening - Pediatric	X	X	N/A	X	Bright Futures recommends hearing screening at ages: newborn between 3-5 days old to 2 months old, 4 years, 5 years, 6 years, 8 years, 10 years, once between ages 11-14 years, once between ages 15-17 years and once between ages 18-21 years. Screening is also recommended for those that have a positive risk assessment. Risk assessment is recommended at ages 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 3 years, 7 years, and 9 years of age.
Hepatitis B Virus Infection Screening	X	X	X	Adults only	USPSTF recommends screening for hepatitis B infection in persons at high risk for infection and pregnant women at their first prenatal visit.
Hepatitis C Virus Infection Screening	X	X	X	Adults only	The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.
High Blood Pressure in Adults – Screening	X	X	X	Adults only	This screening test is for adults aged 18 years of age or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
Human Immunodeficiency Virus (HIV) – Screeningfor Adolescents and Adults	X	X	X	X	This screening is for HIV infection in adolescents and adults aged 15-65 years. Younger adolescents and older adults who are at increased risk should also be screened. This screening is also for pregnant women, including those who present in labor who are untested and whose HIV status is unknown. Bright Futures recommends HIV screening lab work be conducted once between ages 15-18 years. It is also recommended anytime between ages 11-14 years and 19-21 years when a risk assessment is positive.
Human Papillomavirus DNA Testing	N/A	X	X	Adults only	This screening test is recommended every 5 years for women who are 30 years or older who have normal pap smear results.
Hypothyroidism Screening – Newborn	X	X	N/A	X	This screening test is for all newborninfants from birth to 90 days old.

Item	Gender		Adults	Newborns, Children and/or Teens	Comments About Screening Test, Counseling, Exam or Shot
	Male	Female			
Intimate Partner Violence Screening	N/A	X	X	X	The USPSTF recommends that clinicians screen for intimate partner violence in women of reproductive age and provider orrefer women who screen positive to ongoing support services.
Latent Tuberculosis Infection (LTBI) Screening	X	X	X	Adults only	The USPSTF recommends screening for LBTI in populations at increased risk. This recommendation applies to asymptomatic adults 18 years and older.
Obesity Screening – Adults	X	X	X	Adults only	This screening is for all adults. Clinicians should offer or refer patients with a body mass index (BMI) of 30kg/m^2 or higher to intensive, multicomponent behavioral interventions.
Obesity Screening – Children and Adolescents	X	X	N/A	X	This screening is recommended for children and adolescents 6 years and older. Clinicians should offer or refer to a comprehensive, intensive behavioral intervention to promote improvements in weight status.
Osteoporosis Screening	N/A	X	X	Adults only	This screening is for women aged 65 and older and in postmenopausal women younger than 65 years who are at increased risk of osteoporosis.
Other Tests and Exams for Children from Birth to 21 Years	X	X	N/A	X	Other tests and exams for children and teens from birth to 21 years may be considered preventive. These tests and exams are covered according to individual benefit plans. Please refer to your health plan documents to determine you and your family's specific coverage.
Phenylketonuria (PKU) Screening	X	X	N/A	X	This screening test is for all newborninfants from birth to 90 days old.
Primary Care Interventions to Prevent Tobacco Use inAdults and Children	X	X	X	X	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to those who use tobacco. USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.

Item	Gender		Adults	Newborns, Children and/or Teens	Comments About Screening Test, Counseling, Exam or Shot
	Male	Female			
					Bright Futures recommends tobacco use assessments from age 11-21 years.
Rh(D) Incompatibility Screening	N/A	X	X	X	Rh(D) blood typing and antibody testing is recommended for all pregnant women during their first visit for pregnancy-related care. Repeated Rh(D) antibody testing for all unsensitized Rh(D) negative women at 24-28 weeks gestation, unless biological father is known to be Rh(D) negative.
Screening for Lung Cancer with Low-Dose Computer Tomography	X	X	X	Adults only	USPSTF recommends annual screening for lung cancer with low-dose computer tomography for adults aged 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within thepast 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Sexually Transmitted Infections - Behavioral Counseling for Prevention	X	X	X	X	Behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STI).
Sickle Cell Screening - Newborn	X	X	N/A	X	This screening test is for all newborninfants from birth to 90 days old.
Skin Cancer Prevention - Behavioral Counseling	X	X	X	X	USPSTF recommends counseling young adults, adolescents, children, and parents ofyoung children about minimizing exposure to ultraviolet (UV) radiation for persons ages 6 months to 24 years with fair skin types to reduce their risk of skin cancer.
Syphilis Screening	X	X	X	X	USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection (asymptomatic, non-pregnant adults and adolescents who are at increased risk for syphilis infection). USPSTF recommends that clinicians screen all pregnant women for syphilis infection. Bright Futures recommends sexually transmitted infection screening be conducted if risk assessment is positive between ages 11-21 years.

Item	Gender		Adults	Newborns, Children and/or Teens	Comments About Screening Test, Counseling, Exam or Shot
	Male	Female			
Screening for Visual Impairment in Children	X	X	N/A	X	USPSTF recommends vision screening at least once in all children aged 3-5 years to detect amblyopia or its risk factors. Bright Futures recommends instrument-based screening for children ages 1-5 years if the screening is available and ages 6 years and older if unable to test visual acuity monocularly with age appropriate optotypes.
Wellness Examinations (Well Baby, Well Child and Well Adult)	X	X	X	X	Wellness exams include an initial preventive medicine evaluation and management of an individual. This exam includes an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction strategies and the ordering of laboratory and diagnostic procedures. These include breastfeeding support and counseling and follow-up care, domestic violence screening, annual HIV counseling, well woman visits and screening for urinary incontinence.

Section 2: Preventive Screening Tests and Exams for Pregnant Women

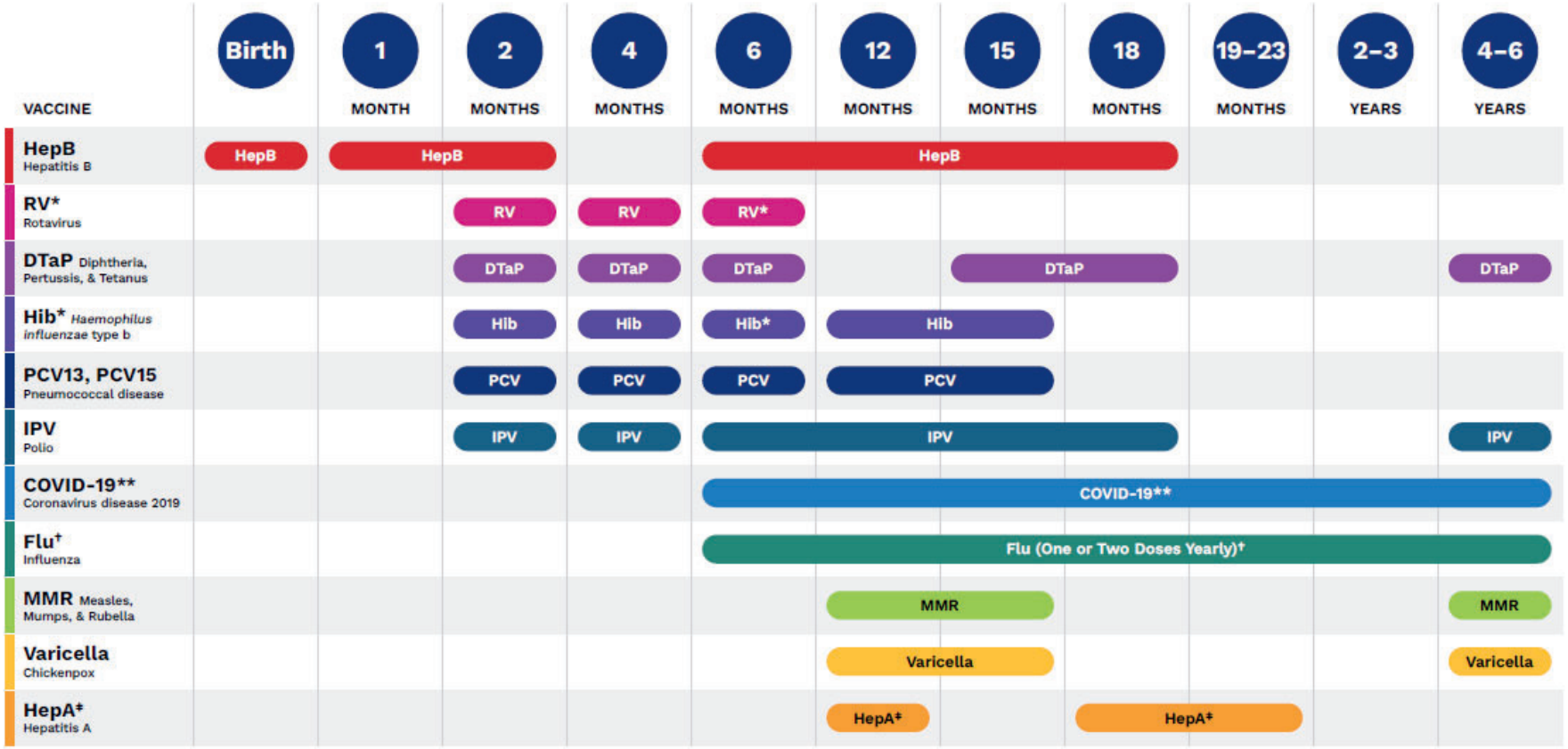
Screening	Comments
Bacteriuria Screening	Screening for asymptomatic bacteriuria with urine culture for pregnancy women at 12-16 weeks gestation or at the first prenatal visit, if later.
Chlamydia Screening	Screening test is for all sexually active women, including pregnant women, 24 years of age or younger and in older women who are at increased risk for infection.
Gestational Diabetes Screening	Screening pregnant women for gestational diabetes mellitus after 24 weeks of gestation.
Gonorrhea Screening	Screening test is for all sexually active women, including pregnant women, 24 years of age or younger and in older women who are at increased risk of infection.
Hepatitis B Virus Infection Screening	Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Human Immunodeficiency Virus (HIV) Infection Screening	This screening is for all adults and adolescents at risk for HIV. This also applies to pregnant women including those present in labor or at delivery who are untested and whose HIV status is unknown.
Preeclampsia Screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
Rh(D) Incompatibility Screening	This screening test is for all pregnant women during their first prenatal visit. Repeat testing is for all unsensitized Rh(D) negative women at 24-48 weeks gestation, unless the biological father is known to be Rh(D) negative.
Syphilis Screening	The USPSTF recommends early screening for syphilis infection in all pregnant women.
Tobacco Smoking Cessation in Adults Including Pregnant Women: Behavioral and Pharmacotherapy Interventions	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and advise them to stop using tobacco and provide behavioral interventions for cessation.
Wellness Visits (Preconception, Prenatal & Postpartum)	Well woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.

Section 3: Immunizations/Shots for Adults, Children and Teens

Please refer to the most current immunization (shot) recommendations to find out which immunizations are right for you and your family. These recommendations are revised each year by the Centers by Disease Control and Prevention (CDC).

For more information, please visit the CDC website at: www.cdc.gov

2023 Recommended Immunizations for Children from Birth Through 6 Years Old



FOOTNOTES

RV* Hib*

Administering a third dose at age 6 months depends on the brand of Hib or rotavirus vaccine used for previous dose.

COVID-19**

Number of doses recommended depends on your child's age and type of COVID-19 vaccine used.

Flu†

Two doses given at least 4 weeks apart are recommended for children age 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.

HepA‡

Two doses of Hep A vaccine are needed for lasting protection. The 2 doses should be given between age 12 and 23 months. Both doses should be separated by at least 6 months. Children 2 years and older who have not received 2 doses of Hep A should complete the series.

ADDITIONAL INFORMATION

1. If your child misses a shot recommended for their age, talk to your child's doctor as soon as possible to see when the missed shot can be given.

2. If your child has any medical conditions that put them at risk for infection (e.g., sickle cell, HIV infection, cochlear implants) or is traveling outside the United States, talk to your child's doctor about additional vaccines that they may need.

Talk with your child's doctor if you have questions about any shot recommended for your child.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

FOR MORE INFORMATION
Call toll-free: 1-800-CDC-INFO (1-800-232-4636)
Or visit: cdc.gov/vaccines/parents

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Diseases and the Vaccines that Prevent Them

BIRTH–6 YEARS OLD

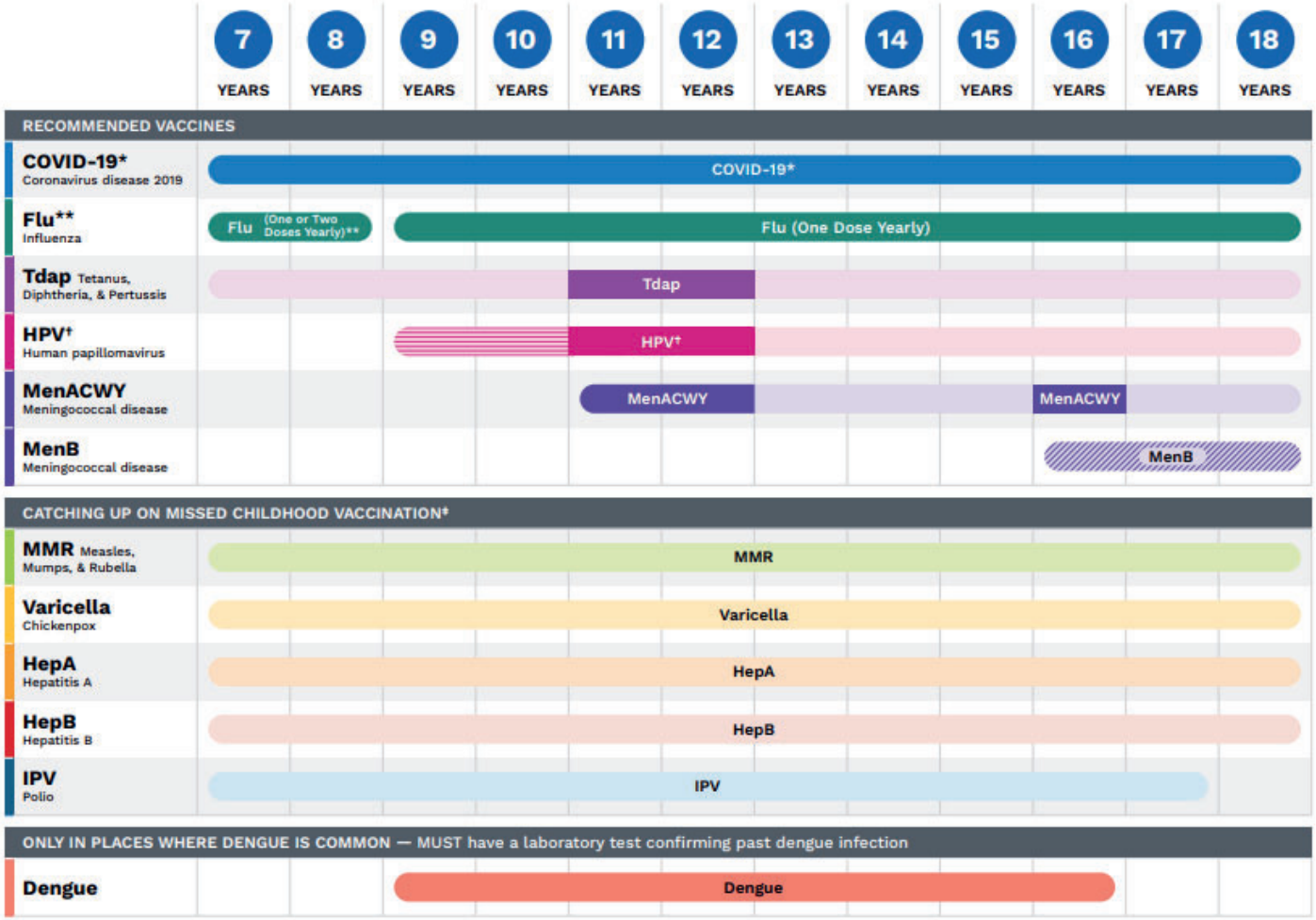
DISEASE	VACCINE	DISEASE SPREAD BY	DISEASE SYMPTOMS	DISEASE COMPLICATIONS
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer, death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration, death
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Pertussis (whooping cough)	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death
***Haemophilus influenzae* type b** (Hib)	Hib vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Pneumococcal disease (PCV13, PCV15)	PCV vaccine protects against pneumococcal disease.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Coronavirus disease 2019 (COVID-19)	COVID-19 vaccine protects against severe complications from coronavirus disease 2019.	Air, direct contact	May be no symptoms, fever, muscle aches, sore throat, cough, runny nose, diarrhea, vomiting, new loss of taste or smell	Pneumonia (infection in the lungs), respiratory failure, blood clots, bleeding disorder, injury to liver, heart or kidney, multi-system inflammatory syndrome, post-COVID syndrome, death
Influenza (Flu)	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs), bronchitis, sinus infections, ear infections, death
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pink eye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR** vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness, death
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders, death

DTaP* DTaP combines protection against diphtheria, tetanus, and pertussis.

MMR** MMR combines protection against measles, mumps, and rubella.

Last updated December 2022 • CS322257-A

2023 Recommended Immunizations for Children 7–18 Years Old



KEY

Indicates when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

Indicates the vaccine series can begin at this age.

Indicates the vaccine **should** be given if a child is catching up on missed vaccines. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses.

Indicates children not at increased risk **may** get the vaccine if they wish after speaking to a provider.

ADDITIONAL INFORMATION

1. If your child misses a shot recommended for their age, talk to your child's doctor as soon as possible to see when the missed shot can be given.

2. If your child has any medical conditions that put them at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that they may need.

Talk with your child's doctor if you have questions about any shot recommended for your child.

FOOTNOTES

COVID-19* Number of doses recommended depends on your child's age and type of COVID-19 vaccine used.

Flu** Two doses given at least 4 weeks apart are recommended for children age 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.

HPV† Ages 11 through 12 years old should get a 2-shot series separated by 6 to 12 months. The series can begin at 9 years old. A 3-shot series is recommended for those with weakened immune systems and those who start the series after their 15th birthday.

†Originally recommended age ranges for missed childhood vaccinations: 2-dose series of **MMR** at 12–15 months and 4–6 years; 2-dose series of **Varicella** at 12–15 months and 4–6 years; 2-dose series of **HepA** (minimum interval: 6 months) at age 12–23 months; 3-dose series of **HepB** at birth, 1–2 months, and 6–18 months; and 4-dose series of **Polio** at 2 months, 4 months, 6–18 months, and 4–6 years.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

FOR MORE INFORMATION
Call toll-free: 1-800-CDC-INFO (1-800-232-4636)
Or visit: cdc.gov/vaccines/parents

AAFP American Academy of Family Physicians
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Diseases and the Vaccines that Prevent Them

7–18 YEARS OLD

DISEASE	VACCINE	DISEASE SPREAD BY	DISEASE SYMPTOMS	DISEASE COMPLICATIONS
Coronavirus disease 2019 (COVID 19)	COVID-19 vaccine protects against severe complications from coronavirus disease 2019.	Air, direct contact	May be no symptoms, fever, muscle aches, sore throat, cough, runny nose, diarrhea, vomiting, new loss of taste or smell	Pneumonia (infection in the lungs), respiratory failure, blood clots, bleeding disorder, injury to liver, heart or kidney, multi-system inflammatory syndrome, post-COVID syndrome, death
Influenza (Flu)	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs), bronchitis, sinus infections, ear infections, death
Tetanus	Tdap* and Td** vaccines protect against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death
Diphtheria	Tdap* and Td** vaccines protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Pertussis (whooping cough)	Tdap* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Human papillomavirus	HPV vaccine protects against human papillomavirus.	Direct skin contact	May be no symptoms, genital warts	Cervical, vaginal, vulvar, penile, anal, oropharyngeal cancers
Meningococcal disease	MenACWY MenB vaccines protect against meningococcal disease.	Air, direct contact	Sudden onset of fever, headache, and stiff neck, dark purple rash	Loss of limb, deafness, nervous system disorders, developmental disabilities, seizure disorder, stroke, death
Measles	MMR† vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pink eye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR† vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness, death
Rubella	MMR† vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders, death
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer, death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Dengue	Dengue† vaccine protects against dengue.	Bite from infected mosquito	May be no symptoms, fever, headache, pain behind the eyes, rash, joint pain, body ache, nausea, loss of appetite, feeling tired, abdominal pain	Severe bleeding, seizures, shock, damage to the liver, heart, and lungs, death

Tdap* Tdap combines protection against diphtheria, tetanus, and pertussis.

Td** Td combines protection against diphtheria and tetanus.

MMR† MMR combines protection against measles, mumps, and rubella.

Dengue† Recommended where dengue is common.

Last updated December 2022
CS322257-B

Table 1 COVID-19 vaccination recommendations have changed. Find the latest recommendations at www.cdc.gov/covidschedule

Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2023

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
COVID-19	2- or 3- dose primary series and booster (See Notes)			
Influenza inactivated (IIV4) or **Influenza recombinant** (RIV4)	1 dose annually			
or	or			
Influenza live, attenuated (LAIV4)	1 dose annually			
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)			
	1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			For healthcare personnel, see notes
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses	
Zoster recombinant (RZV)	2 doses for immunocompromising conditions (see notes)		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal (PCV15, PCV20, PPSV23)	1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)			See Notes
				See Notes
Hepatitis A (HepA)	2, 3, or 4 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, see notes for booster recommendations			
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations			
	19 through 23 years			
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication			

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

Recommended vaccination based on shared clinical decision-making

No recommendation/ Not applicable

Health Education and Wellness

We've got you covered.

Our Health Education and Disease Management teams provide support and resources to help you stay well.

Nutrition

Diabetes

Weight management

Asthma

Stop tobacco/nicotine

Kidney health

Prediabetes

Online education

Telephonic support

Registered nurses

Registered dietitians

1:1 consultations

Health education and wellness programs are available to you at no additional cost. For more information, visit your health plan's website or call **702-877-5356** or toll-free **1-800-720-7253**, TTY **711**, Monday through Friday, 8 a.m. to 5 p.m.

Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan o los documentos de su plan.

Health plan coverage provided by Health Plan of Nevada.
Insurance coverage provided by Sierra Health and Life.

HPN/HEW SHL/HEW

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Educación de Salud y Bienestar

Lo tenemos cubierto.

Nuestros equipos de Educación de Salud y Manejo de Enfermedades le brindan apoyo y recursos para ayudarle a estar bien.

Nutrición

Diabetes

Control del peso

Asma

Dejar de fumar/nicotina

Salud renal

Prediabetes

Educación en línea

Apoyo telefónico

Enfermeras registradas

Dietistas registrados

Consultas individuales

Los programas de bienestar y educación de salud están disponibles para usted sin costo adicional. Para obtener más información, visite el sitio web de su plan de salud o llame al **702-877-5356** o al número gratuito **1-800-720-7253**, TTY **711**, de lunes a viernes, de 8 a.m. a 5 p.m.

La cobertura del plan de salud es proporcionada por Health Plan of Nevada.
La cobertura de seguro es proporcionada por Sierra Health and Life.

HEW2751_21.1

(06/21)

HPN/HEW

SHL/HEW

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Health Plan of Nevada
A UnitedHealthcare Company

Student Endorsement

This Endorsement offers eligible Dependents, as defined in the HPN Evidence of Coverage (EOC), access to Covered Services outside the HPN Service Area, if the Dependent is enrolled in an accredited university, college or vocational school in the United States. HPN may request proof of full-time student status at any time.

This Endorsement is a supplement to your EOC issued by HPN and subject to the applicable terms, conditions, limitations and exclusions stated in the EOC. Nothing in this Endorsement will change the terms of the EOC except as otherwise stated herein. This Endorsement shall terminate upon termination of the Plan and under the same terms and conditions specified therein, and Members shall no longer be entitled to any of the benefits set forth in this Endorsement. Nothing contained in this Endorsement shall vary, waive, alter, or extend any of the terms, conditions or limitations of the EOC, except as specifically stated in this Endorsement.

This Endorsement is subject to the HPN Managed Care Program requirements. HPN's Managed Care Program requires the Member, Plan Providers and HPN to work together. All Plan Providers have agreed to participate in HPN's Managed Care Program. Plan Providers have agreed to accept HPN's Reimbursement Schedule amount as payment in full for Covered Services, less the Member's payment of any applicable Copayment, Deductible or Coinsurance amount, whereas Non-Plan Providers have not. Members enrolled in this Endorsement who use the services of Non-Plan Providers will receive no benefit payments or reimbursement for amounts for any Covered Service, except in the case of Emergency Services or Urgently Needed Services as defined in this Endorsement. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.

With the exception of Urgent or Emergently Needed Services, all Covered Services outside the HPN Service Area require Prior Authorization from HPN. It is the Member's responsibility to verify that the Provider selected is a Plan Provider before receiving any non-Emergency Services and to comply with all other rules of HPN's Managed Care Program. Compliance by the Member with HPN's Managed Care Program is mandatory. Failure to comply with the rules of HPN's Managed Care Program means the Member will be responsible for costs of services received. Contact the Member Services Department at the number on your ID card for the list of out of area Plan Providers, prior to obtaining Covered Services.

Health Plan of Nevada
A UnitedHealthcare Company

Travel Endorsement

This Endorsement offers Subscribers and their Dependents access to certain Covered Services when, while travelling for business or pleasure in the United States, unanticipated healthcare issues occur. This Endorsement does not provide access to services that a Member could have obtained within the HPN Service Area. Except in the case of Emergency Services and Urgently Needed Services, the Member will be fully responsible for the cost of services not Prior Authorized by the HPN Managed Care Program.

This Endorsement is a supplement to your Evidence of Coverage (EOC) issued by HPN and subject to the applicable terms, conditions, limitations and exclusions stated in the EOC. Nothing in this Endorsement will change the terms of the EOC except as otherwise stated herein. This Endorsement shall terminate upon termination of the Plan and under the same terms and conditions specified therein, and Members shall no longer be entitled to any of the benefits set forth in this Endorsement. Nothing contained in this Endorsement shall vary, waive, alter, or extend any of the terms, conditions or limitations of the EOC, except as specifically stated in this Endorsement.

This Endorsement is governed by the HPN Managed Care Program requirements. HPN's Managed Care Program requires the Member, Plan Providers and HPN to work together. All Plan Providers have agreed to participate in HPN's Managed Care Program. Plan Providers have agreed to accept HPN's Reimbursement Schedule amount as payment in full for Covered Services, less the Member's payment of any applicable Copayment, Deductible or Coinsurance amount, whereas Non-Plan Providers have not. Members enrolled in this Endorsement who use the services of Non-Plan Providers will receive no benefit payments or reimbursement for amounts for any Covered Service, except in the case of Emergency Services or Urgently Needed Services as defined in this Endorsement. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.

With the exception of Urgent or Emergently Needed Services, all Covered Services outside the HPN Service Area require Prior Authorization from HPN. It is the Member's responsibility to verify that the Provider selected is a Plan Provider before receiving any non-Emergency Services and to comply with all other rules of HPN's Managed Care Program. Compliance by the Member with HPN's Managed Care Program is mandatory. Failure to comply with the rules of HPN's Managed Care Program means the Member will be responsible for costs of services received. Contact the Member Services Department at the number on your ID card for the list of out of area Plan Providers, prior to obtaining Covered Services.

2024 Endorsement

This endorsement is a supplement to your Health Plan of Nevada, Inc. (HPN) [ ] Evidence of Coverage (EOC), Attachment A Benefit Schedule and HPN Point-Of-Service (POS) Rider. These provisions are effective **January 1, 2024**.

Glossary Section

Add the following terms:

"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.

"Convenient Care" means a facility that provides services for Medically Necessary, non-urgent or non-emergent injuries or illnesses. Examples of such conditions include:

- Blood pressure checks;
- Diagnostic laboratory services;
- General health screenings;
- Minor illnesses (cold/flu);
- Minor wound treatment and repair;
- Treatment of burns and sprains.

"Covered Person" means a Member who meets the eligibility requirements of Section 1., who has enrolled under this Plan and for whom premiums have been received and accepted by HPN.

Pharmacy Provisions Section

Add the below zero cost share medications:

Zero Cost Share Medications

You may obtain up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy up to a consecutive 90-day supply.

You are not responsible for paying any applicable deductible for Prescription Drug Products on the List of Zero Cost Share Medications unless required by state or federal law.

List of Zero Cost Share Medications - A list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share. You may find the List of Zero Cost Share Medications by contacting us at www.healthplanofnevada.com or the telephone number on your ID card.

Modify the following as indicated under the Limitations subsection as noted in red font below:

Limitations

- Prior Authorization or Step Therapy may be required for certain Covered Drugs.
- Benefits are available for refills of Covered Drugs, including prescription eye drops and opioids, only when dispensed as ordered by a duly licensed health care provider. Refills are provided once a given amount of the Covered Drug is used through the course of therapy; amounts vary by the type of Covered Drug. Refill dates of Covered Drugs can be aligned so that drugs that are refilled at the same frequency can be refilled concurrently.
- A pharmacy may refuse to fill or refill a prescription order when, in the professional judgment of the pharmacist, the prescription should not be filled.

- Benefits are not payable if the Member is directed to a Designated Plan Pharmacy and chooses not to obtain the Covered Drug from that Designated Plan Pharmacy.
- If HPN determines that the Member may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, the Member's selection of Plan Pharmacies may be limited. If this happens, HPN may require the Member to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if the Member uses the assigned single Plan Pharmacy. If a selection is not made by the Member within thirty-one (31) days of the date of notification, then HPN will select a single Plan Pharmacy for the Member.
- Certain Specialty Prescription Drugs may be dispensed by the Designated Pharmacy in fifteen (15) day supplies up to ninety (90) days and at a pro-rated Copayment or Coinsurance. The Member will receive a fifteen (15) day supply of the Specialty Prescription Drug Product to determine if the Member will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Member each time prior to dispensing the fifteen (15) day supply to confirm if the Member is tolerating the Specialty Prescription Drug Product. The list of these certain Specialty Prescription Drugs is available through review of the HPN Prescription Drug List (PDL).
- If a Prescription Drug is excluded from coverage, the Member or representative may request an exception to gain access to the excluded Prescription Drug. Exceptions do not apply to drugs that are considered benefit exclusions, such as drugs for sexual dysfunction, cosmetic products and infertility.
    - To make a request, contact HPN in writing or call the toll-free number on your ID card. Please note, if the request for an exception is approved by HPN, the Member may incur the cost of the excepted Prescription Drug at the highest tier. If the request requires immediate action and a delay could significantly increase a health risk or the ability regain maximum function, call HPN as soon as possible. HPN will provide a written or electronic determination within twenty-four (24) hours. If the Member is not satisfied with HPN's determination of the exclusion exception, they may request External Review. Please refer to the *Appeals Procedure* section herein for further information.
- If a Prescription Drug requires step therapy, the Member or representative may request an exception from the step therapy protocol to gain access to the Prescription Drug.
    - To make a request, contact HPN via web at https://healthplanofnevada.com/Member/Step-Therapy-Exception-Request. The Member will be informed of the determination within two (2) business days. If the Members provider requests an expedited review and a delay could significantly increase a health risk, HPN will provide a determination within twenty-four (24) hours.
- HPN may have certain programs in which the Member may receive an enhanced or reduced benefit based on their actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. Questions about these programs can be directed to the Member Services telephone number on your ID card.
- ~~HIV preventative drugs, subject to reasonable management techniques as determined by Nevada state law, when prescribed by a participating Pharmacist.~~
- Coverage for all drugs approved by the FDA for prevention and treatment of HIV or Hepatitis C, when prescribed by a participating provider.
- Coverage for self-administered hormonal contraceptives, provided without a prescription, when a Pharmacist complies with the providing requirements protocols of the State Board of Pharmacy.

Appeals Procedures Section

Remove existing language under the No Surprises Act subsection and **replace** with the following:

No Surprises Act

The Policy complies with the applicable provisions of the *Consolidated Appropriations Act (the "Act") (P.L. 116-260)*.

Balance Billing

The No Surprises Act prohibits balance billing by out-of-network providers in the following instances:

- When ancillary services are received at certain network facilities on a non-emergency basis from out-of-network Physicians.

- When non-ancillary services are received at certain network facilities on a non-emergency basis from out-of-network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described in the Act.
- When emergency health care services are provided by an out-of-network provider.
- When air ambulance services are provided by an out-of-network provider.

In these instances, the out-of-network provider may not bill you for amounts in excess of your applicable copayment, coinsurance or deductible (cost share). Your cost share will be provided at the same level as if provided by a plan provider and is determined based on the recognized amount.

For the purpose of this summary, "certain network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Determination of Our Payment to the Out-of-Network Provider:
When covered health care services are received from out-of-network providers for the instances as described above, the recognized amount, which are used to determine our payment to out-of-network providers, are based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state All Payer Model Agreement.
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-network provider and us.
- The amount determined by Independent Dispute Resolution (IDR).

Continuity of Care
The Act provides that if you are currently receiving treatment for covered health care services from a provider whose network status changes from network to out-of-network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, please call the telephone number on your ID card.

Provider Directories
The Act provides that if you receive a covered health care service from an out-of-network provider and were informed incorrectly by us prior to receipt of the covered health care service that the provider was a plan provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from a plan provider.

Managed Care Program Section

Modify the Services Requiring Prior Authorization subsection as noted in red font below:

Services Requiring Prior Authorization
All Covered Services not provided by the Member's Primary Care Provider (PCP) require Prior Authorization from the PCP and HPN's Managed Care Program. The following Covered Services require Prior Authorization and review through HPN's Managed Care Program:

- Non-emergency Inpatient admissions and extensions of stay in a Hospital, Skilled Nursing Facility, Residential Treatment Center or Hospice.
- Outpatient surgery provided in any setting, including technical and professional services.
- Diagnostic and Therapeutic Services.
- Home Healthcare Services.

- All Inpatient and non-routine Outpatient non-Emergency Mental Health, Severe Mental Illness, and Substance Related and Addictive Disorder Services, including but not limited to:
  - Intensive outpatient program treatment.
  - Partial hospitalization program treatment.
  - Outpatient electro-convulsive treatment.
  - Psychological testing.
- All Specialist visits or consultations.
- Prosthetic Devices, Orthotic Devices and Durable Medical Equipment.
- Allergy testing or treatment (e.g., skin, RAST); angioplasty; physiotherapy or Manual Manipulation and; habilitative and rehabilitation therapy (physical, speech, occupational).

Covered Services Section

Add the following covered service:

Biomarker Testing
Covered Services include medically necessary biomarker testing for appropriate management and ongoing monitoring of a disease or condition.

Modify the following as indicated in red font below under the Preventive Healthcare Services subsection:

Preventive Healthcare Services
Covered Preventive Healthcare Services will be paid at 100% of Eligible Medical Expenses, or the Recognized Amount when applicable, without application of any Calendar Year Deductible, Copayment and/or Coinsurance when such services are provided by a Plan Provider.

Covered Services include the following Preventive Healthcare Services in accordance with the recommended schedule outlined in the HPN Preventive Guidelines included in your member kit or you may access the most current version of these guidelines at any time by visiting HPN's web site at https://www.healthplanofnevada.com.

- Evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations(1) that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, as long as they are not otherwise addressed by the recommendations of the USPSTF.
- Contraceptive coverage includes the insertion of implantable rods, copper-based intrauterine devices and progesterone-based intrauterine devices at a hospital immediately after a Member gives birth.

For a complete list of Preventive Services, including all FDA approved contraceptives, go to http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/.

(1)Certain immunizations may be administered in a Plan pharmacy.

Modify the following as indicated in red font below under the Gender Dysphoria subsection:

Breast Surgery:
The Member must provide documentation in the form of a written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Member meets all of the following criteria:

- Has persistent, well-documented Gender Dysphoria;
- Has the capacity to make a fully informed decision and to consent for treatment;
- ~~Must be 18 years or older; and~~
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

Genital Surgery:
The Member must provide documentation in the form of a written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Member. The assessment must document that the Member meets all of the following criteria:
- Has persistent, well-documented Gender Dysphoria;
- Has the Capacity to make a fully informed decision and to consent for treatment;
- ~~Must 18 years or older;~~
- If significant medical or mental health concerns are present, they must be reasonably well controlled;
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender; and
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

HPN may direct you to a plan provider or facility that is outside your service area. If you are required to travel to obtain such Gender Dysphoria Covered Services from a plan provider, HPN may reimburse certain reasonable and necessary travel expenses.

HPN makes no representation or warranty as to the medical competence or ability of any Gender Dysphoria Treatment Center/Facility or its respective staff or Physicians. HPN shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, or any actions or inactions, whether negligent or otherwise, on the part of any Gender Dysphoria Treatment Center/Facility or its respective staff or Physicians.

Exclusions Section

Modify the following exclusion to remove the following services noted in red font:

Services received in connection with Gender Dysphoria, which includes the following:
- Abdominoplasty;
- Blepharoplasty;
- Body contouring, such as lipoplasty;
- ~~Breast enlargement, including augmentation mammoplasty and breast implants;~~
- Brow lift;
- Calf implants;
- Cheek, chin, and nose implants;
- Cryopreservation of fertilized embryos;
- Drugs for hair loss or growth;
- Face lift, forehead lift, or neck tightening;
- Facial bone remodeling for facial feminizations;
- Hair removal, except as part of a genital reconstruction procedure;
- Hair transplantation;
- Injection of fillers or neurotoxins;
- Lip augmentation;
- Lip reduction;
- Liposuction;
- Mastopexy;
- Pectoral implants for chest masculinization;
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;
- Rhinoplasty;
- Skin resurfacing;
- Sperm preservation in advance of hormone treatment or gender surgery;

- ~~Surgical or hormone treatment on Members under eighteen (18) years of age;~~
- Surgical treatment not Prior Authorized by HPN;
- ~~Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple);~~
- ~~Transportation, meals, lodging or other similar expenses;~~
- ~~Voice lessons and voice therapy; and~~
- ~~Voice modification surgery.~~

Modify the following as indicated in red font below under the exclusions section:

Mental Health Services and Substance-Related and Addictive Disorder Services performed in connection with conditions not listed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or conditions listed as "Other Conditions" that may be of focus of clinical attention. This exclusion does not apply to conditions defined as *Medically Necessary* in Section 14: Glossary.

Outside of an initial assessment, Mental Health and Substance-Related and Addictive Disorder Services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. This exclusion does not apply to conditions defined as *Medically Necessary* in Section 14: Glossary.

Outside of an initial assessment, unspecified disorders for which the provider is not obligated to provide the clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, unless determined to be medically necessary.

High intensity residential care, including American Society of Addiction Medicine (ASAM) Criteria, for Members with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment, unless determined to be medically necessary.

Remove the below exclusion:

~~Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.~~

Attachment A, Benefit Schedule

Add the following benefits:

1. Convenient Care
2. Outpatient Office-based Individual and Group Therapy, and Medical Management (including Telemedicine Services)
3. Diagnostic Breast Cancer Imaging

HPN POS Rider

Modify the following as indicated in red font under the Services Requiring Prior Authorization subsection:

Tier I HMO Benefit:

All Inpatient and non-routine Outpatient non-Emergency Mental Health, Severe Mental Illness, and Substance Related and Addictive Disorder Services, including but not limited to:

- Intensive outpatient program treatment.
- Partial hospitalization program treatment.
- Outpatient electro-convulsive treatment.
- Psychological testing.

Health Plan of Nevada
A UnitedHealthcare Company

Evidence of Coverage

This Plan may include a Calendar Year Deductible; please refer to the Attachment A Benefit Schedule.

This Evidence of Coverage ("EOC") describes the healthcare plan made available to Eligible Employees of the Employer (referred to as "Group") and their Eligible Family Members.

Health Plan of Nevada, Inc. ("HPN"), and the Group have agreed to all of the terms of this EOC, and the EOC has been incorporated by reference into the Group Enrollment Agreement ("GEA") entered into by HPN and Group. HPN or the Group, upon appropriate written notice in accordance with the GEA, may terminate this EOC. This plan is guaranteed renewable. The Group is responsible for giving Members notice of termination.

This EOC and your attached Attachment A Benefit Schedule tell you about your benefits, rights and duties as an HPN Member. They also tell you about HPN's duties to you.

This EOC including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, your Enrollment Form, health statements, Member Identification Card and all other applications received by HPN are all part of your HPN membership package. Please read them carefully and keep them in a safe place. **Words that are capitalized are defined in Section 14. - Glossary.**

Please carefully review your EOC and your Attachment A Benefit Schedule to determine which Covered Services require Prior Authorization. Failure of the Member to comply with the requirements of HPN's Managed Care Program and the Prior Authorization process will result in a denial or reduction of benefits.

Table of Contents

The Department of Business and Industry

State of Nevada

Division of Insurance

Telephone Numbers
for
Consumers of Healthcare

The Division of Insurance ("Division") has established a telephone service to receive inquiries and complaints from consumers of healthcare concerning healthcare plans in Nevada.

Hours of operation for the Division:

Monday through Friday from 8 a.m. until 5 p.m., Pacific Time (PT)

The Division is closed during state holidays.

Contact information for the Division:

Carson City Office:
Phone: (775) 687-0700
Fax: (775) 687-0787
1818 East College Pkwy., Suite 103
Carson City, NV 89706

Las Vegas Office:
Phone: (702) 486-4009
Fax: (702) 486-4007
3300 W. Sahara Ave., Suite 275
Las Vegas, NV 89102

The Division also provides a toll-free number for consumers residing outside of the above areas:

1-800-992-0900

Please listen to the greeting and select the appropriate prompt.

If you have any questions regarding your health care coverage, please contact HPN's Member Services Department at the following:

Address:

Health Plan of Nevada, Inc.
Attn: Member Services Department
P.O. Box 15645
Las Vegas, NV 89114-5645

Phone:

1-877-545-7378

(Monday – Friday from 8:00 a.m. until 5:00 p.m., Pacific Time):

SECTION 1. Eligibility, Enrollment and Effective Date

Subscribers and Dependents who meet the following criteria are eligible for coverage under this EOC.

1.1 Who Is Eligible

Subscriber. To be eligible to enroll as a Subscriber, an employee must be an employee of the enrolling Group or other person whose connection with the enrolling Group meets the eligibility requirements specified in both the application and the policy and meets the following criteria:

- Be employed full-time;
- Be in an active employment status;
- Work at least the minimum number of hours per week indicated by the Group in its Attachment A to the Group Enrollment Agreement (GEA);
- Meet the applicable waiting period indicated by the Group in its Attachment A to the GEA;
- Enroll during an enrollment period;
- Live or work in HPN's Service Area; and
- Work for an employer that meets the minimum employer contribution percentage for the applicable coverage as set forth in the Attachment A to the GEA.

The active employment status requirement will not apply to individuals covered under Group's prior welfare benefit plan on the date of that plan's discontinuance, provided that this EOC is initially effective no more than sixty (60) days after the prior plan's discontinuance. All other requirements will apply to such individuals.

Dependent. To be eligible to enroll as a Dependent, an individual must be one of the following:

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage.
- A Domestic Partner.
- A child by birth. Adopted child. Stepchild. Minor child for whom a court has ordered coverage. Child being Placed for Adoption with the Subscriber. A child for whom a court has appointed the Subscriber or the Subscriber's spouse the legal guardian.
- An unmarried Dependent Child under a legal permanent guardianship and who is eligible to be claimed as a Dependent by the Subscriber and/or his Spouse or Domestic partner and is a grandchild, brother, sister, step-brother, step-sister or descendent of such relative.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under the limiting age of 26.
- A Dependent includes a Dependent child who is incapable of self-sustaining employment due to mental or physical handicap, chiefly dependent upon the Subscriber for economic support and maintenance, and who has satisfied all of the requirements of (a) or (b) below:
  a. The child must be covered as a Dependent under this Plan before reaching the limiting age, and proof of incapacity and dependency must be given to HPN by the Subscriber within thirty (30) days of the child reaching the limiting age; or
  b. The handicap started before the child reached the limiting age, but the Subscriber was covered by another health insurance carrier that covered the child as a handicapped Dependent prior to the Subscriber applying for coverage with HPN.

Evidence of any court order needed to prove eligibility must be given to HPN.

1.2 Who Is Not Eligible

Eligible Dependent does not include:

- A foster child.
- A child placed in the Subscriber's home other than for adoption.
- A grandchild unless otherwise identified in Section 1.1
- Any other person not defined in Section 1.1.

1.3 Changes In Eligibility Status

It is the Subscriber's responsibility to give HPN written notice within thirty-one (31) days of changes that affect his Dependent's eligibility. Changes include, but are not limited to:

- Reaching the limiting age.
- Ceasing to satisfy the mental or physical handicap requirements.
- Death.
- Divorce.

- Transfer of residence or work outside HPN's Service Area.
- The Eligible Person and/or Dependent loses eligibility under Medicaid or the Children's Health Insurance Program (CHIP). Coverage will begin only if HPN receives the completed enrollment form and any required Premium within 60 days of the date coverage ended.
- Any other event which affects a Dependent's eligibility.

If the Subscriber fails to give notice which would have resulted in termination of coverage, HPN shall have the right to terminate coverage in accordance with the Group Enrollment Agreement.

1.4 Enrollment

Eligible Employees and Eligible Family Members must enroll during one of the Enrollment Periods described below or within thirty-one (31) days of first becoming eligible in order to have coverage under this Plan.

1. **Initial Enrollment Period.** An Initial Enrollment Period is the period of time during which an Eligible Employee and Eligible Family Member may enroll under this Plan as shown in the GEA signed by the Group.

2. **Group Open Enrollment Period.** An Open Enrollment Period of at least thirty-one (31) days may be held at least once a year allowing Eligible Employees and Eligible Family Members to enroll under this Plan.

3. **Special Enrollment Period**. A Special Enrollment Period allows a Special Enrollee to enroll for coverage under this Plan upon a Special Enrollment Event as defined herein during a period of at least thirty-one (31) days following the Special Enrollment Event.

4. **Right to Deny Application.** HPN can deny membership to any person who:
   a. Violates or has violated any provision of the HPN EOC.
   b. Misrepresents and/or fails to disclose a material fact which would affect coverage under this Plan.
   c. Fails to follow HPN rules.
   d. Fails to make a premium payment.

5. **Right to Deny Application for Renewal.** As a condition of Group's renewal under this Plan, HPN may require Group to exclude a Subscriber and/or Dependent who committed fraud upon HPN or misrepresented and/or failed to disclose a material fact which affected his coverage under this Plan.

1.5 Effective Date of Coverage

Before coverage can become effective, HPN must receive and accept premium payments and an Enrollment Form for the person applying to become a Member.

When a person applies to become a Member on or before the date he is eligible, coverage starts as shown in the GEA signed by Group.

- If a person applies to be a Member within thirty-one (31) days of the date he is first eligible to apply, coverage the first day of the month following the last day of the required waiting period(s) as stated in the Group's GEA.

- Subscriber's newborn natural child is covered for the first thirty-one (31) days from birth. Coverage continues after thirty-one (31) days only if the Subscriber enrolls the child as a Dependent and pays the premium within sixty (60) days of the date of birth.

- An adopted child is covered for the first thirty-one (31) days from birth only if the adoption has been legally completed before the child's birth. A child Placed for Adoption at any other age is covered for the first thirty-one (31) days after the Placement for Adoption.

  Coverage continues after the applicable thirty-one (31) day period only if the Subscriber enrolls the child as a Dependent and pays any premium within sixty (60) days following the placement of the child in the Subscriber's home. In the event adoption proceedings are terminated, coverage of a child Placed for Adoption ends on the date the adoption proceedings are terminated.

- If a court has ordered Subscriber to cover his or her legal spouse or unmarried minor child, that person will be covered for the first thirty-one (31) days following the date of the court order. Coverage continues after thirty-one (31) days if the Subscriber enrolls the Dependent and pays any Dependent's premium. A copy of the court order must be given to HPN.

- For a Special Enrollee, an Enrollment Form must be received during the Special Enrollment Period. The Effective Date of Coverage will be the date of action of the event, unless otherwise specified in the GEA.

- When a person applies to become a Member during the Open Enrollment Period, coverage starts on the first day of the calendar month following the Open Enrollment Period.

The Subscriber must give HPN a copy of the certified birth certificate, decree of adoption, or certificate of Placement for Adoption for coverage to continue after sixty (60) days for newborn and adopted children. The Subscriber must give HPN a copy of the certified marriage certificate or any other required documents before coverage can be effective for other Eligible Family Members.

SECTION 2. Termination

This section tells you under what conditions your coverage under this Plan will terminate and the date that the coverage will end. In the event a Member's coverage is terminated pursuant to Sections 2.1 and 2.2 below, the coverage of his Dependents will also be terminated.

2.1 Termination by HPN

HPN may terminate coverage under this Plan at the times shown for any one or more of the following reasons:

- Failure to maintain eligibility requirements as set forth in Section 1.
- On the first day of the month that a payment was due and not received by HPN.
- With thirty (30) days written notice, if the Member allows his or any other Member's HPN ID Card to be used by any other person, or uses another person's HPN ID Card. The Member will be liable to HPN for all costs incurred as a result of the misuse of the HPN ID Card.
- If the Member performs an act or practice that constitutes fraud, or makes any intentional misrepresentation of material fact, as prohibited by the terms of coverage, HPN has the right to rescind coverage and declare coverage under the Plan null and void as follows:
  - For a material breach that occurred in the application process, rescission of coverage back to the original Effective Date of Coverage, with a refund any applicable premium; or
  - For any other act of fraud, termination effective no earlier than the date that the fraud had taken place.

  Thirty (30) days written notice shall be provided to the Member prior to any rescission of coverage. A Member/ has the right to appeal any such rescission.

- Subject to Section 3, Continuation of Coverage, on the last day of the calendar month (or sooner, if provided in the GEA) when a Member no longer meets the requirements of Section 1.; this paragraph also applies to Dependents who become ineligible as Members for any reason including the death of the Subscriber.
- On the 61st day after a change in residence if a Subscriber moves his primary residence outside HPN's Service Area. A Subscriber and Eligible Dependents may continue coverage after a change in residence as long as his place of work is within HPN's Service Area. During the sixty (60) consecutive day period after the change in residence, the only Covered Services that HPN will provide outside HPN's Service Area are Emergency Services and Urgently Needed Services.
- When a Subscriber or Dependent moves his primary residence outside HPN's Service Area and/or the Subscriber no longer has his place of work within HPN's Service Area, Subscriber must notify HPN within thirty-one (31) days of the change.
- The end of the month in which a Dependent Child under permanent legal guardianship turns age 19 unless the Child is unmarried and either resides with the Subscriber or is enrolled as a full-time student at an accredited institution.
- On the date the GEA terminates for any reason, including but not limited to:
  - Nonpayment of premiums.
  - Failure to meet minimum enrollment requirements.
  - HPN amends this EOC and the Group does not accept the amendment.

2.2 Termination by the Subscriber

Subscriber has the right to terminate his coverage under this Plan by written notice to HPN. Such termination is effective on the last day of the month in which the notice is received by HPN, unless stated otherwise in the GEA.

2.3 Reinstatement

Any EOC which has been terminated in any manner may be reinstated by HPN at its sole discretion.

2.4 Retroactive Termination

A request for retroactive termination by Group may be granted as shown in the GEA.

2.5 Effect of Termination

No benefits will be paid under this Plan by HPN for services provided after termination of a Member's coverage under this Plan. The Member will be responsible for payment of medical services and supplies incurred after the Effective Date of the termination of this Plan and/or the GEA.

SECTION 3. Continuation of Coverage

This section tells you under what conditions your coverage can continue at Group rates in certain instances for a limited period of time when coverage under the Group Health Benefit Plan ends.

3.1 COBRA

The following rules apply only to Groups with twenty (20) or more employees on 50% of the workdays in the previous Calendar Year. For the purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Omnibus Budget Reconciliation Act of 1989 (OBRA), Group shall be considered the Plan Administrator.

Important Note: This EOC does not, and cannot, contain all of the information that is required under the COBRA continuation coverage regulations. Federal laws and regulations regarding COBRA are publicly available.

a) A Subscriber and any enrolled Dependent who would lose coverage under this Plan because of:
   1) a reduction in the Subscriber's regularly scheduled work hours, or
   2) because of termination of the Subscriber's employment with the Group for any reason, other than gross misconduct, has the right to elect COBRA continuation coverage. Such coverage may continue for up to eighteen (18) months.

      The premium for this COBRA continuation coverage may be increased to 102% of the premium for providing coverage to other Subscribers under this Plan. COBRA continuation coverage will not take effect until the Subscriber or Dependent elects COBRA and makes the required payment. The Subscriber or Dependent will have an initial grace period of forty-five (45) days from the date of COBRA election to make the first premium payment.

   If the qualifying event is:
   1) A reduction in the Subscriber's regularly scheduled work hours, or
   2) Because of termination of the Subscriber's employment with the Group for any reason other than gross misconduct and the Subscriber became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, then COBRA continuation coverage for Dependents may continue for up to thirty-six (36) months after the initially determined date of Medicare entitlement.

b) A Dependent who would lose coverage under this Plan due to any of the qualifying events shown below has the right to elect COBRA continuation coverage. Such coverage may continue for up to thirty-six (36) months.
   i) The Subscriber's death.
   ii) The Subscriber's divorce or legal separation.
   iii) The Subscriber becomes entitled to Medicare benefits under Part A, Part B, or both.
   iv) A Dependent no longer qualifies as a Dependent child as provided in Section 1. of this EOC.

   The premium for continuation coverage may be increased to 102% of the premium for providing coverage to other individuals under this Plan.

c) **Election of COBRA Continuation Coverage**. A Subscriber or Dependent identified in 3.1(a) or (b) above must elect to continue coverage within sixty (60) days of the election notice which qualifies him to continue coverage. If the election is not made within sixty (60) days, the Subscriber or Dependent is not eligible to continue coverage under this Plan.

   Each Subscriber or Dependent will have an independent right to elect COBRA continuation coverage. Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Plans Offered Under COBRA Continuation Coverage. Subscribers and Dependents who qualify and elect COBRA continuation coverage must be offered the same Plan as similarly situated employees for whom a qualifying event has not occurred. When a qualified Subscriber or his Dependent leaves HPN's Service Area, they will be given the opportunity to elect alternate coverage that the Group makes available to its active employees.

For purposes of COBRA continuation coverage, "similarly situated employees" means the group of covered employees, spouses of covered employees, or Dependent children of covered employees receiving coverage under a Group Health Benefit Plan maintained by the employer. Similarly situated employees receive healthcare coverage for a reason other than under COBRA continuation coverage and who, based on all of the facts and circumstances are most similarly situated to the circumstances of the qualified Subscriber immediately before the qualifying event.

For the purposes of determining the cost of COBRA continuation coverage, the Plan is entitled to take into account the Plan under which COBRA continuation coverage is provided.

d) **Notice from Plan Administrator (Group)**. The Plan Administrator will have up to forty-four (44) days from the qualifying event to provide the Subscriber or Dependent with the COBRA election notice which contains information concerning the actions required to elect COBRA continuation coverage and the premium to be paid. The Plan Administrator has the sole obligation to provide the Subscriber or Dependent with a notice of unavailability in the event that the Plan Administrator determines that such Subscriber or Dependent is not entitled to COBRA continuation coverage. HPN assumes no responsibility for the Plan Administrator's failure to provide COBRA notifications to the eligible Members.

HPN assumes no further obligation to provide COBRA continuation coverage if:

- The Plan Administrator does not notify the Member within forty-four (44) days of the qualifying event; or
- The Member does not make a timely election; or
- The Plan Administrator fails to notify HPN of the election within sixty (60) days of the election; or
- Timely premium payments are not made as described in 3.1(f).

There are two (2) ways in which the eighteen (18)-month period of COBRA continuation coverage identified in 3.1(a) can be extended:

1. **Disability Extension**. If a Subscriber or Dependent covered under the Plan is disabled as determined under Title II (OASDI) or Title XVI (SSI) of the Social Security Act (SSA), COBRA continuation coverage will be extended from eighteen (18) months up to a total maximum of twenty-nine (29) months, provided the disability started at some time before the sixtieth (60th) day of COBRA continuation coverage, continues until the end of the eighteen (18)-month period of COBRA continuation coverage, and notice is received by Group before the initial eighteen (18)-month period expires.

   The premium for the extension period of COBRA continuation coverage will be increased to 150% of the applicable Group premium for providing coverage to other Subscribers under this Plan. During the extended period, a disabled individual's coverage will be terminated automatically as of the first day of the month that is more than thirty (30) days after a final determination that the Subscriber or Dependent is no longer disabled.

   The individual is required to notify the Group within sixty (60) days of such determination. Disabled individuals are also subject to termination as set forth in 3.1(f).

2. **Second Qualifying Event Extension**. If a second qualifying event occurs while receiving eighteen (18) months of COBRA continuation coverage, an enrolled spouse and Dependent children can qualify for eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan.
   This extension may be available to the spouse and any Dependent children receiving COBRA continuation coverage if the Subscriber or former Subscriber:
   - Dies;
   - Becomes entitled to Medicare benefits (under Part A, Part B, or both);
   - Gets divorced or legally separated; or
   - If the Dependent child no longer qualifies as a Dependent child as provided in Section 1. of this EOC.

e) **Required Notification**. The Subscriber or Dependent must notify Group and Group must notify HPN within sixty (60) days beginning from the latest of:

1. The date on which the relevant qualifying event occurs;
2. The date on which there is a loss of coverage under the Plan as a result of the qualifying event; or
3. The date on which the Subscriber or Dependent is informed through the Plan's EOC or the general COBRA notice of their obligation to provide notice and the procedures for providing such notice.

The Subscriber or Dependent must provide notice to Group of any of the following qualifying events:

- A Subscriber's divorce.
- A Subscriber's legal separation.
- A Dependent no longer meets HPN's eligibility rules.
- A second qualifying event after a Subscriber or Dependent has become entitled to COBRA continuation coverage with a maximum duration of eighteen (18) or twenty-nine (29) months.
- A Subscriber or Dependent entitled to receive COBRA continuation coverage with a maximum duration of eighteen (18) months has been determined by the Social Security Administration under Title II or XVI of SSA to be disabled at any time during the first sixty (60) days of COBRA continuation coverage.

  The Member who seeks the disability extension must notify the Plan Administrator and HPN of the Social Security Administration disability determination no later than sixty (60) days after the latest of:
  1. The date of Social Security Administration determination;
  2. The date on which the qualifying event occurs;
  3. The date on which the Subscriber or Dependent loses coverage under the Plan as a result of a qualifying event;
  4. The date on which the Subscriber or Dependent is informed through the Plan's EOC or the general COBRA notice of their obligation to provide notice.

- A disabled Subscriber or Dependent, who has subsequently been determined by the Social Security Administration under Title II or XVI of the SSA to no longer be disabled.
- If a Member is determined by the Social Security Administration to no longer be disabled, the Member must notify the Plan of that fact within sixty (60) days after the Social Security Administration's determination.

Any Subscriber, Dependent or any representative designated or authorized to act on behalf of the Subscriber or Dependent may provide the notice and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of the Subscriber and all Dependents with respect to the qualifying event.

f) **Non-Eligibility and Termination**. In addition to HPN's other rights to terminate this coverage as shown in Section 2., COBRA continuation coverage will not be allowed or shall be terminated prior to the end of the applicable eighteen (18) month, the nineteen (19) to twenty-nine (29) month extension period for the disability extension, or thirty-six (36) month period for Dependents, if any of the following occur:

- The GEA is terminated in its entirety.
- The Subscriber, spouse or Dependent fails to pay premiums in full when due.

  The Subscriber or Dependent will have a one-time only initial grace period of forty-five (45) days from the date of COBRA election to make the first premium payment. Thereafter, payments for COBRA continuation coverage are due by the first day of each monthly period to which the payment applies (payments must be postmarked on or before the thirty (30)-day grace period).

  If you do not make payments on a timely basis, COBRA continuation coverage will terminate as of the last day of the period for which timely payment was made.

- The Subscriber or Dependent becomes eligible for coverage under another Group Health Benefit Plan.
- The divorced spouse remarries and becomes eligible for coverage under another Group Health Benefit Plan.
- The Subscriber or Dependent becomes entitled to Medicare benefits (under Part A, Part B or both) after electing COBRA continuation coverage.
- A disabled Subscriber is found to be no longer disabled.

The Plan Administrator has the sole obligation to provide the Subscriber or Dependent with a notice of termination in the event that COBRA continuation coverage is terminated prior to the end of the maximum period. HPN assumes no responsibility for the Plan Administrator's failure to provide such notification to the eligible Members.

g) **Address Changes**. The Member shall be responsible for notifying Group of any changes in the addresses of enrolled Dependents.

h) **Plan Contact Information**. For additional information about the Plan or your rights under COBRA continuation coverage, contact HPN's Member Services Department by calling 1-877-545-7378.

i) **COBRA and FMLA**. If the Subscriber has taken a leave of absence under the Family Medical Leave Act of 1993 (FMLA) and does not return to work at the end of the FMLA leave, the Subscriber and Dependents may elect COBRA continuation coverage for up to eighteen (18) months from the earliest to occur of the following:

- The date that the Subscriber states that they will not be returning to work at the end of the leave;
- The end of the approved leave, assuming that the Subscriber does not return, and
- The date that the FMLA entitlement ends.

For purposes of an FMLA leave, the Subscriber and Dependents will be eligible for COBRA continuation coverage only if:

- The Subscriber and Dependents are covered by the Group Health Benefit Plan on the day before the leave begins (or become covered during the FMLA leave);
- The Subscriber does not return to employment at the end of the FMLA leave; and
- The Subscriber or Dependents lose coverage under HPN's Group Health Benefit Plan before the end of what would be the maximum COBRA continuation coverage period.

3.2 Federal Continuation of Coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

For Groups of any size, the Subscriber or any Dependents shall have the right to continue Group coverage as follows.

(a) **Eligibility**. In the event that Subscriber and any Dependent would lose coverage under the Plan because of Subscriber's absence from work due to Subscriber's service in the uniformed services, Subscriber may elect to continue coverage under the Plan on behalf of Subscriber and any Dependents.

(b) **Duration of COBRA Continuation Coverage**. The maximum period of COBRA continuation coverage under this section shall be the lesser of:

1. The 24-month period beginning on the date on which the Subscriber's absence from work begins; or

2. The day after the date on which the Subscriber fails to apply for or return to work with the Group as follows:

   a) If the Subscriber served in the uniformed services and is absent from work for less than thirty-one (31) days:
      1) COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment which must not be later than the beginning of the first full regularly scheduled work period on the first full calendar day following completion of the period of service and the expiration of eight (8) hours after a period allowing for the Subscriber's transportation from the place of that service to the Subscriber's residence; or
      2) As soon as possible after the expiration of the eight (8) hour period referred to in (1) if reporting within the period under (1) is impossible or unreasonable through no fault of the Subscriber.

   b) If the Subscriber is absent from work for any period for purposes of determining the Subscriber's fitness to perform service in the uniformed service, not later than the period described in (1) above.

   c) If the Subscriber served in the uniformed services and is absent from work for more than thirty (30) days but less than 181 days, COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment, which must not be later than fourteen (14) days after completion of the period of service. If applying within that period is impossible or unreasonable through no fault of the Subscriber, then the application for reemployment must be made by the next first full calendar day when applying becomes possible.

   d) If the Subscriber served in the uniformed services and is absent from work for more than 180 days, COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment which must not be later than ninety (90) days after completion of such period of service.

(c) **Premium for COBRA Continuation Coverage.** A Subscriber electing COBRA continuation coverage under this section shall be responsible for paying the applicable premium for such coverage. The premium for COBRA continuation coverage shall not exceed 102% of the applicable premium for providing coverage to other Subscribers of the Group. However, if the Subscriber performs service in the uniformed services for less than thirty-one (31) days, the Subscriber shall be liable only for the premium contribution (if any) that the Subscriber was paying for coverage under the Plan immediately prior to serving in the uniformed services.

3.3 Total Disability of Subscriber

For Groups of any size, continuation of coverage shall be offered to each Subscriber and their Dependents who are otherwise covered by this Plan while the Subscriber is on leave without pay (as defined by the GEA), as a result of Total Disability. This coverage is for any Injury or Illness suffered by the Subscriber, which is not related to the Total Disability or for any Injury or Illness suffered by a Dependent. This coverage will continue, subject to the payment of the applicable premium, until the earliest to occur of:

- The date Subscriber's employment is terminated.
- The date Subscriber obtains other healthcare coverage on an insured or self-insured basis.
- The date the GEA is terminated.
- After a period of twelve (12) months during which benefits for such coverage are provided to the Subscriber.
- The date the Subscriber no longer resides or works within the HPN Service Area or a Dependent no longer resides within the HPN Service Area.

NOTE: In this Section 3., "Totally Disabled" or "Total Disability" refers to the continuing inability of the Subscriber to substantially perform duties related to his employment. Coverage is equal to coverage provided in this Plan.

3.4 Non-Election

For Groups of any size, if a Subscriber and/or Dependent does not elect to continue coverage under the Group Plan, or does not qualify for continuation of coverage, coverage under this Plan shall terminate on the date provided for in this EOC.

3.5 State Law

In the event that applicable state law requires different continuation of coverage provisions for any size Group, the provisions required by such state law will apply.

SECTION 4. Managed Care Program

This section tells you about HPN's Managed Care Program and which Covered Services require Prior Authorization.

4.1 Managed Care Program

HPN's Managed Care Program, using the services of professional medical peer review committees, utilization review committees, and/or the Medical Director, determines whether services and supplies are Medically Necessary. HPN's Managed Care Program helps direct care to the most appropriate setting to provide healthcare in a cost-effective manner.

4.2 Managed Care Program Requirements

HPN's Managed Care Program requires the Member, Plan Providers and HPN to work together. All Plan Providers have agreed to participate in HPN's Managed Care Program. Plan Providers have agreed to accept HPN's Reimbursement Schedule amount as payment in full for Covered Services, less the Member's payment of any applicable Calendar Year Deductible, Copayment or Coinsurance amount, whereas Non-Plan Providers have not.

Members enrolled under HPN's HMO Plans who use the services of Non-Plan Providers will receive no benefit payments or reimbursement for amounts for any Covered Service, except

- In the case of Emergency Services or Urgently Needed Services; or
- For other Covered Services, as defined in this EOC, provided by a Non-Plan Provider that **are** Prior Authorized by HPN's Managed Care Program.

This includes any Prior Authorized Covered Services obtained from a Non-Plan outpatient facility, such as a laboratory, radiological facility (x-ray), or any complex diagnostic or therapeutic services. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.

It is the Member's responsibility to verify that the Provider selected is a Plan Provider before receiving any non-Emergency Services and to comply with all other rules of HPN's Managed Care Program.

Compliance by the Member with HPN's Managed Care Program is mandatory. Failure to comply with the rules of HPN's Managed Care Program means the Member will be responsible for costs of services received.

4.3 Managed Care Process

The Medical Director and/or HPN's Utilization Review Committee will review proposed services and supplies to be received by a Member to determine:

- If the services are Medically Necessary and/or appropriate.
- The appropriateness of the proposed setting.
- The required duration of treatment or admission.

Following review, HPN will complete the Prior Authorization written notification and send a copy to the Provider and the Member. The Prior Authorization form will specify approved Covered Services and supplies. **Prior Authorization is not a guarantee of payment for Covered Services**.

The final decision as to whether any care should be received is between the Member and the Provider. If HPN denies a request by a Member and/or Provider for Prior Authorization of a service or supply, the Member or Provider may appeal the denial to the Grievance Review Committee (see the Appeals Procedures Section herein).

4.4 Services Requiring Prior Authorization

All Covered Services not provided by the Member's Primary Care Physician (PCP) require Prior Authorization from the PCP and HPN's Managed Care Program. The following Covered Services require Prior Authorization and review through HPN's Managed Care Program:

- Non-emergency Inpatient admissions and extensions of stay in a Hospital, Skilled Nursing Facility, Residential Treatment Center or Hospice.
- Outpatient surgery provided in any setting, including technical and professional services.
- Diagnostic and Therapeutic Services.
- Home Healthcare Services.
- All Inpatient and non-routine Outpatient non-Emergency Mental Health, Severe Mental Illness, and Substance-Related and Addictive Disorder Services, including but not limited to:
  - Intensive outpatient program treatment.
  - Partial hospitalization program treatment.
  - Outpatient electro-convulsive treatment.
  - Psychological testing.
- All Specialist visits or consultations.
- Prosthetic Devices, Orthotic Devices and Durable Medical Equipment.
- Allergy testing or treatment (e.g., skin, RAST); angioplasty; physiotherapy or Manual Manipulation; and habilitative and rehabilitation therapy (physical, speech, occupational).

4.5 Emergency Admission Notification

The Member must report all emergency admissions to the Member Services Department by calling 1-877-545-7378 within 24 hours of admission, or as soon as reasonably possible, to authorize continued care.

All emergency admissions are reviewed Retrospectively to determine if the treatment received was Medically Necessary and appropriate and was for Emergency Services as defined in this EOC. If such Emergency Services are provided by Non-Plan Providers, all Medically Necessary professional, Inpatient or outpatient Emergency Services will be Covered Services.

4.7 Appeals Rights

All decisions of HPN's Managed Care Program may be appealed by the Member through the Appeals Procedures. If an imminent and serious threat to the health of the Member exists, the appeal will be directed to HPN's Medical Director.

SECTION 5. Obtaining Covered Services

This section tells you under what conditions services are available under this Plan and your obligations as a Member. You should also carefully review the Exclusions and Limitations Sections (Section 7. and Section 8. respectively) prior to obtaining any healthcare services.

5.1 Availability of Covered Services

Members are entitled to receive the Covered Services set forth in Section 6 herein and the Attachment A Benefit Schedule subject to all terms and conditions of this EOC, and payment of required premium. These Covered Services are available only if and to the extent that they are:

- Provided, prescribed or arranged by the Member's PCP;
- Specifically authorized through HPN's Managed Care Program;
- Received in HPN's Service Area through a Plan Provider; and
- Medically Necessary as defined in this EOC.

This section does not apply to Emergency Services or Urgently Needed Services as defined in this EOC, or other Covered Services provided by a Non-Plan Provider which have otherwise been approved by HPN's Managed Care Program.

5.2 Agreement of Member

Each Member entitled to receive Covered Services under this Plan agrees to:

- Choose a PCP from the list of available PCPs. The Subscriber and each Dependent may select a different PCP.
- A female Member may choose two (2) PCPs: A general practice Physician and an Obstetrician or Gynecological Physician. Members may receive benefits only as provided by or approved in advance by the chosen PCP.
- Receive specialty consultation and/or treatment from Plan Providers only upon written Prior Authorization according to HPN's Managed Care Program.
- Obtain Prior Authorization from HPN's Managed Care Program before receiving any non-Emergency Services from Non-Plan Providers.
- Be financially responsible for the cost of services in excess of Eligible Medical Expenses or the Recognized Amount, when applicable, when these services are approved by HPN's Managed Care Program and received outside of HPN's Service Area or from Non-Plan Providers.
- Except in the case of Emergency Services and Urgently Needed Services, be fully responsible for the cost of services not provided by the PCP according to HPN's Managed Care Program or Prior Authorized by the PCP or HPN's Managed Care Program.

5.3 Continuity of Care from Plan Providers

Termination of a Plan Provider's contract will not release the Provider from treating a Member, except for reasons of medical incompetence or professional misconduct as determined by HPN.

Coverage provided under this section is available until the latest of the following dates:

- The 120th day following the date the contract was terminated between the Provider and HPN; or
- If the medical condition is pregnancy, the 90th day after the date of delivery or if the pregnancy does not end in delivery, the date of the end of the pregnancy.

The Member or Plan Provider may submit a request for continuity of care to the following address. If the Plan agrees to the continued treatment, the Plan will pay for Covered Services at the Plan Provider level of benefits for a limited time, as outlined above. The Plan Provider may not seek payment from the Member for any amounts for which the Member would not be responsible if the Provider were still a Plan Provider.

Health Plan of Nevada
PO Box 14856
Las Vegas, NV 89114-4856
Attention: Transition of Care/Continuity of Care
ProviderAdvocateTE@uhc.com

SECTION 6. Covered Services

This section tells you what services are covered under this Plan. Only services and supplies which meet HPN's definition of Medically Necessary will be considered to be Covered Services. The Attachment A Benefit Schedule shows, if applicable, the Calendar Year Deductible, Copayments, Coinsurance and benefit limitations for Covered Services. All Covered Services are subject to HPN's Managed Care Program.

Ambulance Services

Covered Services include Ambulance Services to the nearest appropriate Hospital. HPN will make direct payment to a Provider of Ambulance Services if the Provider does not receive payment from any other source. Ambulance Services will be reviewed on a Retrospective basis to determine Medical Necessity. The Member will be fully liable for the cost of Ambulance Services that are not Medically Necessary.

Assistant Surgical Services

Covered Services include services performed by an assistant surgeon in connection with a covered surgical procedure but only to the extent that the surgical assistance is necessary due to the complexity of the procedure involved.

Autism Spectrum Disorder Services

Covered Services include Medically Necessary services that are generally recognized and accepted procedures for screening, diagnosing and treating Autism Spectrum Disorders. Covered Services must be provided by a duly licensed physician, psychologist or Behavior Analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst and are subject to HPN's Managed Care Program. With the exception of the specific limitation on benefits for Applied Behavior Analysis ("ABA") as outlined in Attachment A Benefit Schedule, benefits for all Covered Services for the treatment of Autism Spectrum Disorders are payable to the same extent as other Covered Services and Covered Drugs under the Plan.

Covered Services for the treatment of Autism Spectrum Disorder Services do not include services provided through school services.

Biomarker Testing

Covered Services include medically necessary biomarker testing for appropriate management and ongoing monitoring of a disease or condition.

Clinical Trial or Study

Covered Services include coverage for Prior Authorized medical treatment received as part of a clinical trial or study if the following provisions apply:

- The clinical trial or study is conducted in the state of Nevada and the medical treatment is provided:
  1. In a Phase I, Phase II, Phase III or Phase IV clinical trial or study for the treatment of cancer or other life-threatening disease or condition;
  2. In a Phase II, Phase III or Phase IV clinical trial or study for the treatment of chronic fatigue syndrome;
  3. For cardiovascular disease (cardiac/stroke) which is not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
  4. For surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
  5. Other diseases or disorders which are not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
- The clinical trial or study is approved by one of the following entities:
  1. An agency of the National Institutes of Health (NIH) as set forth in 42 U.S.C. § 281 (b);
  2. The Centers for Disease Control and Prevention (CDC);
  3. The Agency for Healthcare Research and Quality (AHRQ);
  4. Centers for Medicare and Medicaid Services (CMS);
  5. A cooperative group;
  6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
  7. The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet the both of following criteria:
     - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
     - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. HPN may, at any time, request documentation about the trial;

- The medical treatment is provided by a duly licensed Provider of healthcare and the facility and personnel have the experience and training to provide the medical treatment in a capable manner;
- There is no medical treatment available which is considered a more appropriate alternative than the medical treatment provided in the clinical trial or study;
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment; and
- The Member has signed a statement of consent before his participation in the clinical trial or study indicating that he has been informed of:
  1. The procedure to be undertaken;
  2. Alternative methods of treatment; and
  3. The risks associated with participation in the clinical trial or study.

Benefit coverage for medical treatment received during a clinical trial or study is limited to the following Covered Services:

- The initial consultation to determine whether the Member is eligible to participate in the clinical trial or study;
- Any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the Member, if the drug or device is not paid for by the manufacturer, distributor, or Provider:
- Services normally covered under this Plan that are required as a result of the medical treatment or related complications provided in the clinical trial or study when not provided by the sponsor of the clinical trial or study;
- Services required for the clinically appropriate monitoring of the Member during the clinical trial or study when not provided by the sponsor of the clinical trial or study.

Benefits for Covered Services in connection with a clinical trial or study are payable under this Plan to the same extent as any other Illness or Injury.

Services must be provided by an HPN Plan Provider. In the event an HPN Plan Provider does not offer a clinical trial with the same protocol as the one the Member's Plan Provider recommended, the Member may select a Non-Plan Provider performing a clinical trial with that protocol within the State of Nevada. If there is no Provider offering the clinical trial with the same protocol as the one the Member's Plan Provider recommended in Nevada, the Member may select a clinical trial outside of Nevada but within the United States of America. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.

HPN will require a copy of the clinical trial or study certification approval, the Member's signed statement of consent, and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment.

Corrective Appliances

Corrective Appliances are devices that are designed to support a weakened body part and are manufactured or custom-fitted to an individual. Covered Services include custom-made or custom-fitted Medically Necessary Corrective Appliances when Prior Authorized by HPN's Managed Care Program, to include the following:

- Rigid Cervical Collars;
- Abdominal Binder/Corsets;
- Shoes when prescribed for a diabetic condition, otherwise only when an integral part of a lower body brace;
- Helmets when prescribed in connection with cranial orthosis.

Corrective Appliances do not include:

- Bionic, myoelectric, microprocessor-controlled, and computerized prosthetics; or
- Deluxe upgrades determined not to be Medically Necessary.

Replacements, repairs and adjustments to Corrective Appliances are Covered Services when required by normal wear and tear or by a significant change in the Member's condition when ordered by a duly-licensed Provider.

Dental Anesthesia Services

Covered Services include general anesthesia when rendered in a Plan Hospital, Plan outpatient surgical facility, or other duly licensed Plan facility for an enrolled Dependent child, when such child, in the treating dentist's opinion and as Prior Authorized by the Plan, satisfies one or more of the following criteria:

- Has a physical, mental or medically compromising condition;
- Has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy;
- Is extremely uncooperative, unmanageable or anxious; or
- Has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

Coverage for dental anesthesia pursuant to this section is limited to services provided by a Plan anesthesia Provider. Coverage is provided only during procedures performed by:

- An educationally qualified Specialist in pediatric dentistry; or
- Another dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted; or
- Who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

Durable Medical Equipment

All benefits for Durable Medical Equipment ("DME") includes administration, maintenance and operating costs of such equipment, if the equipment is Medically Necessary or Prior Authorized. DME includes, but is not limited to:

- Braces;
- Canes;
- Crutches;
- Hospital beds;
- Intermittent positive pressure breathing machine;
- Standard outpatient oxygen delivery systems;
- Traction equipment;
- Walkers;
- Wheelchairs; or
- Any other items that are determined to be Medically Necessary by HPN's Managed Care Program.

Replacements, repairs and adjustments to DME are limited to normal wear and tear or because of significant change in the Member's physical condition.

HPN will not be responsible for the following:

- Non-Medically Necessary optional attachments and modifications to DME for the comfort or convenience of the Member;
- Accessories for portability or travel;
- A second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment;
- Home and car remodeling; and
- Replacement of lost or stolen equipment.

Emergency or Urgently Needed Services

Emergency Services obtained from Non-Plan providers will be payable at the same benefit level as would be applied to care received from Plan Providers.

Benefits are limited to Eligible Medical Expenses or the Recognized Amount, when applicable, for Non-Plan Provider Emergency Services as defined under "HPN Reimbursement Schedule". You are responsible for any Non-Plan Provider Emergency Service charges that exceed payments made by HPN.

Benefits for Emergency Services are subject to any limit shown in the Attachment A Benefit Schedule.

IMPORTANT NOTE: No benefits are payable for treatment received by a Member in a Hospital emergency room or other emergency facility for a condition other than an Emergency Service as defined in this EOC.

Examples of conditions which require Medically Necessary treatment, but **are not Emergency Service**s, include:

- Earaches.
- Flu or fever.
- Medication refills.
- Routine dental services.
- Sore or stiff muscles.
- Sore throats.
- Sprains, strains or minor cuts.
- Suture removal.

(a) **Within the HPN Service Area**. If an Injury or Illness requires Emergency Services, the Member should notify HPN as soon as reasonably possible after the onset of the emergency.

HPN will review the use of the emergency room retrospectively for appropriateness and to determine if the services received were Medically Necessary. Benefits for such services are payable if the services are determined to be Emergency Services as defined in this EOC.

1. **Non-Plan Providers**. If Emergency Services are provided by Non-Plan Providers, all Medically Necessary professional services and Inpatient or Outpatient Hospital Services will be covered subject to the other terms of this EOC.

   The Member should, at the earliest time reasonably possible, notify his PCP.

2. **Payment**. Benefits for Emergency or Urgently Needed Services received from Non-Plan Providers are limited to Eligible Medical Expenses or the Recognized Amount, when applicable, for care required before the Member can safely receive services from his PCP.

3. **Follow-Up Care**. In order for benefits to be payable, the Member's PCP must provide follow-up care, unless authorized by HPN's Managed Care Program.

(b) **Outside the HPN Service Area**. Benefits for Covered Services received while outside the HPN Service Area are limited to Emergency Services and Urgently Needed Services when care is required immediately and unexpectedly.

The Member should notify HPN as soon as reasonably possible after the onset of the emergency medical condition. Elective or specialized care will not be covered if the circumstances leading to the need for such care could have been foreseen before leaving HPN's Service Area.

1. **Payment**. Benefits are limited to the Eligible Medical Expenses or the Recognized Amount, when applicable, for such Covered Services. In addition, benefits for such Covered Services are not payable unless the services are determined to be Urgently Needed Services or Emergency Services as defined in this EOC.

2. **Follow-Up Care**. Continuing or follow-up treatment for Injury or Illness is limited to care required before the Member can safely return to HPN's Service Area.

Once the patient is stabilized, benefits for continuing or follow-up treatment are provided only in HPN's Service Area, subject to all provisions of this EOC.

24/7 Advice Nurse. If you are feeling ill and are not sure about where you should go to obtain care or do not know whom to call, you may call the 24/7 Advice Nurse for help. A nurse is available twenty-four (24) hours a day, seven (7) days a week at (702) 242-7330, or for the hearing-impaired through Relay Nevada's TDD/TYY at 1-800-326-6888. If you are traveling outside HPN's Service Area, you may call toll free for assistance at 1-800-288-2264.

Free Standing Emergency Room Facilities

These facilities are licensed to provide emergency medical care and are physically separate from hospitals. However, unlike hospital-based emergency rooms, these facilities often do not provide services for critical conditions such as trauma, stroke or heart attacks; most do not receive ambulances or have an operating room on site. Please contact the 24/7 Advice Nurse if you have questions on where to go to obtain the appropriate level of service.

Gastric Restrictive Surgical Services

Covered Services include Prior Authorized Medically Necessary Gastric Restrictive Surgical Services for extreme obesity under the following circumstances:

- Have a body mass index (BMI) of greater than or equal to 40kg/m2; or
- Have a BMI between 35.1-39.9kg/m2 with significant co-morbidities; and
- Can provide documented evidence that dietary attempts at weight control are ineffective; and
- Must be at least 18 years old.

Documentation supporting the reasonableness and necessity of a Gastric Restrictive Surgical Service is required, including compliant attendance at a medically supervised weight loss program (within the last twenty-four (24) months) for at least six (6) consecutive months with documented failure of weight loss. Significant clinical evidence that weight is affecting overall health and is a threat to life will also be required.

HPN requires that an initial psychological/ psychiatric evaluation resulting in a recommendation for Gastric Restrictive Surgical Services is performed prior to review consideration by HPN's Managed Care Program. HPN may also require participation in a post-operative group therapy program.

Treatment for complications resulting from Gastric Restrictive Surgical Services will be covered the same as any other illness.

Gender Dysphoria

Covered Services for Gender Dysphoria, a disorder characterized by diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association,* are provided if Prior Authorized and if the following diagnostic criteria are met:

For Adults and Adolescents:

- A marked incongruence between the Member's experienced/expressed gender and the Member's assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

For Children:

- A marked incongruence between the Member's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender) and at least five of the following:
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

The following are Gender Dysphoria Covered Services:

- **Psychotherapy** for Gender Dysphoria and associated co-morbid psychiatric diagnoses.

- **Cross-sex hormone therapy** is available as follows:
  - Oral and injectable therapy, administered by a provider, during an office visit or in an outpatient or inpatient setting.
  - Oral and injectable therapy dispensed from a pharmacy as prescribed by a provider.

  Puberty suppressing medication is not cross-sex hormone therapy.

- **Laboratory Testing:** Benefit coverage includes laboratory testing to monitor continuous hormone replacement therapy provided as any other outpatient diagnostic service under the Plan.

- **Genital Surgery and Surgery to Change Secondary Sex Characteristics:** Provided as any other Medically Necessary service under this Plan (as appropriate to each patient) including:

  Male to Female:
  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:
  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)

  The Member must meet all of the following eligibility qualifications for genital surgery, surgery to change secondary sex characteristics and bilateral mastectomy or breast reduction surgery (in addition to the overall eligibility requirements in the EOC).

  Breast Surgery:
  The Member must provide documentation in the form of a written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Member meets all of the following criteria:
  - Has persistent, well-documented Gender Dysphoria;
  - Has the capacity to make a fully informed decision and to consent for treatment;
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

  Genital Surgery:
  The Member must provide documentation in the form of a written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Member. The assessment must document that the Member meets all of the following criteria:
  - Has persistent, well-documented Gender Dysphoria;
  - Has the Capacity to make a fully informed decision and to consent for treatment;
  - If significant medical or mental health concerns are present, they must be reasonably well controlled;
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender; and
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

HPN may direct you to a plan provider or facility that is outside your service area. If you are required to travel to obtain such Gender Dysphoria Covered Services from a plan provider, HPN may reimburse certain reasonable and necessary travel expenses.

HPN makes no representation or warranty as to the medical competence or ability of any Gender Dysphoria Treatment Center/Facility or its respective staff or Physicians. HPN shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, or any actions or inactions, whether negligent or otherwise, on the part of any Gender Dysphoria Treatment Center/Facility or its respective staff or Physicians.

Genetic Disease Testing Services

Covered Services include Prior Authorized Medically Necessary Genetic Disease testing, when:

- Such testing is prescribed following the Member's history, physical examination and pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, and a definitive diagnosis remains uncertain and a genetic disease diagnosis is suspected, and;
- The Member displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); and
- The result of the test will directly impact the treatment being delivered to the Member.

Healthcare Facility Services

Covered Services include the following accommodations, services and supplies received during an admission to a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility, Residential Treatment Center or Hospice Care Facility.

Accommodations:

- Semiprivate (or multibed unit) room, including bed, board and general nursing care.
- Private room including bed, board, and general nursing care, but only when treatment of the Member's condition requires a private room. The semiprivate room rate will be allowed toward the private room rate when a Member receives private room accommodations for any reason other than Medical Necessity.
- Inpatient accommodations provided in connection with the birth of a child shall be provided for a minimum of forty-eight (48) hours following an uncomplicated vaginal delivery or a minimum of ninety-six (96) hours following an uncomplicated delivery by cesarean section. This provision does not require a Member to deliver in a Hospital or other healthcare facility or to remain therein for the minimum number of hours following delivery.
- Intensive care unit (including Cardiac Care Unit), including bed, board, general and special nursing care, and ICU equipment.
- Observation unit, including bed, board, and general nursing care not to exceed twenty-three (23) hours per day.
- Nursery charges for newborns. Reimbursement for Covered Services provided by a Non-Plan Provider outside HPN's Service Area to a newborn natural child or adopted child is limited to HPN's Eligible Medical Expenses or the Recognized Amount, when applicable, for similar Covered Services provided in HPN's Service Area.

Services and Supplies. Covered Services and supplies provided by a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility, Residential Treatment Center or Hospice Care Facility include:

- Non-surgical Provider visits;
- Operating, recovery, and treatment rooms and equipment (Hospital and Ambulatory Surgical Facility only);
- Delivery and labor rooms and equipment (Hospital and Ambulatory Surgical Facility only);
- Anesthesia materials and anesthesia administration by Hospital staff (Hospital and Ambulatory Surgical Facility only);
- Clinical pathology and laboratory services and supplies;
- Services and supplies for diagnostic tests required to diagnose Member's Illness, Injury or other conditions but only when charges for the services and/or supplies are made by the facility (Hospital, Skilled Nursing Facility and Ambulatory Surgical Facility only);
- Drugs consumed at the time and place dispensed which have been approved for general marketing in the United States by the Food and Drug Administration (FDA);
- Dressings, splints, casts and other supplies for medical treatment provided by the Hospital from a central sterile supply department;
- Oxygen and its administration;
- Non-replaced blood, blood plasma, blood derivatives, and their administration and processing;
- Intravenous injections and solutions;
- Private duty nursing subject to the benefit limitation for such services;
- Supportive services for a Hospice patient's family, including care for the patient which provides a respite from the stresses and responsibilities that result from the daily care of the patient and bereavement services provided to the family after the death of the patient (Hospice Care Facility only); and
- Sterilization procedures.

Hearing Aids

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) and purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Service for which benefits are available under the applicable medical/surgical Covered Services categories in the HPN EOC, only for a Member

- Who is not a candidate for an air-conduction hearing aid; and
- Which is used according to U.S. Food and Drug Administration (FDA) approved indications.

Benefits for bilateral bone anchored hearing aids are available to Members who meet the HPN Managed Care Program criteria.

Home Healthcare Services

Covered Services include services given to a Member in his home by a licensed Home Healthcare Provider or an approved Hospital program for Home Healthcare. Such services are covered when:

- Such care is given in place of Inpatient Hospital or Skilled Nursing Facility care and/or;
- The Member is not physically able to obtain Medically Necessary care on an outpatient basis; and/or
- The Member is under the care of a Physician; and/or
- The Member is homebound for medical reasons.

NOTE: The Member is responsible for one cost-share per day per Home Healthcare agency.

Covered Services and supplies provided by a Home Healthcare agency include:

- Professional services of a registered nurse, licensed practical nurse or a licensed vocational nurse on an intermittent basis.
- Physical therapy, speech therapy and occupational therapy by a licensed therapist.
- Medical and surgical supplies that are customarily furnished by the Home Healthcare agency or program for its patients.
- Prescribed drugs furnished and charged for by the Home Healthcare agency or program. Prescribed drugs under this provision do not include Specialty Prescription Drugs. Please refer to the optional HPN Prescription Drug Benefit Rider, if applicable to your Plan, for information on benefits available for Specialty covered drugs.
- One (1) medical social service consultation per course of treatment.
- One (1) nutrition consultation by a certified registered dietitian.
- Health aide services furnished to Member only when receiving nursing services or therapy.

Laboratory Services

Covered Services include prescribed diagnostic clinical and anatomic pathological laboratory services and materials when authorized by a Member's PCP and HPN's Managed Care Program.

Mastectomy Reconstructive Surgical Services

Covered Services are provided in the same manner and at the same level as those for any other Covered Health Service, and also as required by the *Women's Health and Cancer Rights Act of 1998*, as follows:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy, including lymphedema, in a manner determined in consultation with the attending provider and the patient.

Medical – Physician Services

Covered Services include services which are generally recognized and accepted non-surgical procedures for diagnosing or treating an Illness or Injury, performed by a Physician in his office, the patient's home, or a licensed healthcare facility. Medical Services include:

- Direct physical examination of the patient;
- Examination of some aspect of the patient by means of pathology laboratory or electronic monitoring procedure which is a generally recognized and accepted procedure for diagnostic or therapeutic purposes in the treatment of an Illness or Injury;
- Procedures for prescribing or administering medical treatment;
- Manual Manipulation (except for reductions of fractures or dislocations);
- Treatment of the temporomandibular joint including Medically Necessary dental procedures, such as dental splints;
- Anesthesia services;
- Family planning services including sterilization procedures; and
- Limited diagnostic and therapeutic infertility services determined to be Medically Necessary by HPN and Prior Authorized by HPN's Managed Care Program. In order for the Member to be eligible for infertility benefits, all of the following criteria must be met. The Member:
  - Is not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
    - One year, if a female under age 35; or
    - Six months, if a female age 35 or older.
  - Has infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

  For the purposes of this benefit, "therapeutic donor insemination" means using a donor sperm sample to enable a female to become pregnant.

Covered Services do not include those services specifically excluded in the Exclusions section herein, but do include limited:

- Laboratory studies.
- Diagnostic procedures.
- Artificial insemination services, up to six (6) cycles per Member per lifetime.

Medical Supplies

Medical Supplies are routine expendable supplies that are essential to carry out the course of treatment for an Illness or Injury or are necessary for the effective use of Durable Medical Equipment. Medical Supplies include, but are not limited to the following:

- Catheter and catheter supplies – urinary catheters, drainage bags, irrigation trays;
- Colostomy bags (and other ostomy supplies);
- Dressing/wound care-sterile dressings, ace bandages, sterile gauze and toppers, Kling and Kerlix rolls, Telfa pads, eye pads, incontinent pads, lamb's wool pads;
- Elastic stockings; and
- Splints and slings.

Mental Health Services and Severe Mental Illness Services

All benefits are subject to the Utilization Management process through HPN Behavioral Health. Services must be offered in a treatment setting that is appropriate for the Medically Necessary level of care, as determined by staffing, ability to provide patient safety, treatment intensity, the diagnostic and therapeutic modalities available, the extent of supportive services and access to general medical care. All non-routine, outpatient Mental Health or Severe Mental Illness Services require Prior Authorization.

Inpatient: A structured hospital-based program which provides twenty-four (24) hours a day, seven (7) days a week nursing care, medical monitoring, and physician availability; assessment and diagnostic services, daily physician visits, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the Member or others.

Partial Hospitalization Program (PHP): A structured ambulatory program that may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Intensive Outpatient Program (IOP): A structured program that maintains hours of service for at least nine (9) hours per week for adults and six (6) hours per week for children or adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided.

Outpatient: Assessment, diagnosis and active behavioral health treatment that are provided in an ambulatory setting, including individual and group counseling services.

No benefits are available for psychosocial rehabilitation or care received as a custodial Inpatient.

Residential Treatment Center Services (RTC): a sub-acute facility or acute care facility which delivers twenty-four (24) hours/ seven (7) days a week assessment, diagnostic services and active behavioral health treatment to Members. The level of care and length of stay, in a facility with the appropriate licensure level, is authorized through the HPN Managed Care program. NOTE: Transitional Living services are not covered under RTC and are not a covered benefit.

All inpatient Mental Health or Severe Mental Illness Services require Prior Authorization. Network facilities must provide notification of all inpatient admissions to the Plan. When these services are provided out of network, the Member is responsible for providing the notification and relevant information to the Plan. The Member should provide notice of emergent admissions within twenty-four (24) hours of admission or as soon as reasonably possible given the circumstances. Member may delegate their responsibility to provide notification to the non-network facility but it is the Member's responsibility to ensure that the Plan receives notification. Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.

All admissions for Emergency Services are reviewed retrospectively to determine if the treatment received was Medically Necessary and appropriate. If the Member is admitted to a Mental Health or Severe Mental Illness facility for non-emergency treatment without Prior Authorization, Member will be responsible for the cost of services received.

Oral Physician Surgical Services

Although dental services are not Covered Services, the following Oral Surgical Services are Covered Services:

- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Removal of teeth which are necessary in order to perform radiation therapy.
- Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an Injury (not to include injuries caused by chewing) when the treatment starts within the first ten (10) days after the Injury and ends within sixty (60) days from the date of injury. Examples of Covered Services, in such instances, include:
  - Root canal therapy, post and build up.
  - Temporary crowns.
  - Temporary partial bridges.
  - Temporary and permanent fillings.
  - Pulpotomy.
  - Extraction of broken teeth.
  - Incision and drainage.
  - Tooth stabilization through splinting.

No benefits are provided for removable dental prosthetics, dentures (partial or complete) or subsequent restoration of teeth, including permanent crowns.

Organ and Tissue Transplant Surgical Services

All Covered Transplant Procedures are subject to the provisions of HPN's Managed Care Program and all other terms and provisions of the Plan, including the following:

- HPN will determine if the Member satisfies HPN's Medically Necessary criteria before receiving benefits for transplant services.
- HPN will provide a written Referral for care to a Transplant Facility.
- If, after Referral, either HPN or the medical staff of the Transplant Facility determines that the Member does not satisfy the Medically Necessary criteria for the service involved, benefits will be limited to Covered Services provided up to such determination.

Covered Transplant Procedures include the following services for human-to-human organ or tissue transplants received during a Transplant Benefit Period on an Inpatient basis due to an Injury or Illness as follows:

- Hospital room and board and medical supplies.
- Diagnosis, treatment, surgery and other Covered Services provided by a Physician.
- Organ and tissue retrieval which includes removing and preserving the donated part.
- Organ procurement.
- Rental of wheel chairs, Hospital-type beds and mechanical equipment required to treat respiratory impairment.
- Ambulance services.
- Medication, x-rays and other diagnostic services.

- Laboratory tests.
- Oxygen.
- Surgical dressings and supplies.
- Immunosuppressive drugs.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- Transportation of the Member and a companion to and from the site of the transplant. If the Member is a minor, transportation of two (2) persons who travel with the minor is included. Reasonable and necessary lodging and meal costs incurred by such companions are included. Itemized receipts for these expenses are required. Daily lodging and meal costs will be paid up to the limit shown in the Attachment A Benefit Schedule. Benefits for all transportation, lodging and meal costs shall not exceed the maximum shown in the Attachment A Benefit Schedule for transportation, lodging and meals.

HPN makes no representation or warranty as to the medical competence or ability of any Transplant Facility or its respective staff or Physicians. HPN shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, for any actions or inaction, whether negligent or otherwise, on the part of any Transplant Facility or its respective staff or Physicians.

HPN shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, in the event a transplant patient is injured or dies, by whatever cause, while enroute to a Transplant Facility.

If a Covered Transplant Procedure is not performed as scheduled due to a change in the Member's medical condition or death, benefits will be paid for Prior Authorized Eligible Medical Expenses or the Recognized Amount, when applicable, incurred during the Transplant Benefit Period.

Other Diagnostic and Therapeutic Services

Diagnostic and Therapeutic Covered Services when authorized by a Member's PCP and HPN's Managed Care Program include the following:

- Therapeutic radiology services;
- Complex diagnostic imaging services including nuclear medicine, computerized axial tomography (CT scan), cardiac ultrasonography, magnetic resonance imaging (MRI) and arthrography;
- Complex vascular diagnostic and therapeutic services including Holter monitoring, treadmill or stress testing and impedance venous plethysmography;
- Complex neurological diagnostic services including electroencephalograms (EEG), electromyogram (EMG) and evoked potential;
- Complex psychological diagnostic testing;
- Complex pulmonary diagnostic services including pulmonary function testing and apnea monitoring;
- Anti-cancer drug therapy;
- Hemodialysis and peritoneal renal dialysis;
- Complex allergy diagnostic services including RAST and allergoimmuno therapy;
- Otologic evaluations only for the purpose of obtaining information necessary for evaluation of the need for or appropriate type of medical or surgical treatment for a hearing deficit or a related medical problem;
- Treatment of temporomandibular joint disorder;
- Other Medically Necessary intravenous therapeutic services as approved by HPN, including but not limited to, non-cancer related intravenous injection therapy; and
- Positron Emission Tomography (PET) Scans.

Different Copayment and/or Coinsurance amounts may apply to these Covered Services. Please refer to your Attachment A Benefit Schedule.

Physician Surgical Services – Inpatient and Outpatient

Covered Services include surgical services that are generally recognized and accepted procedures for diagnosing or treating an Illness or Injury.

Post-Cataract Surgical Services

Covered Services include Medically Necessary services provided for the initial prescription for corrective lenses (eyeglasses or contact lenses) and frames or intra-ocular lens implants for Post-Cataract Surgical Services.

Contact lenses will be covered if a Member's visual acuity cannot be corrected to 20/70 in the better eye except for the use of contact lenses.

Preventive Healthcare Services

Covered Preventive Healthcare Services will be paid at 100% of Eligible Medical Expenses or the Recognized Amount, when applicable, without application of any Calendar Year Deductible, Copayment and/or Coinsurance when such services are provided by a Plan Provider**.**

Covered Services include the following Preventive Healthcare Services in accordance with the recommended schedule outlined in the HPN Preventive Guidelines included in your member kit or you may access the most current version of these guidelines at any time by visiting HPN's web site at https://www.healthplanofnevada.com.

- Evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations[(1)] that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, as long as they are not otherwise addressed by the recommendations of the USPSTF.
- Contraceptive coverage includes the insertion of implantable rods, copper-based intrauterine devices and progesterone-based intrauterine devices at a hospital immediately after a Member gives birth.

For a complete list of Preventive Services, including all FDA approved contraceptives, go to http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/.

[(1)]Certain immunizations may be administered in a Plan pharmacy.

Prosthetic and Orthotic Devices

Covered Services include the following devices when received in connection with an Illness or Injury and authorized by HPN's Managed Care Program:

- Cardiac pacemakers.
- Breast prostheses for post-mastectomy patients.
- Terminal devices (example: hand or hook) and artificial eyes.
- Braces which include only rigid and semi-rigid devices used for supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.
- Adjustment of an initial Prosthetic or Orthotic Device required by wear or by change in the patient's condition when ordered by a Plan Provider.

Routine Radiological and Non-Radiological Diagnostic Imaging Services

Covered Services include prescribed routine diagnostic radiological and non-radiological diagnostic imaging services and materials, including general radiography, fluoroscopy, mammography, and sonography, when authorized by a Member's PCP and HPN's Managed Care Program, but only when no charges are made for the same services and/or supplies by a Hospital, Skilled Nursing Facility or an Ambulatory Surgery Center.

Self-Management and Treatment of Diabetes

Coverage includes medication, equipment, supplies and appliances for the treatment of diabetes. Diabetes includes type I, type II and gestational diabetes. Covered Services include:

- Medically Necessary training and education provided to a Member for the care and management of diabetes, after he is initially diagnosed with diabetes, to include counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
- Medically Necessary training and education which is a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the Member and which requires modification of his program of self-management of diabetes; and
- Medically Necessary training and education because of the development of new techniques and treatment for diabetes.

Short-Term Habilitation Services – Inpatient and Outpatient

Covered Services are provided for Short-Term Habilitation Services provided for Members with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist and
- The initial or continued treatment must be proven and not Experimental, Investigational or Unproven.

HPN will cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. 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.

Coverage for Short-Term Habilitation Services does not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Short-Term Habilitation Services. A service that does not help the Member to meet functional goals in a treatment plan within a prescribed time frame is not an Habilitative Service. When the Member reaches his maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

HPN may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Member's condition is clinically improving as a result of the Habilitative Service. When the treating provider anticipates that continued treatment is or will be required to permit the Member to achieve demonstrable progress, HPN may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Short-Term Habilitation Services that are provided in the home by a licensed Home Healthcare Provider are covered as described under the Home Healthcare Services section.

Short-Term Rehabilitation Services – Inpatient and Outpatient

Short-Term Rehabilitation therapy Covered Services include:

- Speech therapy.
- Occupational therapy.
- Physical therapy on an Inpatient or outpatient basis when ordered by the Member's PCP and authorized by HPN's Managed Care Program.

Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that, in the judgment of the Member's PCP and HPN's Managed Care Program, are subject to significant improvement through Short-Term therapy.

Covered Services do not include cardiac rehabilitation services provided on a non-monitored basis nor do they include treatment for intellectual disability.

Special Food Product / Enteral Formulas

Covered Services include enteral formulas and special food product when prescribed by a Physician and authorized by HPN's Managed Care Program for treatment of an inherited metabolic disease.

- "Inherited Metabolic Disease" means a disease caused by an inherited abnormality of the body chemistry of a person characterized by congenital defects or defects arising shortly after birth resulting in deficient metabolism or malabsorption of amino acid, organic acid, carbohydrate or fat.
- "Special Food Product" means a food product specially formulated to have less than one gram of protein per serving intended to be consumed under the direction of a Physician. The term does not include food that is naturally low in protein.

Specialty Services, Second and Third Opinion and Consultations

Covered Services include medical services rendered by a Plan Specialist or other duly licensed Plan Provider whose opinion or advice is requested by a Member's treating PCP or the Medical Director for further evaluation of an Illness or Injury on an Inpatient or outpatient basis. All services must be arranged through HPN's Managed Care Program.

- **Second Opinions.** When, as a result of an Illness or Injury, a procedure is recommended by a Physician, HPN or the Member may request a Second Opinion from a Physician qualified to diagnose and treat the specific Illness or Injury.

- **Third Opinions.** In the event a first and Second Opinion for a Covered Service are in conflict, HPN or the Member may request a Third Opinion from a Physician qualified to diagnose and treat the specific Illness or Injury.

Benefits are payable for expenses incurred in connection with an authorized Second or Third Opinion whether or not the elective surgery or Inpatient care is performed. Payment will be subject to all terms of the EOC, except as otherwise provided in this section.

Limitations. No payment will be made for expenses incurred for second or third opinions/consultations in connection with:
1. Any services not covered under this Plan, including cosmetic and dental procedures;
2. Minor surgical procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions; or
3. Diagnostic tests ordered in connection with second and third opinions/consultations, unless Prior Authorized by HPN's Managed Care Program.

Substance-Related and Addictive Disorder Services

All benefits for Substance-Related and Addictive Disorder Services are subject to the Utilization Management process through HPN Behavioral Health. Services must be offered in a treatment setting that is appropriate for the Medically Necessary level of care, as determined by staffing, ability to provide patient safety, treatment intensity, the diagnostic and therapeutic modalities available, the extent of supportive services and access to general medical care. All non-routine, outpatient Substance-Related and Addictive Disorder Services require Prior Authorization.

Inpatient Detoxification: A hospital-based program which provides twenty-four (24) hours a day, seven (7) days nursing care, medical monitoring, and physician availability; daily physician visits, assessment, diagnostic services, and active behavioral health treatment services for the purpose of completing a medically safe and appropriate withdrawal from alcohol or other substances.

Outpatient Detoxification: Outpatient Detoxification is comprised of services that are provided in an ambulatory setting for the purpose of completing a medically safe withdrawal from alcohol or drugs.

Inpatient Rehabilitation: A hospital-based program which provides twenty-four (24) hours a day, seven (7) days nursing care, medical monitoring, and physician availability; daily physician visits, assessment and diagnostic services, and active behavioral health treatment services for the purpose of initiating the process of assisting a Member with gaining the knowledge and skills needed to prevent recurrence of a substance-related disorder.

Partial Hospitalization Program (PHP): A structured ambulatory program that may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Intensive Outpatient Program (IOP): A structured program that maintains hours of service for at least nine (9) hours per week for adults and six (6) hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided.

Outpatient: Assessment, diagnosis and active behavioral health treatment that are provided in an ambulatory setting, including individual, group, and family counseling services.

Residential Treatment Center (RTC): a sub-acute facility or acute care facility which delivers twenty-four (24) hours/ seven (7) days a week assessment, diagnostic services and active behavioral health treatment to Members. The level of care and length of stay, in a facility with the appropriate licensure level, is authorized through the HPN Managed Care program. NOTE: Transitional Living services are not covered under RTC and are not a covered benefit.

All inpatient Substance-Related and Addictive Disorder Services require Prior Authorization. Network facilities must provide notification of all inpatient admissions to the Plan. When these services are provided out of network, the Member is responsible for providing the notification and relevant information to the Plan. Members should provide notice of emergent admissions within twenty-four (24) hours of admission or as soon as reasonably possible given the circumstances. Members may delegate their responsibility to provide notification to the non-network facility but it is the Member's responsibility to ensure that the Plan receives notification. Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.

All admissions for Emergency Services are reviewed retrospectively to determine if the treatment received was Medically Necessary and appropriate. If the Member is admitted to a Substance-Related and Addictive Disorder facility for non-emergency treatment without Prior Authorization, Member will be responsible for the cost of services received.

Telemedicine Services

Covered Services received through Telemedicine do not require Prior Authorization unless the Covered Service would require Prior Authorization if provided in person. The Member does not have to establish a relationship with a Telemedicine Provider to receive services. HPN does not require the Provider to demonstrate the necessity to provide services through, or to receive additional certifications or licenses in, Telemedicine. Benefits are available for urgent, on-demand healthcare delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency medical needs. HPN will not refuse to provide coverage because of the distant site from which the contracted Telemedicine Provider provides Covered Services or the originating site at which the Member receives Telemedicine Services. HPN will not require Covered Services to be provided through Telemedicine as a condition of coverage. Telemedicine Services received from any Provider will be subject to the applicable facility and professional Copayments and/or Coinsurance amount as set forth in the Attachment A Benefit Schedule.

Benefits are also provided for Remote Physiologic Monitoring.

NowClinic Urgent Care Virtual Visits: covered Services received through virtual visits do not require Prior Authorization when provided through an HPN contracted Provider. Refer to the Attachment A Benefit Schedule for the Member's Cost-share responsibility. Benefits are available for urgent, on-demand healthcare delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency medical needs.

SECTION 7. Exclusions

This section tells you what services or supplies are excluded from coverage under this Plan.

7.1 Services or supplies for which coverage is not specifically provided in this EOC, complications resulting from non-Covered Services, or services which are not Medically Necessary, whether or not recommended or provided by a Provider.

7.2 Services not provided, directed, and/or Prior Authorized by a Member's PCP and HPN's Managed Care Program except for Emergency Services and Urgently Needed Services.

7.3 Medical care received outside HPN's Service Area without Prior Authorization from HPN's Managed Care Program if the need for such services could reasonably have been foreseen prior to leaving HPN's Service Area.

7.4 Any charges for non-Emergency Services provided outside the United States.

7.5 Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

7.6 Any services provided before the Effective Date or after the termination of this Plan. This includes admission to an Inpatient facility when the admission began before the Effective Date or extended beyond the termination date of the Plan.

7.7 Services and supplies that are included in the basic hospital charges for room, board and nursing services. Housekeeping or meal services as part of Home Healthcare. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.

7.8 Services for a private room when not Medically Necessary Services and charges in excess of the average semi-private room and board rate.

7.9 Dental or orthodontic splints or dental prostheses, or any treatment on or to teeth, gums, or jaws and other services customarily provided by a dentist. Treatment of pain or infection known or thought to be due to a dental condition and in close proximity to the teeth or jaw; surgical correction of malocclusion; maxillofacial orthognathic surgery, oral surgery (except as provided under the Covered Services Section), orthodontia treatment, pre-prosthetic surgery and any procedure involving osteotomy of the jaw, including outpatient Hospital or ambulatory surgical services, anesthesia and related costs when determined by HPN to relate to a dental condition.

Charges for dental services in connection with temporomandibular joint dysfunction are also not covered unless they are determined to be Medically Necessary. Such dental-related services are subject to the limitation shown in the Attachment A Benefit Schedule.

7.10 Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered cosmetic procedures. Cosmetic procedures include:

- Surgery for sagging or extra skin;
- Any augmentation or reduction procedures;
- Rhinoplasty and associated surgery; and
- Any procedures utilizing an implant which does not alter physiologic functions unless Medically Necessary.

Psychological factors (example: for self-image, difficult social or peer relations) do not constitute restoring a physical bodily function and are not relevant to such determinations.

7.11 The following infertility services and supplies are excluded, in addition to any other infertility services or supplies determined by HPN not to be Medically Necessary:

- Advanced reproductive techniques such as embryo transplants, in vitro fertilization, ZIFT procedures, assisted hatching, intracytoplasmic sperm injection, egg retrieval via laparoscope or needle aspiration, sperm preparation, specialized sperm retrieval techniques, sperm washing except prior to artificial insemination if required;
- Home pregnancy or ovulation tests;
- Monitoring of ovarian response to stimulants;
- CT or MRI of sella turcica unless elevated prolactin level;
- Evaluation for sterilization reversal;
- Removal of fibroids, uterine septae and polyps;
- Open or laparoscopic resection, fulguration, or removal of endometrial implants; and
- Surgical tube reconstruction.

7.12 Powered and non-powered exoskeleton devices.

7.13 Any separate charges for anesthesia services associated with pain management procedures.

7.14 Services for the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and, except as provided in the Covered Services Gender Dysphoria section, implantation of a penile prosthesis.

7.15 Reversal of surgically performed sterilization or reversal of subsequent resterilization.

7.16 Amniocentesis, except when Medically Necessary under the guidelines of the American College of Obstetrics and Gynecology.

7.17 Third-party physical exams and/or medical services for employment, licensing, insurance, school, camp or adoption purposes. Immunizations related to foreign travel unless otherwise provided as a required preventive immunization identified by the USPSTF. Expenses for medical reports, including presentation and preparation. Exams or treatment ordered by a court, or in connection with legal proceedings are not covered.

7.18 Venipuncture (drawing of blood for laboratory tests).

7.19 Except as provided in the Covered Services Gastric Restrictive Surgical Services section, weight reduction procedures are excluded. Also excluded are any weight loss programs, whether or not recommended, provided or prescribed by a Physician or other medical Practitioner.

7.20 Except as provided in the Covered Services Organ and Tissue Transplant Surgical Services section, any human or animal transplant (organ, tissue, skin, blood, blood transfusions of bone marrow), whether human-to-human or involving a non-human device, artificial organs, or prostheses.

7.21 The following services when related to any excluded transplant service, procedure or treatment:

- Any and all services, supplies treatments, laboratory tests or x-rays received by the donor (including donor search, donor transportation, testing, registry and retrieval costs);
- Any and all treatment and costs related to cadaver or animal retrieval or maintenance of a donor for such retrieval; and/or
- Any and all Hospital, Physician, laboratory or x-rays services.

7.22 Institutional care which is determined by HPN's Managed Care Program to be for the primary purpose of controlling Member's environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures.

7.23 Mental Health Services and Substance-Related and Addictive Disorder Services performed in connection with conditions not listed in the current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM)* or conditions listed as "Other Conditions" that may be of focus of clinical attention. This exclusion does not apply to conditions defined as *Medically Necessary* in Section 14: Glossary.

7.24 Outside of an initial assessment, Mental Health and Substance-Related and Addictive Disorder Services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. This exclusion does not apply to conditions defined as *Medically Necessary* in Section 14: Glossary.

7.25 Outside of an initial assessment, treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, personality disorders (with the exception of dialectical behavior therapy for borderline personality disorders) and paraphilic disorder.

7.26 Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

7.27 Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.

7.28 Outside of an initial assessment, unspecified disorders for which the provider is not obligated to provide the clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association,* unless determined to be medically necessary.

7.29 Neuropsychological testing when not required for the diagnosis of a Mental Illness, Substance use disorder, or developmental disability.

7.30 Vision exams to determine refractive errors of vision and eyeglasses or contact lenses other than as specifically covered in this EOC. Coverage is provided for vision exams only when required to diagnose an Illness or Injury. Vision exams are not considered adult preventive care services.

7.31 Any prescription corrective lenses (eyeglasses or contact lenses) or frames following Post-Cataract Surgical Service which include, but are not limited to the following:

- Coated lenses;
- Cosmetic contact lenses;
- Costs for lenses and frames in excess of the Plan allowance;
- No-line bifocal or trifocal lenses;
- Oversize lenses;
- Plastic multi-focal lenses;
- Tinted or photochromic lenses;
- Two (2) pairs of lenses and frames in lieu of bifocal lenses and frames; or
- All prescription sunglasses.

7.32 Coverage is provided for hearing exams only when required to diagnose an Illness or Injury. Hearing exams are not considered adult preventive care services.

7.33 Bone anchored hearing aids are excluded except when both of the following applies:

- The Member is not a candidate for an air-conduction hearing aid; and
- The bone-anchored hearing aid is used according to FDA approved indications.

Repairs and/or replacements for a bone anchored hearing aid, other than for malfunctions, are excluded for Member's who meet the above coverage criteria.

7.34 Ecological or environmental medicine. Use of chelation, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile or gerovital.

7.35 Pain management invasive procedures as defined by HPN's protocols for chronic, intractable pain unless Prior Authorized by HPN and provided by a Plan Provider who is a pain management Specialist. Any Prior Authorized pain management procedures will be subject to the applicable facility and professional Copayments and/or Coinsurance amount as set forth in Attachment A, Benefit Schedule.

7.36 Acupuncture or Hypnosis.

7.37 Treatment of an Illness or Injury caused by or arising out of a riot, declared or undeclared war or act of war, insurrection, rebellion, armed invasion or aggression.

7.38 Treatment of an occupational Illness or Injury which is any Illness or Injury arising out of or in the course of employment for pay or profit.

7.39 Travel and accommodations, whether or not recommended or prescribed by a Provider, other than as specifically covered in this Plan.

7.40 Services provided at a Free Standing Facility or diagnostic Hospital-based Facility without Prior Authorization through the HPN Managed Care Program. Services which are self-directed to a Free Standing Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Free Standing Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

- Has not been involved in your medical care prior to ordering the service, or
- Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography.

7.41 Care for conditions that federal, state or local law requires to be treated in a public facility for which a charge is not normally made.

7.42 Any equipment or supplies that condition the air. Arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace. Heating pads, hot water bottles, wigs and their care and other primarily nonmedical equipment. Incontinence supplies (diapers, pads, adult briefs) and bath aids (rails, shower chairs, bath benches).

7.43 Any service or supply in connection with routine foot care, including the removal of warts, corns, or calluses, the cutting and trimming of toenails, or foot care for flat feet, fallen arches and chronic foot strain, in the absence of severe systemic disease.

7.44 Special formulas, orally administered formulas, nutritional supplements, food supplements other than as specifically covered in this Plan or special diets on an outpatient basis (except for the treatment of inherited metabolic disease).

7.45 Services, supplies or accommodations provided without cost to the Member or for which the Member is not legally required to pay.

7.46 Milieu therapy, biofeedback treatment, behavior modification, sensitivity training, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolffing, vocational rehabilitation and wilderness adventure, camping, outdoor or similar programs.

7.47 Experimental, Investigational or Unproven treatment or devices as determined by HPN.

7.48 Sports medicine treatment plans intended to primarily improve athletic ability.

7.49 Radial keratotomy or any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses.

7.50 Services requested or performed by a Provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the Provider may perform on him/herself. Services performed by a Provider with the same legal address as the Member.

7.51 Ambulance services when a Member could be safely transported by other means. Air Ambulance services when a Member could be safely transported by ground Ambulance or other means.

7.52 Late discharge billing and charges resulting from a canceled appointment or procedure.

7.53 Telemetry readings, EKG interpretations when billed separately from the EKG procedure.

7.54 Arterial blood gas interpretations when billed separately from the procedure.

7.55 Services of more than one (1) assistant surgeon at one (1) operative session, unless approved in advance by HPN or its Medical Director. Service of an assistant surgeon when the Hospital provides or makes available qualified staff personnel (including Physicians in training status) as surgical assistants. Services of an assistant surgeon provided solely to meet a Hospital's institutional requirements when the complexity of the surgery does not warrant an assistant surgeon.

7.56 Covered services received in connection with a clinical trial or study, which includes the following:

- Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;
- Healthcare services that are specifically excluded from coverage under this Plan regardless of whether such services are provided under the clinical trial or study;
- Healthcare services that are customarily provided by the sponsors of the clinical trial or study free of charge to the Member in the clinical trial or study;
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing and other expenses that a Member may incur;
- Any expenses incurred by a person who accompanies the Member during the clinical trial or study;
- Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the Member; and
- Any cost for the management of research relating to the clinical trial or study.

7.57 Services or materials provided under Workers' Compensation or Employer's Liability laws.

7.58 Services provided or paid for by governmental agency or under any governmental program or law, except charges which the Member is legally obligated to pay.

7.59 Services performed for cosmetic purposes or to correct congenital malformations.

7.60 Services received in connection with Gender Dysphoria, which includes the following:

- Abdominoplasty;
- Blepharoplasty;
- Body contouring, such as lipoplasty;
- Brow lift;
- Calf implants;
- Cheek, chin, and nose implants;
- Cryopreservation of fertilized embryos;
- Drugs for hair loss or growth;
- Face lift, forehead lift, or neck tightening;
- Facial bone remodeling for facial feminizations;
- Hair removal, except as part of a genital reconstruction procedure;
- Hair transplantation;
- Injection of fillers or neurotoxins;
- Lip augmentation;
- Lip reduction;
- Liposuction;
- Mastopexy;
- Pectoral implants for chest masculinization;
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;
- Rhinoplasty;
- Skin resurfacing;
- Sperm preservation in advance of hormone treatment or gender surgery;

- Surgical treatment not Prior Authorized by HPN;

7.61 Non-Medical 24-Hour Withdrawal Management.

7.62 Nutritional supplements, vitamins, herbal medicines, appetite suppressants, and over-the-counter drugs, except as specifically covered herein. Drugs and medicines approved by the FDA for Experimental, Investigational or Unproven use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan.

7.63 Drugs and medicine approved by the FDA for Experimental, Investigational or Unproven use or any drug that has been approved by the FDA for less than one (1) year.

7.64 Physician-assisted Suicide and any information, services or pharmaceuticals associated.

7.65 Healthcare services from an out of network Provider for non-emergent, sub-acute inpatient or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Free Standing Facility, Residential Treatment Center, Inpatient Rehabilitation Facility or Skilled Nursing Facility received outside of the Member's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Member is a legal resident, plus any geographically bordering adjacent state or, for a Member who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or if prior authorization has been obtained in advance.

7.66 Any care or delivery at a birthing center.

7.67 Transitional Living.

7.68 Medical and surgical treatment of excessive sweating (hyperhidrosis).

7.69 High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria*, for Members with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment, unless determined to be medically necessary.

Pharmacy Specific Exclusions

7.70 Prescription Drug furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

7.71 Nutritional supplements, vitamins, herbal medicines, appetite suppressants, and over-the-counter drugs, except as specifically covered herein. Drugs and medicines approved by the FDA for Experimental, Investigational or Unproven use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan. Any drug that has been approved by the FDA for less than one (1) year.

7.72 Prescription Drugs for any condition, Injury, Illness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

7.73 Any product dispensed for the purpose of appetite suppression or weight loss.

7.74 Medications used for cosmetic purposes.

7.75 Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

7.76 Certain Prescription Drugs that have not been prescribed by a Specialist.

7.77 Prescription Drug Products when prescribed to treat infertility.

7.78 Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

7.79 Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs.

7.80 Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the HPN EOC.

7.81 Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members.

7.82 Prescription Drugs, including Covered Drugs, dispensed by a Non-Plan Provider, except in the case of Emergency Services and Urgently Needed Services.

7.83 Drugs or supplies available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless HPN has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that HPN has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and HPN may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

7.84 General vitamins, except the following which require a prescription order or refill: prenatal vitamins; vitamins with fluoride; and single entity vitamins.

7.85 Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury except for Prescription Drug Products that are enteral formulas prescribed for the treatment of inherited metabolic diseases as defined by state law.

7.86 Certain Prescription Drugs that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug.

7.87 Any Prescription Drug for which the actual charge to the Member is less than the amount due under this Plan.

7.88 Any refill dispensed more than one (1) year from the date of the latest prescription order or as permitted by applicable law of the jurisdiction in which the drug is dispensed.

7.89 Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.

7.90 Coverage for Prescription Drugs for the amount dispensed (days' supply, quantity limitation, dose, regimen, or frequency) which is less than or exceeds the supply limit.

7.91 Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to tier III or IV).

7.92 Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.

7.93 Experimental, Investigational or Unproven services and medications; medication used for experimental indications and/or dosage regimens determined by the Plan to be Experimental, Investigational or Unproven except when prescribed for the treatment of cancer or other life-threatening diseases or conditions, chronic fatigue syndrome, cardiovascular disease, surgical musculoskeletal disorder of the spine, hip and knees, and other diseases or disorders which are not life threatening or study approved by the Plan.

7.94 A Prescription Drug that contains an active ingredient(s) which is (are) a modified version of and/or Therapeutically Equivalent to a Covered Drug may be excluded as determined by the Plan.

7.95 Prescription Drugs dispensed outside the United States, except as required for emergency treatment.

7.96 Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission.

7.97 Except as provided in the *Pharmacy Provisions* section, a Biosimilar Prescription Drug or Reference Product.

7.98 Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

7.99 Covered Drugs that are not FDA approved for a specific diagnosis.

7.100 Drugs and medicine approved by the FDA for Experimental, Investigational or Unproven use.

7.101 Drugs and medicine that have been approved by the FDA for less than one (1) year.

7.102 Drugs not approved by the FDA.

7.103 Unit dose packaging and repackaging of Prescription Drugs.

SECTION 8. Limitations

This section tells you when HPN's duty to provide or arrange for services is limited.

8.1 Liability

HPN will not be liable for any delay or failure to provide or arrange for Covered Services if the delay or failure is caused by the following:

- Natural disaster.
- War.
- Riot.
- Civil insurrection.
- Epidemic.
- Or any other emergency beyond HPN's control.

In the event of one of these types of emergencies, HPN and its Plan Providers will provide the Covered Services shown in this EOC to the extent practical according to their best judgment.

8.2 Calendar Year and Lifetime Maximum Benefit Limitations

Please see the Attachment A Benefit Schedule for Calendar Year maximums or lifetime maximums applicable to certain benefits.

8.3 Reimbursement

Reimbursement for Covered Services approved by HPN and provided by a Non-Plan Provider outside HPN's Service Area shall be limited to the average payment which HPN makes to Plan Providers in HPN's Service Area.

SECTION 9. Coordination of Benefits (COB)

This section describes how benefits under this policy will be coordinated with those of any other plan that provides benefits to the Member. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits. NOTE: This plan is always secondary to a stand-alone dental plan for certain services pursuant to Nevada state regulations.

9.1 The Purpose of COB

This provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

Primary Plan. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.

Secondary Plan. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Evidence of Coverage

For purposes of this section, terms are defined as follows:

A. **Plan.** A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: franchise insurance, hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; medical benefits under group or individual automobile contracts; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense.** Allowable Expense means Eligible Medical Expenses or the Recognized Amount, when applicable, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent**. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

9.2 Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse or Domestic Partner does, that parent's spouse's or Domestic Partner plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
      3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
      4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         i. The Plan covering the Custodial Parent.
         ii. The Plan covering the Custodial Parent's spouse or Domestic Partner.
         iii. The Plan covering the non-Custodial Parent.
         iv. The Plan covering the non-Custodial Parent's spouse or Domestic Partner.
   c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph i) or ii) above as if those individuals were parents of the child.
   d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

      (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expense shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

7. If a Member is covered by a stand-alone dental benefit and a policy of health insurance, generally the stand-alone dental benefit is the primary policy and the claim must be first submitted to the health insurer that issued the stand-alone dental benefit.

9.3 Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

9.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply the COB provisions herein and to determine benefits payable under This Plan and other Plans. HPN may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and in determining benefits payable under This Plan and other Plans covering the person claiming benefits.

HPN need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give HPN any facts needed to apply these rules and determine benefits payable. If the Member does not provide HPN the information needed to apply these rules and determine the benefits payable, the Member's Claim for Benefits will be denied.

9.5 Payments Made and Right to Recover Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, HPN may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan and HPN will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

If the amount of the payments HPN made is more than should have paid under this COB provision, HPN may recover the excess from one or more of the persons HPN has paid or for whom has been paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If This Plan is secondary to Medicare, then benefits payable under This Plan will be based on Medicare's reduced benefits.

SECTION 10. Subrogation and Reimbursement

HPN has the right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.
Subrogation applies when HPN has paid benefits on your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that HPN is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that HPN has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to HPN one hundred percent (100%) of any benefits you receive for that Illness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer an Illness, Injury or damages, or who is legally responsible for the Illness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate in protecting HPNs legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying HPN, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
  - Providing any relevant information requested by HPN.
  - Signing and/or delivering such documents as HPN or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining HPNs or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with HPN is considered a breach of contract. As such, HPN will have the right to terminate or deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits we have paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with HPN. If HPN incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, HPN will have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- HPN has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, HPNs first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- HPNs subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. HPN is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from HPN's recovery without its express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, HPN may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which HPN may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by HPN may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of Illness or Injury, and HPN alleges some or all of those funds are due and owed to HPN, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of benefits provided on behalf of the Member), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by HPN to enforce its reimbursement rights.
- HPN's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting benefits from HPN, you agree to assign to HPN any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the benefits we have paid for the Illness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize HPN's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- HPN may, at its option, take necessary and appropriate action to preserve HPN's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Illness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate HPN in any way to pay you part of any recovery HPN might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse HPN, without HPN written approval.
- HPN has the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your Estate, the personal representative of your Estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse HPN is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse HPN for 100% of it's interest unless a written consent to the allocation is provided by HPN.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer an Illness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, HPN may terminate benefits to you, your dependents or the subscriber, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits we have paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by HPN due to your failure to abide by the terms of the Policy. If HPN incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, HPN has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to HPN.
- HPN and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to HPN.

10.1 Refunds of Overpayments

If HPN pays benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to HPN if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount HPN paid in excess of the amount HPN should have paid under the Policy. If the refund is due from another person or organization, you agree to help HPN get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, HPN may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future benefits that are payable under the Policy. If the refund is due from a person or organization other than you, HPN may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part;

- Future benefits that are payable in connection with services provided to other Members under the Policy; or
- Future benefits that are payable in connection with services provided to persons under other plans for which HPN makes payment, pursuant to a transaction in which HPNs overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. HPN may have other rights in addition to the right to reduce future benefits.

10.2 Limitation of Action

You cannot bring any legal action against HPN to recover reimbursement until you have completed all the steps in the appeal process described in the Appeals Procedures section. After completing that process, if you want to bring a legal action against HPN you must do so within three years of the date HPN notified you of the final decision on your appeal or you lose any rights to bring such an action against HPN.

SECTION 11. General Provisions

11.1 Relationship of Parties

The relationship between HPN and Plan Providers is an independent contractor relationship. Plan Providers are not agents or employees of HPN; nor is HPN, or any employee of HPN, an employee or agent of a Plan Provider. HPN is not liable for any claim or demand on account of damages as a result of, or in any manner connected with, any Injury suffered by a Member while receiving care from any Plan Provider or in any Plan Provider's facility. HPN is not bound by statements or promises made by its Plan Providers.

11.2 Entire Agreement

This EOC, including the Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Member's Enrollment Form, health statements, Member Identification Card, and all other applications received by HPN constitutes the entire agreement between the Member and HPN and as of its Effective Date, replaces all other agreements between the parties.

For the duration of time a Member's coverage is continuously effective under HPN, regardless of the occurrence of any specific Plan or product changes during such time, all benefits paid by HPN under any and all such Plans on behalf of such Member shall accumulate towards any applicable lifetime or other maximum benefit amounts as stated in the Member's most current Plan Attachment A Benefit Schedule to the EOC.

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

In the event HPN decides to discontinue offering and renewing health benefit plans delivered or issued for delivery in this state, HPN will provide notice of its intention to all persons covered by the discontinued insurance at least ninety (90) days before the nonrenewal of any health benefit plan by HPN.

11.3 Payment of Benefits

Payment of benefits by HPN shall be in cash or cash equivalents, or in a form of other consideration that HPN determines to be adequate. Where benefits are payable directly to a Provider, such adequate consideration includes the forgiveness in whole or in part of the amount the Provider owes to HPN, or to other Health Benefit Plans' for which HPN makes payments where HPN has taken an assignment of the other plans' recovery rights for value.

11.4 Contestability

Any and all statements made to HPN by Group and any Subscriber or Dependent, will, in the absence of fraud, be considered representations and not warranties. Also, no statement, unless it is contained in a written application for coverage, shall be used in defense to a claim under this Plan.

11.5 Authority to Change the Form or Content of this Plan

No agent or employee of HPN is authorized to change the form or content of this Plan or waive any of its provisions. Such changes can be made only through an amendment authorized and signed by an officer of HPN.

11.6 Identification Card

Cards issued by HPN to Members are for identification only. Possession of an HPN identification card does not give the holder any right to services or other benefits under this Plan.

To be entitled to such services or benefits, the holder of the card must in fact be a Member and all applicable premiums must actually have been paid. Any person not entitled to receive services or other benefits will be liable for the actual cost of such services or benefits.

11.7 Notice

Any notice under this Plan may be given by United States mail, first class, postage prepaid, addressed as follows:

Health Plan of Nevada, Inc.
P.O. Box 15645
Las Vegas, Nevada 89114-5645

Notice to a Member will be sent to the Member's last known address.

11.8 Interpretation of the EOC

The laws of the State of issue shall be applied to interpretation of this EOC. Where applicable, the interpretation of this EOC shall be guided by the direct-service nature of HPN's operation as opposed to a fee-for-service indemnity basis.

11.9 Assignment

This Plan is not assignable by Group without the written consent of HPN. The coverage and any benefits under this Plan are not assignable by any Member without the written consent of HPN.

11.10 Modifications

The Group makes HPN coverage available under this Plan to individuals who are eligible under Section 1. However, this Plan is subject to amendment, modification or termination with sixty (60) days written notice to the Group without the consent or concurrence of the Members.

By electing medical coverage with HPN or accepting benefits under this Plan, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms and provisions.

11.11 Clerical Error

Clerical error in keeping any record pertaining to the coverage will not invalidate coverage in force or continue coverage terminated.

11.12 Policies and Procedures

HPN may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan with which Members shall comply. These policies and procedures are maintained by HPN at its offices. Such policies and procedures may have bearing on whether a medical service and/or supply is covered.

11.13 Overpayments

If HPN pays benefits for expenses incurred on account of an enrolled Member, that Member or any other person or organization that was paid, must make a refund to HPN if any of the following apply:

- If the refund is due from the Member and the Member does not promptly refund the full amount, HPN may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for the Member that are payable under the policy. If the refund is due from a person or organization other than the Member, HPN may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part;
  - Future benefits that are payable in connection with services provided to other Members under the policy; or
  - Future benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which HPNs overpayment recovery rights are assigned to such other Health Benefit Plan's in exchange for such Plans' remittance of the amount of the reallocated payment.

11.14 Cost Containment Features

This Plan contains at least the following cost containment provisions including, but not limited to:

(a) Preventive healthcare benefits.
(b) The Managed Care Program.
(c) Benefit limitations on certain services.
(d) Member Cost-share.

11.15 Release of Records

Each Member authorizes the Physician, Hospital, Skilled Nursing Facility or any other Provider of healthcare to permit the examination and copying of the Member's medical records, as requested by HPN.

Information from medical records and information received from Physicians or Hospitals incident to the Physician/Patient relationship or Hospital/Patient relationship shall be kept confidential and except for use in connection with government requirements established by law or the administration of this Plan, records may not be disclosed to any unrelated third party without the Member's consent.

11.16 Reimbursement for Claims

Non-Plan Providers may require immediate payment for their services and supplies. When seeking reimbursement from HPN for expenses incurred in connection with services received from Non-Plan Providers, the Member must complete a Non-Plan Provider Claim Form and submit it to the HPN Claims Department with copies of all of the medical records, bills and/or receipts from the Provider. Non-Plan Provider Claim Forms can be obtained by calling the Member Services Department at 1-800-777-1840.

If the Member receives a bill for Covered Services from a Non-Plan Provider, the Member may request that HPN pay the Provider directly by sending the bill, with copies of all medical records and a signed completed Non-Plan Provider Claim Form, to the HPN Claims Department.

HPN shall approve or deny a claim within thirty (30) days after receipt of the claim. If the claim is approved, the claim shall be paid within thirty (30) days from the date it was approved. If the approved claim is not paid within that thirty (30) day period, HPN shall pay interest on the claim at the rate set forth by applicable Nevada law. The interest will be calculated from thirty (30) days after the date on which the claim is approved until the date upon which the claim is paid.

HPN may request additional information to determine whether to approve or deny the claim. HPN shall notify the Provider of its request for additional information within twenty (20) days after receipt of the claim. HPN will notify the Provider of the healthcare services of all the specific reasons for the delay in approving or denying the claim. HPN shall approve or deny the claim within thirty (30) days after receiving the additional information. If the claim is approved, HPN shall pay the claim within thirty (30) days after it receives the additional information. If the approved claim is not paid within that time period, HPN shall pay interest on the claim in the manner set forth above.

If HPN denies the claim, notice to the Member will include the reasons for the rejection and the Members right to file a written complaint as set forth in the Appeals Procedures Section herein.

11.17 Timely Filing Requirement

All claims must be submitted to HPN within sixty (60) days from the date expenses were incurred, unless it shall be shown not to have been reasonably possible to give notice within the time limit, and that notice was furnished as soon as was reasonably possible. If Member authorizes payment directly to the Provider, a check will be mailed to that Provider. A check will be mailed to the Member directly if payment directly to the Provider is not authorized. The Member will receive an explanation of how the payment was determined.

No payments shall be made under this Plan with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by HPN within twelve (12) months after the date Covered Services were provided. In no event will HPN pay more than HPN's Eligible Medical Expenses or the Recognized Amount, when applicable, for such services.

11.18 Gender References

Whenever a masculine pronoun is used in this EOC, it also includes the feminine pronoun.

11.19 Legal Proceedings

No action of law or equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of claim has been filed in accordance with the requirements of the Plan. No such action shall be brought at any time unless brought within the time limit allowed by the laws of the jurisdiction of issue.

If the laws of the jurisdiction of issue do not designate the maximum length of time in which such action may be brought, no action may be brought after the expiration of three (3) years from the time proof of loss is required by the Plan.

11.20 Availability of Providers

HPN does not guarantee the continued availability of any specific Plan Provider.

11.21 Physician Incentive Plan Disclosure

You are entitled to ask if HPN has special financial arrangements with their contracted Physicians that may affect Referral services, such as lab tests and hospitalizations that you might need. To receive information regarding contracted Physician payment arrangements, please call the Member Services Department at the number listed on page 3 of this EOC. This information will be sent to you within thirty (30) days of the date that you make your request.

HPN will provide information on the financial arrangements that they have with their contracted Physicians to any requesting Member. The following information is available upon request, to current, previous and potential Plan Members:

1. Whether the managed care organizations' contracts or subcontracts include Physician incentive plans that affect the use of Referral services.
2. Information on the type of arrangements used.
3. Whether special insurance called stop-loss protection is required for Physicians or Physician groups.

11.22 Provisions Deemed to be in Compliance for National Accounts

This Plan meets the requirements for a Federally Qualified HMO for only` those Groups defined as National Accounts. For the purposes of this Plan, a National Account is defined as a company with a principal office located outside the state of Nevada, with employees located in multiple states, to include Nevada. With respect to National Accounts, provisions of the HPN EOC that are determined by the appropriate regulatory agency not to be in compliance or agreement with applicable regulations for Federally Qualified HMOs, are hereby amended in accordance with such requirements.

11.23 Authorized Representative

A Member may elect to designate an "Authorized Representative" to act on their behalf to pursue a Claim for Benefits or the appeal of an Adverse Benefit Determination. The term Member also includes the Member's Authorized Representative, where applicable and appropriate. To designate an Authorized Representative, a written notice, signed and dated by the Member, is required. The notice must include the full name of the Authorized Representative and must indicate specifically for which Claim for Benefits or appeal the authorization is valid. The notice should be sent to:

Health Plan of Nevada, Inc.
Attn: Customer Response and Resolution Dept.
P.O. Box 15645
Las Vegas, NV 89114-5645

Any correspondence from HPN regarding the specified Claim for Benefits or appeal will be provided to both the Member and his Authorized Representative.

In case of an Urgent Care Claim, a healthcare professional with knowledge of the Member's medical condition shall be permitted to act as an Authorized Representative of the Member without designation by the Member.

11.24 Failure to Obtain Prior Authorization

The Member's Provider must initiate all requests for Prior Authorization. If a Physician or Member fails to follow the Plan's procedures for filing a request for Prior Authorization (Pre-Service Claim), the Member shall be notified of the failure and the proper procedures to be followed in order to obtain Prior Authorization. The Member's request for Prior Authorization must be received by an employee or by the department of the Plan customarily responsible for handling benefit matters. The original request must specifically name the Member, the specific medical condition or symptom and the specific treatment, service or product for which approval is requested. The Member notification of correct Prior Authorization procedures from the Plan shall be provided as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of an Urgent Care Claim) following the Plan's receipt of the Member's original request. Notification by HPN may be oral unless specifically requested in writing by the Member.

11.25 Timing of Notification of Benefit Determination

Concurrent Care Decision - If HPN has approved an ongoing course of treatment to be provided over a period of time or number of treatments and reduces or terminates coverage of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, HPN will notify the Member at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination before the benefit is reduced or terminated. Subject to the following paragraph, such request may be treated as a new Claim for Benefits and decided within the timeframes applicable to either a Pre-Service Claim or a Post-Service Claim, as appropriate. Provided, however, any appeal of such a determination must be made within a reasonable time and may not be afforded the full 180 day period as described in the Appeals Procedures Section herein.

Any request by a Member to extend the course of treatment beyond the period of time or number of treatments for an Urgent Care Claim shall be decided as soon as possible. HPN shall notify the Member within twenty-four (24) hours after receipt of the Claim for Benefits by the Plan, provided that the request is received at least twenty-four (24) hours prior to the expiration of the authorized period of time or number of treatments. If the request is not made at least twenty-four (24) hours prior to the expiration of the authorized period of time or number of treatments, the request will be treated as an Urgent Care Claim.

11.26 Notification of an Adverse Benefit Determination

If you receive an Adverse Benefit Determination, you will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the Claim for Benefits to be approved, modified or reversed, and an explanation of why such material or information is necessary;
- A description of the review procedures and the time limits applicable to such procedures;
- For Member's whose coverage is subject to ERISA, a statement of the Member's right to bring a civil action under ERISA Section 502(a) following an appeal of an Adverse Benefit Determination, if applicable;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Member's request; and
- If the Adverse Benefit Determination is based on Medical Necessity or Experimental, Investigational or Unproven treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge.

11.27 Prior Healthcare Coverage

If the Member has prior coverage that, as required by state law, extends benefits for a particular condition or a disability, HPN will not pay benefits for health care services for that condition or disability until the prior coverage ends. HPN will pay benefits as of the day coverage begins under the Plan for all other Covered Services that are not related to the condition or disability for which the Member has other coverage.

11.28 Incentives Available to the Member

Sometimes HPN may offer coupons, enhanced benefits, or other incentives to encourage a Member to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-HPN entity. The Member alone makes the decision about whether or not to take part in a program. However, HPN recommends discussion about taking part in such programs with your Provider. Questions can be directed to:

- Https://www.healthplanofnevada.com; or
- The telephone number on the Member ID card; or
- The Member may be routed to a contact specific to the sponsoring company's program.

SECTION 12. Pharmacy Provisions

12.1 Obtaining Covered Drugs

Benefits for Covered Drugs are payable subject to the following conditions:

- A **Designated** Plan Pharmacy must dispense the Covered Drug, except as otherwise specifically provided herein.
- A Generic Covered Drug will be dispensed when available, subject to the prescribing Provider's "Dispense as written" requirements.
- Benefits for Specialty Covered Drugs as defined herein are payable subject to the applicable tier Copayment and/or Coinsurance for up to a 30 day supply. If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, HPN may direct you to a Designated Plan Pharmacy with whom HPN has an arrangement to provide those Covered Drugs. If you choose not to use the Designated Plan Pharmacy and instead have the Specialty Covered Drugs dispensed by a non-Designated Plan Retail Pharmacy, you will be responsible for paying the two times amount of the Specialty Covered Drug Tier cost-share as stated in the applicable plan Attachment A, Schedule of Benefits.
- When a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive thirty (30) day supply, the Cost-share that applies will reflect the number of days dispensed.

12.2 Designated Plan Pharmacy Benefit Payments

Benefits for Covered Drugs obtained at a Designated Plan Pharmacy are payable according to the applicable benefit tiers described below, subject to the Member obtaining any required Prior Authorization or meeting any applicable Step Therapy requirement.

- **Tier I –** is the low Cost-share option for Covered Drugs.
- **Tier II –** is the midrange Cost-share option for Covered Drugs.
- **Tier III –** is the high Cost-share option for Covered Drugs.
- **Tier IV –** is the highest Cost-share option for Covered Drugs.
- **Mandatory Generic/Biosimilar benefit provision applies when:**
  - A Brand Name or Reference (originator) Covered Drug is dispensed and a Generic or Biosimilar Covered Drug equivalent is available. After satisfying any applicable CYD, the Member will pay the applicable tier Copayment and/or Coinsurance plus the difference between the Eligible Medical Expenses, or the Recognized Amount when applicable, of the Generic or Biosimilar Covered Drug and of the Brand Name or Reference Covered Drug to the Designated Plan Pharmacy for each Therapeutic Supply. The difference in the amount between such Brand Name or Reference and Generic or Biosimilar Covered Drug paid by the Member does not accumulate to any otherwise applicable plan Calendar Year Prescription Drug Deductible, overall plan CYD or annual Out of Pocket Maximum.

When a Drug is dispensed through the Mail Order Plan Pharmacy, benefits are subject to the applicable tier Copayment and/or Coinsurance per Mail Order Therapeutic Supply.

12.3 Emergency or Urgently Needed Services Prescription Drugs

Dispensed by a Plan Pharmacy. When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Plan Pharmacy at the time the Covered Drug is dispensed, the Cost-share amount subject to the applicable tier benefit.

Dispensed by a Non-Plan Pharmacy. When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Non-Plan Pharmacy at the time the Covered Drug is dispensed, the full cost of the Covered Drug subject to the Non-Plan Pharmacy Benefits Payment subsection.

12.4 Non-Plan Pharmacy Benefit Payments

In order for claims for Covered Drugs obtained at a Non-Plan Pharmacy to be eligible for benefit payment, the Member must complete and submit a Pharmacy Reimbursement Claim Form with the prescription label and register receipt to HPN or its designee.

Benefit payments are subject to the limitations and exclusions set forth in the HPN EOC as follows:

1. When any Covered Drug is dispensed, the benefit payment will be subject to HPN's Eligible Medical Expenses or the Recognized Amount, when applicable, and any applicable tier Copayment and/or Coinsurance. The Member is responsible for any amounts exceeding HPN's benefit payment.
2. The Mandatory Generic benefit provision applies when any Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The benefit payment is subject to HPN's Eligible Medical Expenses or the Recognized Amount, when applicable, of the Generic Covered Drug less the applicable tier Copayment and/or Coinsurance. The Member is responsible for any amounts exceeding HPN's benefit payment.
3. No benefits are payable if HPN's Eligible Medical Expenses or the Recognized Amount, when applicable, of the Covered Drug is less than the applicable Copayment and/or Coinsurance.

12.5 90 Day Retail Plan Network [(1)] and Mail Order Plan Pharmacy Benefit Payments

Benefits for Covered Drugs are available when dispensed by an HPN Retail[(1)] and Mail Order Plan Pharmacy subject to the applicable tier Copayment. Information on how to obtain Mail Order Drugs is provided in the Mail Order Brochure provided after enrollment with HPN.

[(1)] Applies to select retail pharmacies, please consult your Provider directory.

12.6 Zero Cost Share Medications

You may obtain up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy up to a consecutive 90-day supply.

You are not responsible for paying any applicable deductible for Prescription Drug Products on the List of Zero Cost Share Medications unless required by state or federal law.

List of Zero Cost Share Medications - A list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share. You may find the List of Zero Cost Share Medications by contacting us at www.healthplanofnevada.com or the telephone number on your ID card.

12.7 Limitations

- Prior Authorization or Step Therapy may be required for certain Covered Drugs.
- Benefits are available for refills of Covered Drugs, including prescription eye drops and opioids, only when dispensed as ordered by a duly licensed health care provider. Refills are provided once a given amount of the Covered Drug is used through the course of therapy; amounts vary by the type of Covered Drug. Refill dates of Covered Drugs can be aligned so that drugs that are refilled at the same frequency can be refilled concurrently.
- A pharmacy may refuse to fill or refill a prescription order when in the professional judgment of the pharmacist the prescription should not be filled.
- Benefits for prescriptions for Mail Order Drugs submitted following HPN's receipt of notice of Member's termination will be limited to the appropriate Therapeutic Supply from the date such notice of termination is received to the Effective Date of termination of the Member.
- Benefits are not payable if the Member is directed to a Designated Plan Pharmacy and chooses not to obtain the Covered Drug from that Designated Plan Pharmacy.
- If HPN determines that the Member may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, the Member's selection of Plan Pharmacies may be limited. If this happens, HPN may require the Member to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if the Member uses the assigned single Plan Pharmacy. If a selection is not made by the Member within thirty-one (31) days of the date of notification, then HPN will select a single Plan Pharmacy for the Member.

- Certain Specialty Prescription Drugs may be dispensed by the Designated Pharmacy in fifteen (15) day supplies up to ninety (90) days and at a pro-rated Copayment or Coinsurance. The Member will receive a fifteen (15) day supply of the Specialty Prescription Drug Product to determine if the Member will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Member each time prior to dispensing the fifteen (15) day supply to confirm if the Member is tolerating the Specialty Prescription Drug Product. The list of these certain Specialty Prescription Drugs is available through review of the HPN Prescription Drug List (PDL).
- If a Prescription Drug is excluded from coverage, the Member or representative may request an exception to gain access to the excluded Prescription Drug. Exceptions do not apply to drugs that are considered benefit exclusions, such as drugs for sexual dysfunction, cosmetic products and infertility.
  - To make a request, contact HPN in writing or call the toll-free number on your ID card. Please note, if the request for an exception is approved by HPN, the Member may incur the cost of the excepted Prescription Drug at the highest tier. If the request requires immediate action and a delay could significantly increase a health risk or the ability regain maximum function, call HPN as soon as possible. HPN will provide a written or electronic determination within seventy-two (72) hours. If the Member is not satisfied with HPNs determination of the exclusion exception, they may request an External Review. Please refer to the *Appeals Procedure* section herein for further information.
- If a Prescription Drug requires step therapy, the Member or representative may request an exception from the step therapy protocol to gain access to the Prescription Drug.
  - To make a request, contact HPN via web at https://healthplanofnevada.com/Member/Step-Therapy-Exception-Request. The Member will be informed of the determination within two (2) business days. If the Members provider requests an expedited review and a delay could significantly increase a health risk, HPN will provide a determination within twenty-four (24) hours.
- HPN may have certain programs in which the Member may receive an enhanced or reduced benefit based on their actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. Questions about these programs can be directed to the Member Services telephone number on your ID card.
- Coverage for all drugs approved by the FDA for prevention and treatment of HIV or Hepatitis C, when prescribed by a participating provider.
- Coverage for self-administered hormonal contraceptives, provided without a prescription, when a Pharmacist complies with the providing requirements protocols of the State Board of Pharmacy.

12.8 Coverage Policies and Guidelines

HPNs Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on HPN's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug to a certain tier by considering a number of factors including but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug's acquisition cost including, but not limited to, available rebates and assessments of the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others; therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed, or according to whether it was prescribed by a Specialist Physician.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding covered persons as a general population. Whether a particular Prescription Drug is appropriate for an individual covered person is a determination that is made by the covered person and the prescribing Physician.

NOTE: the tier status of a Prescription Drug may change periodically based on the process described above but only at times specified by NRS 687B.4095 . As a result of such changes, you may be required to pay more or less for that Prescription Drug.

Questions about HPN's PDL should be directed to the Member Services Department at 1-877-545-7378 or the PDL and the Pharmacy Reimbursement Claim Form is available at http://healthplanofnevada.com/~/media/Files/HPN/pdf/Forms/OptumRx-Reimbursement.ashx?la=en.

Coupons

HPN may not permit certain coupons or offers from pharmaceutical manufacturers or their affiliates to apply to the Member's annual CYD and/or Out of Pocket Maximum or to reduce the Member's Copayments and/or Coinsurance. Costs defrayed for the Member as a result of pharmaceutical coupons are not Eligible Medical Expenses, or the Recognized Amount when applicable. Questions regarding which coupons or offers are available can be addressed at healthplanofnevada.com.

At various times, HPN may send mailings or provide other communications that include a variety of messages, including information about prescription and non-prescription drugs. These communications may include offers that enable the Member to purchase the described product at a discount. In some instances, non-HPN entities may support and/or provide content for these communications and offers. Only the Member and the Provider can determine whether a change in prescription and/or non-prescription drug regimen is appropriate for the Member's medical condition.

Variable Copayment Program
Certain Specialty Prescription Drugs are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for the Member's Prescription Drug and HPN may help the Member determine whether the Specialty Prescription Drug is eligible for this reduction. If the Member redeems a coupon from a pharmaceutical manufacturer or affiliate, the Copayment and/or Coinsurance may vary. Please contact the telephone number on your ID card for an available list of Specialty Prescription Drugs. If the Member chooses not to participate, they will pay the Copayment or Coinsurance as described in the Outpatient Prescription Drug Rider.

The amount of the coupon will not count toward any applicable Calendar Year Deductible or Out of Pocket Maximums.

Rebates and Other Payments
HPN may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that a Member purchased prior to meeting any applicable deductible. As determined by HPN, a portion of any rebates may be passed on to the Member and may be taken into account in determining any applicable Copayment and/or Cost-share.

HPN, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from the Outpatient Prescription Drug benefit. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug benefit and, therefore, such amounts do not pass on to the Member.

SECTION 13. Appeals Procedures

The HPN Appeals Procedures are available to you in the event you are dissatisfied with some aspect of the Plan administration or you wish to appeal an Adverse Benefit Determination. This procedure does not apply to any problem of misunderstanding or misinformation that can be promptly resolved by the Plan supplying the Member with the appropriate information.

If a Member's Plan is governed by ERISA, the Member must exhaust the mandatory level of appeal before bringing a claim in court for a Claim of Benefits.

Concerns about medical services are best handled at the medical service site level before being brought to HPN. If a Member contacts HPN regarding an issue related to the medical service site and has not attempted to work with the site staff, the Member may be directed to that site to try to solve the problem there, if the issue is not a Claim for Benefits.

The following Appeals Procedures will be followed if the medical service site matter cannot be resolved at the site or if the concern involves the Adverse Benefit Determination of a Claim for Benefits. All Appeals will be adjudicated in a manner designed to ensure independence and impartiality on the part of the persons making the decision.

Informal Review: An Adverse Benefit Determination or medical site service complaint/concern which is directed to the HPN Member Services Department via phone or in person. If an Informal Review is resolved to the satisfaction of the Member, the matter ends. The Informal Review is **voluntary**.

1st Level Formal Appeal: An appeal of an Adverse Benefit Determination filed either orally or in writing which HPN's Customer Response and Resolution Department investigates. If a 1st Level Formal Appeal is resolved to the satisfaction of the Member, the appeal is closed. The 1st Level Formal Appeal is **mandatory** if the Member is not satisfied with the initial determination and the Member wishes to appeal such determination.

2nd Level Formal Appeal: If a 1st Level Formal Appeal is not resolved to the Member's satisfaction, a Member may then file a 2nd Level Formal Appeal. A 2nd Level Formal Appeal is submitted either orally or in writing and reviewed by the Grievance Review Committee. The 2nd Level Formal Appeal is **voluntary** for ~~all~~ Adverse Benefit Determinations. Appeals that meet expedite criteria are not eligible for 2nd Level Formal Appeal and may be processed through the Expedited External Review process.

Grievance Review Committee: A committee in which the majority of those individuals who are voting members must be members of an HPN Health Benefit Plan.

Member Services Representative: An employee of HPN that is assigned to assist the Member or the Member's Authorized Representative in filing a grievance with HPN or appealing an Adverse Benefit Determination.

13.1 Informal Review

A Member who has received an Adverse Benefit Determination of a Claim for Benefits may request an Informal Review. All Informal Reviews must be made to HPN's Member Services Department within 180 days of the Adverse Benefit Determination. Informal Reviews not filed in a timely manner will be deemed waived. The Informal Review is a **voluntary** level of appeal.

Upon the initiation of an Informal Review, a Member must provide Member Services with at least the following information:

- The Member's name (or name of Member and Member's Authorized representative), address, and telephone number;
- The Member's HPN membership number and Group name; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

The Member Services Representative will inform the Member that upon review and investigation of the relevant information, HPN will make a determination of the Informal Review. The determination will be made as soon as reasonably possible but will not exceed thirty (30) days unless more time is required for fact-finding. If the determination of the Informal Review is not acceptable to the Member and the Member wishes to pursue the matter further, the Member may file a 1st Level Formal Appeal.

13.2 1st Level Formal Appeal

When an Informal Review is not resolved in a manner that is satisfactory to the Member or when the Member chooses not to file an Informal Review and the Member wishes to pursue the matter further, the Member must file a 1st Level Formal Appeal. The 1st Level Formal Appeal must be submitted orally or in writing to HPN's Customer Response and Resolution Department within 180 days of an Adverse Benefit Determination. Such 180 days will run concurrently with the 180 day time period applicable to an Informal Review as set forth herein. NOTE: 1st Level Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

The 1st Level Formal Appeal shall contain at least the following information:

- The Member's name (or name of Member and Member's Authorized Representative), address, and telephone number;
- The Member's HPN membership number and Group name; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

Additionally, the Member may submit any supporting medical records, Physician's letters, or other information that explains why HPN should approve the Claim for Benefits. The Member can request the assistance of a Member Services Representative at any time during this process.

The 1st Level Formal Appeals should be sent or faxed to the following:

Health Plan of Nevada, Inc.
Attn: Customer Response and Resolution Department
PO Box 14865
Las Vegas, NV 89114

HPN will investigate the appeal. When the investigation is complete, the Member will be informed in writing of the resolution within thirty (30) days of receipt of the request for the 1st Level Formal Appeal. This period may be extended one (1) time by HPN for up to fifteen (15) days, provided that the extension is necessary due

- To matters beyond the control of HPN and
- HPN notifies the Member prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension and the date by which HPN expects to render a decision. If the extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Member shall be afforded at least forty-five (45) days from receipt of the notice to provide the information.

If HPN is unable to resolve the Members appeal as additional information is required, HPN will contact the Member to obtain their permission to withdraw the appeal. The Member will receive written notification that the appeal has been withdrawn and advise of the ninety (90) day timeframe in which to reopen their appeal.

If the 1st Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Claim for Benefits;
- A statement describing any voluntary appeal procedures offered by HPN and the Member's right to receive additional information describing such procedures;
- For Member's whose coverage is subject to ERISA, a statement of the Member's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination, if applicable;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Member's request; and
- If the Adverse Benefit Determination is based on Medical Necessity or Experimental, Investigational or Unproven treatment or similar exclusion or limit, either
  - An explanation of the scientific or clinical judgment or
  - A statement that such explanation will be provided free of charge as well as information regarding the Member's right to request an External Review by the State of Nevada's Office for Consumer Health Assistance (OCHA).

Limited extensions may be required if additional information is required in order for HPN to reach a resolution.

If the resolution to the 1st Level Formal Appeal is not acceptable to the Member and the Member wishes to pursue the matter further, the Member is entitled to file a 2nd Level Formal Appeal. The Member will be informed of this right at the time the Member is informed of the resolution of his 1st Level Formal Appeal.

13.3 Expedited Appeal – 1st Level Formal Appeal

The Member can ask (either orally or in writing) for an Expedited Appeal of an Adverse Benefit Determination for a Pre-Service Claim that involves an Urgent Care Claim if the Member or his Physician believe that the health of the Member could be seriously harmed by waiting for a routine appeal decision. Expedited Appeals are not available for appeals regarding denied claims for benefit payment (Post-Service Claim) or for Pre-Service Claims that are not Urgent Care Claims. Expedited Appeals must be decided no later than seventy-two (72) hours after receipt of the appeal, provided all necessary information has been submitted to HPN. If the initial notification was oral, HPN shall provide a written or electronic explanation to the Member within seventy-two (72) hours after the expedited appeal being filed.

If insufficient information is received, HPN shall notify the Member as soon as possible, but no later than twenty-four (24) hours after receipt of the claim of the specific information necessary to complete the claim. The Member will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. HPN shall notify the Member of the benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

- HPN's receipt of the specified information, or
- The end of the period afforded the Member to provide the specified information.

If the Member's Physician

- Requests an Expedited Appeal, or
- Supports a Member's request for an Expedited Appeal, and indicates that waiting for a routine appeal could seriously harm the health of the Member or subject the Member to unmanageable severe pain that cannot be adequately managed without care or treatment that is the subject of the Claim for Benefits, HPN will automatically grant an Expedited Appeal.

If a request for an Expedited Appeal is submitted without support of the Member's Physician, HPN shall decide whether the Member's health requires an Expedited Appeal. If an Expedited Appeal is not granted, HPN will provide a decision within thirty (30) days, subject to the routine appeals process for Pre-Service Claims.

13.4 2nd Level Formal Appeal

When a 1st Level Formal Appeal is not resolved in a manner that is satisfactory to the Member, the Member may initiate a 2nd Level Formal Appeal. This appeal must be submitted orally or in writing within thirty (30) days after the Member has been informed of the resolution of the 1st Level Formal Appeal.

Exhaustion of the 1st Level Formal Appeal procedure is a precondition to filing a 2nd Level Formal Appeal. A 2nd Level Formal Appeal not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which it relates. The 2nd Level Formal Appeal is **voluntary** for all Pre-Service and Post-Service Claims for Benefits.

Expedited appeals are not eligible for 2nd Level Formal Appeal. Expedited appeals may be processed through the Expedited External Review process. Please reference Expedited External Review of this plan document.

The notice to the Member or the Member's Authorized Representative will also include

- A HIPAA compliant authorization form by which the Member or the Member's Authorized Representative can authorize HPN and the Member's Physician to disclose protected health information ("PHI"), including medical records, that are pertinent to the 2nd Level Formal Appeal and
- Any other forms as required by Nevada law or regulation.

The 2nd Level Formal Appeal review cannot be scheduled without the written authorization from the Member or the Member's Authorized Representative.

The Member shall be entitled to the same reasonable access to copies of documents referenced above under the 1st Level Formal Appeal. Any new or additional information considered, relied upon or generated by the Plan will be provided to the Member, free of charge and in advance of the date on which the notice of the final internal adverse determination is required, in order to give the Member a reasonable opportunity to respond prior to this date.

The Member can request the assistance of a Member Services Representative at any time during this process.

Upon request, the Member is entitled to present telephonically and provide a formal presentation on a 2nd Level Formal Appeal. If such a hearing is requested, HPN shall make every reasonable effort to schedule a mutually convenient time for the parties involved. Repeated refusal on the part of the Member to cooperate in the scheduling of the formal presentation shall relieve the Grievance Review Committee of the responsibility of hearing a formal presentation, but not of reviewing the 2nd Level Formal Appeal. If a formal presentation is held, the Member will be permitted to provide documents to the Grievance Review Committee and to have assistance in presenting the matter to the Grievance Review Committee, including representation by counsel. However, HPN must be notified at least five (5) business days before the date of the scheduled formal presentation of the Member's intent to be represented by counsel and/or to have others present during the formal presentation. Additionally, the Member must provide HPN with copies of all documents the Member may use at the formal presentation five (5) business days before the date of the scheduled formal presentation. Upon HPN's receipt of the written request, the request will be forwarded to the Grievance Review Committee along with all available documentation relating to the appeal.

The Grievance Review Committee shall:

- Consider the 2nd Level of Appeal;
- Schedule and conduct a formal presentation if applicable;
- Obtain additional information from the Member and/or staff as it deems appropriate; and
- Make a decision and communicate its decision to the Member within thirty (30) days following HPN's receipt of the request for a 2nd Level Formal Appeal.

If the resolution of the 2nd Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement describing any additional voluntary levels of appeal; and
- A statement describing the Member's External Appeals Rights, if applicable, or judicial review.

Limited extensions may be required if additional information is required or a formal presentation is requested and the Member agrees to the extension of time.

13.5 External Review

HPN offers to the Member or the Member's Authorized Representative the right to an External Review of an adverse determination. For the purposes of this section, a Member's Authorized Representative is a person to whom a Member has given express written consent to represent the Member in an External Review of an adverse determination; or a person authorized by law to provide substituted consent for a Member; or a family member of a Member or the Member's treating provider only when the Member is unable to provide consent.

Adverse determinations eligible for External Review set forth in this section are only those relating to Medical Necessity, appropriateness of service, healthcare service, healthcare setting, or level of care or effectiveness of a healthcare service. HPN will provide the Member notice of such an adverse determination which will include the following statement:

> *HPN has denied your request for the provision or payment of a requested healthcare service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for External Review to the Office for Consumer Health Assistance (OCHA).*

Additionally, as per applicable law and regulations, the notice will provide the Member the information outlined herein as well as the following:

- The telephone number for the Office for Consumer Health Assistance for the state of jurisdiction of the health carrier and the state in which the Member resides.
- The right to receive correspondence in a culturally and linguistically appropriate manner.

The notice to the Member or the Member's Authorized Representative will also include:

- A HIPAA compliant authorization form by which the Member or the Member's Authorized Representative can authorize HPN and the Member's Physician to disclose protected health information ("PHI"), including medical records, that are pertinent to the External Review and
- Any other forms as required by Nevada law or regulation.

The Member or the Member's Authorized Representative may submit a request directly to OCHA for an External Review of an adverse determination by an Independent Review Organization ("IRO") within four (4) months of the Member or the Member's Authorized Representative receiving notice of such determination. The IRO must be certified by the Nevada Division of Insurance. Requests for an External Review must be made in writing and submitted to OCHA at the address following and should include the signed HIPAA authorization form, authorizing the release of your medical records. The entire External Review process and any associated medical records are confidential.

Office of the Governor, Consumer Health Assistance
3320 W. Sahara Ave., Suite 100, Las Vegas, NV 89102
Telephone: 702-486-3587 Toll-free: 1-888-333-1597
Web: dhhs.nv.gov/Programs/CHA/
Email: cha@govcha.nv.gov

The determination of an IRO concerning an External Review in favor of the Member of an adverse determination is final, conclusive and binding. If your plan is governed by Employee Retirement Income and Security Act (ERISA), you may have the right to file a civil action under ERISA if all required mandatory reviews of your claim have been completed. Upon receipt of the notice of a decision by the IRO reversing an adverse determination, HPN shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination. The cost of conducting an External Review of an adverse determination will be paid by HPN.

13.6 Standard External Review

The Member may submit a request for an External Review of an adverse determination under this section only after

- The Member has exhausted all applicable internal HPN Appeals Procedures provided under this Plan or
- If HPN fails to issue a written decision to the Member within thirty (30) days after the date the Appeal was filed, and the Member or Member's Authorized Representative did not request or agree to a delay or,
- If HPN agrees to permit the Member to submit the adverse determination to OCHA without requiring the Member to exhaust all internal HPN Appeals Procedures.

In such event, the Member shall be considered to have exhausted the applicable internal HPN Appeals Process.

Within five (5) days after OCHA receives a request for External Review, OCHA shall notify the Member, the Member's Authorized Representative and HPN that such request has been received and filed. As soon as practical, OCHA shall assign an IRO to review the case.

Within five (5) days after receiving notification specifying the assigned IRO from OCHA, HPN shall provide to the selected IRO all documents and materials relating to the adverse determination, including, without limitation:

- Any medical records of the Member relating to the adverse determination;
- A copy of the provisions of the healthcare Plan upon which the adverse determination was based;
- Any documents used and the reason(s) given by HPN's Managed Care Program for the adverse determination; and
- If applicable, a list that specifies each Provider who provided healthcare to the Member and the corresponding medical records from the Provider relating to the adverse determination.

Within five (5) days after the IRO receives the required documentation from HPN, they shall notify the Member or the Member's Authorized Representative, if any additional information is required to conduct the review. If additional information is required, it must be provided to the IRO within five (5) days after receiving the request. The IRO will forward a copy of the additional information to HPN within one (1) business day after receipt.

The IRO shall approve, modify, or reverse the adverse determination within fifteen (15) days after it receives the information required to make such a determination. The IRO shall submit a copy of its determination, including the basis thereof, to the:

- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

13.7 Expedited External Review

A request for an Expedited External Review may be submitted to OCHA when the mandatory 1st Level Appeal has been exhausted and after it receives proof from the Member's Provider that the adverse determination concerns:

- An inpatient admission;
- Availability of inpatient care;
- Continued stay or health care service for Emergency Services while still admitted to an inpatient facility; or
- Failure to proceed in an expedited manner may jeopardize the life or health of the Member.

The OCHA shall approve or deny this request for Expedited External Review within seventy-two (72) hours after receipt of the above required proof. If OCHA approves the request, it shall assign the request to an IRO no later than one (1) business day after approving the request. HPN will supply all relevant medical documents and information used to establish the adverse determination to the IRO within twenty-four (24) hours after receiving notice from the OCHA.

The IRO shall complete its Expedited External Review within forty-eight (48) hours after initially being assigned the case unless the Member or the Member's Authorized Representative and HPN agree to a longer time period.

The IRO shall notify the following parties no later than twenty-four (24) hours after completing its Expedited External Review:

- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

The IRO shall then submit a written copy of its determination within forty-eight (48) hours to the applicable parties listed above.

13.8 Request for an External Review Due to Denial of Experimental, Investigational or Unproven Healthcare Service or Treatment.

A Standard or Expedited External Review of an adverse determination due to a requested or recommended healthcare service or treatment being deemed Experimental, Investigational or Unproven is available in limited circumstances as outlined in the following sections.

13.9 Standard External Review

The Member or Member's Authorized Representative may within four (4) months after receiving notice of an adverse determination subject to this section, submit a request to the OCHA for an External Review. All requests for standard external review must be made in writing to the Office for Consumer Health Assistance.

OCHA will notify HPN and/or any other interested parties within one (1) business day after the receipt of the request for External Review. Within five (5) business days after HPN receives such notice and, subject to applicable Nevada law and regulation and pursuant to this section, HPN will make a preliminary determination of whether the case is complete and eligible for External Review.

Within one (1) business day of making such a determination, HPN will notify in writing, the Member or the Member's Authorized Representative and OCHA, accordingly. If HPN determines that the case is incomplete and/or ineligible, HPN will notify the Member in writing of such determination. Such notice shall include the required additional information or materials needed to make the request complete and, if applicable, state the reasons for ineligibility and also state that such determination may be appealed to OCHA. Upon appeal, OCHA may overturn HPN's determination that a request for External Review of an adverse determination is ineligible, and submit the request to External Review, subject to all of the terms and provisions of this Plan and applicable Nevada law and regulation.

Within one (1) business day after receiving the confirmation of eligibility for External Review from HPN, OCHA will assign the IRO accordingly and notify in writing the Member or the Member's Authorized Representative and HPN that the request is complete and eligible for External Review and provide the name of the assigned IRO. HPN, within five (5) days after receipt of such notice from the OCHA, will supply all relevant medical documents and information used to establish the adverse determination to the assigned IRO who will select and assign one or more clinical reviewers to the External Review.

The IRO shall approve, modify, or reverse the adverse determination pursuant to this section within twenty (20) days after it receives the information required to make such a determination.

The Independent Review Organization shall submit a copy of its determination, including the basis thereof, to the:

- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

13.10 Expedited External Review

The Member or the Member's Authorized Representative may request in writing, an internal Expedited Appeal by HPN and an Expedited External Review from OCHA simultaneously

- If the adverse determination of the requested or recommended service or treatment is determined by HPN to be Experimental, Investigational or Unproven and
- If the treating Provider certifies, in writing, that such service or treatment would be less effective if not promptly initiated.

An oral request for an Expedited External Review may be submitted directly to the OCHA upon the written submission of proof from the Member's Provider to OCHA. Upon receipt of such request and proof, OCHA shall immediately notify HPN accordingly.

HPN will immediately determine if the request meets the requirements for Expedited External Review pursuant to this section and notify the Member or the Member's Authorized Representative and the OCHA of the determination. If HPN determines the request to be ineligible, the Member will be notified that the request may be appealed to OCHA.

If OCHA approves the request for Expedited External Review, it shall immediately assign the request to an IRO and notify HPN. The IRO has one (1) business day to select one or more clinical reviewers. HPN must submit the documentation used to support the adverse determination to the IRO within five (5) business days. If HPN fails to provide the information within the specified time, the IRO may terminate the External Review and reverse the adverse determination.

The Member or Member's Authorized Representative may, within five (5) business days after receiving notice of the assigned IRO, submit any additional information in writing to the IRO. Any information submitted by the Member or the Member's Authorized Representative after five (5) business days to the IRO may be considered as well. Any information received by the Member or the Member's Authorized Representative must be submitted to HPN by the IRO within one (1) business day.

The clinical reviewers have no more than five (5) days to provide an opinion to the IRO. The IRO has forty-eight (48) hours to review the opinion of the clinical reviewers and make a determination.

The IRO shall notify the following parties no later than twenty-four (24) hours after completing its External Review:
- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

The IRO shall then submit a written copy of its determination within forty-eight (48) hours to the applicable parties listed above.

13.11 No Surprises Act

The Policy complies with the applicable provisions of the *Consolidated Appropriations Act (the "Act") (P.L. 116-260).*

Balance Billing
The No Surprises Act prohibits balance billing by out-of-network providers in the following instances:
- When ancillary services are received at certain network facilities on a non-emergency basis from out-of-network Physicians.
- When non-ancillary services are received at certain network facilities on a non-emergency basis from out-of-network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described in the Act.
- When emergency health care services are provided by an out-of-network provider.
- When air ambulance services are provided by an out-of-network provider.

In these instances, the out-of-network provider may not bill you for amounts in excess of your applicable copayment, coinsurance or deductible (cost share). Your cost share will be provided at the same level as if provided by a plan provider and is determined based on the recognized amount.

For the purpose of this summary, "certain network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Determination of Our Payment to the Out-of-Network Provider:
When covered health care services are received from out-of-network providers for the instances as described above, the recognized amount, which are used to determine our payment to out-of-network providers, are based on one of the following in the order listed below as applicable:
- The reimbursement rate as determined by a state All Payer Model Agreement.
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-network provider and us.
- The amount determined by Independent Dispute Resolution (IDR).

Continuity of Care
The Act provides that if you are currently receiving treatment for covered health care services from a provider whose network status changes from network to out-of-network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, please call the telephone number on your ID card.

Provider Directories
The Act provides that if you receive a covered health care service from an out-of-network provider and were informed incorrectly by us prior to receipt of the covered health care service that the provider was a plan provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from a plan provider.

13.12 Office for Consumer Health Assistance

(702) 486-3587 in the Las Vegas area

1-888-333-1597 outside the Las Vegas area (toll free)

SECTION 14. Glossary

This section tells you meanings of some of the more important words in the Evidence of Coverage. Please read it carefully. It will help you to understand the rest of the Evidence of Coverage.

❖ "**Adverse Benefit Determination**" means a rescission of coverage; a decision by HPN to deny, reduce, terminate, fail to provide, or make payment for a benefit, including a denial, reduction termination, or failure to provide, or make a payment for a benefit that is based on:

- An individual's eligibility;
- A determination that a benefit is not a Covered Service;
- The imposition of a limitation of an otherwise Covered Service; or
- A determination that a benefit is Experimental, Investigational or Unproven or not Medically Necessary or appropriate.

External Review is only available for a Final Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service. An Adverse Benefit Determination is final if the Member has exhausted all complaint and Appeal Procedures set forth herein for the review of such Adverse Benefit Determination.

❖ **"Air Ambulance"** means medical transport by rotary wing air ambulance or fixed wing air ambulance as defined in *CRF 414.605*.

❖ "**Alternate Facility**" means a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Illness or Substance-Related and Addictive Disorders Services on an Outpatient or Inpatient basis.

❖ "**Ambulance**" means a ground or air vehicle licensed to provide Ambulance services.

❖ "**Ambulatory Surgical Facility**" means a facility that:

- Is licensed by the state where it is located.
- Is equipped and operated mainly to provide for surgeries or obstetrical deliveries.
- Allows patients to leave the facility the same day the surgery or delivery occurs.

❖ "**Ancillary Services**" means items and services provided by a Non-Plan Provider at a Plan facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a Non-Plan Provider when no other Plan Provider is available.

❖ **"Applied Behavior Analysis"** or **"ABA"** means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

❖ "**Authorized Representative**" means a person designated by the Member to act on his behalf in pursuing a Claim for Benefits, to file an appeal of an adverse determination., or in obtaining an External Review of an adverse determination. The designation must be in writing unless the claim or appeal involves an Urgent Care Claim and a healthcare professional with knowledge of the Member's medical condition is seeking to act on the Member's behalf as his Authorized Representative.

❖ **"Autism Spectrum Disorders"** means a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined.

- "**Benefit Schedule**" means the brief summary of benefits, limitations and Copayments given to the Subscriber by HPN. It is Attachment A to this EOC.

- **"Biomarker"** means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.

- **"Biosimilar Prescription Drug"** means a biological Prescription Drug approved based on showing that it is highly similar to a Reference Product, and has no clinically meaningful differences in terms of safety and effectiveness from the Reference Product.

- **"Brand Name Drug"** means a Prescription Drug which is marketed under or protected by:
  - A registered trademark; or
  - A registered trade name; or
  - A registered patent.

- "**Calendar Year**" means January 1 through December 31 of the same year.

- **"Calendar Year Out of Pocket Maximum**" means the maximum amount of Out of Pocket expenses a Member is required to pay for Covered Services in a Calendar Year, as outlined in the Attachment A, Schedule of Benefits. Once the Calendar Year Out of Pocket Maximum is met, no further cost share is required for the remainder of the Calendar Year. For purposes of accumulating benefits paid toward any applicable benefit maximums under the Plan, the period of such accumulation will coincide with the time period of the Calendar Year applicable to the Group.

  The Out of Pocket Maximum does not include any amounts:
  - Resulting from the Member's failure to comply with HPN's Managed Care Program, including the inappropriate use of an emergency room facility for a condition which does not require Emergency Services;
  - In excess of Eligible Medical Expenses or the Recognized Amount, when applicable,;
  - For services that are not Covered Services; for services that are not Prior Authorized through HPN's Managed Care Program; or
  - In excess of the Calendar Year, per Illness or any other benefit maximums as set forth in Attachment A Benefit Schedule.

- "**Claim for Benefits**" means a request for a Plan benefit or benefits made by a Member in accordance with the Plan's Appeals Procedures, including any Pre-Service Claims (requests for Prior Authorization) and Post-Service Claims (requests for benefit payment).

- "**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended.

- **"Coinsurance"** means the percentage of the charges billed or the percentage of Eligible Medical Expenses or the Recognized Amount, when applicable, whichever is less, that a Member must pay a Provider for Covered Services. Coinsurance amounts are to be paid by the Member directly to the Provider who bills for the Covered Services. (See Attachment A, Benefit Schedule.)

- **"Compound"** means to form or create a Medically Necessary customized composite product by combining two (2) or more different ingredients according to a Physician's specifications to meet an individual patient's need.

- **"Congenital Anomaly"** means a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

- "**Contract Year**" means the twelve (12) months beginning with and following the Effective Date of the Group Enrollment Agreement (GEA).

❖ **"Convenient Care"** means a facility that provides services for Medically Necessary, non-urgent or non-emergent injuries or illnesses. Examples of such conditions include:
- Blood pressure checks;
- Diagnostic laboratory services;
- General health screenings;
- Minor illnesses (cold/flu);
- Minor wound treatment and repair;
- Treatment of burns and sprains.

❖ "**Copayment" or "Cost-share"** means the amount the Member pays at the time a Covered Service is received.

❖ **"Covered Drug"** means a Brand Name or Generic Prescription Drug or diabetic supply or equipment which:
- Can only be obtained with a prescription;
- Has been approved by the Food and Drug Administration ("FDA") for general marketing;
- Is dispensed by a licensed pharmacist;
- Is prescribed by a Plan Provider, except in the case of Emergency Services and Urgently Needed Services;
- Is a Prescription Drug that does not have an over-the-counter Therapeutic Equivalent available; and
- Is not specifically excluded herein.

❖ **"Covered Person"** means a Member who meets the eligibility requirements of Section 1., who has enrolled under this Plan and for whom premiums have been received and accepted by HPN.

❖ "**Covered Services**" means the health services, supplies and accommodations for which HPN pays benefits under this Plan.

❖ "**Covered Transplant Procedure**" means any Medically Necessary, human-to-human, organ or tissue transplants performed upon a Member who satisfies medical criteria developed by HPN for receiving transplant services.

❖ "**Custodial Care**" means care that mainly provides room and board (meals) for a physically or mentally disabled person. Such care does not reduce the disability so that the person can live outside a Hospital or nursing home. Examples of Custodial Care include:
- Non-Skilled Nursing Care.
- Supervisory care by a Physician in a custodial facility to meet regulatory requirements.
- Training or assistance in personal hygiene.
- Other forms of self-care.

❖ **"Deductible"** means the portion of Eligible Medical Expenses or the Recognized Amount, when applicable,, excluding Copayments, that a Member must pay, either in the aggregate or for a particular service, before HPN will make any benefit payments for Covered Services. (See Attachment A Benefit Schedule.)

❖ "**Dependent**" means an Eligible Family Member of the Subscriber's family who:
- Meets the eligibility requirements of the Plan as set forth in Section 1 of this EOC;
- Is enrolled under this Plan; and
- For whom premiums have been received and accepted by HPN.

❖ **"Domestic Partner"** is as defined in NRS 122A.030.

❖ **"Designated Plan Pharmacy"** means a pharmacy that has entered into an agreement with HPN to provide specific Covered Drugs and/or supplies to Members. The fact that a pharmacy is a Plan Pharmacy does not mean that it is a Designated Plan Pharmacy. For the purposes of the Prescription Drug Benefit, please refer to the HPN PDL on the website or contact Member Services for the specific Designated Plan Pharmacy for your Covered Drug and/or supply/equipment.

❖ **"Dispensing Period"** as established by HPN means 1) a predetermined period of time; or 2) a period of time up to a predetermined age attained by the Member that a specific Covered Drug is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition.

❖ "**Durable Medical Equipment**" or "**DME**" means medical equipment that:
- Can withstand repeated use;
- Is used primarily and customarily for a medical purpose rather than convenience or comfort;
- Generally is not useful to a person in the absence of an Illness or Injury;
- Is appropriate for use in the home; and
- Is prescribed by a Physician.

❖ "**Effective Date**" means the initial date on which Members are covered for services under the HPN Plan provided any applicable premiums have been received and accepted by HPN.

❖ **"Eligible Medical Expenses"** or **"EME"** means the maximum amount HPN will pay for a particular Covered Service as determined by HPN in accordance with HPN's Reimbursement Schedule.

❖ "**Eligible Employee**" means a natural person that meets the following criteria:
- Is employed full-time;
- Is in an active employment status;
- Works at least the minimum number of hours per week indicated by the Group in the Attachment A to the GEA (typically 30 hours);
- Meets the applicable waiting period indicated by the Group in the Attachment A to the GEA;
- Enrolls during an enrollment period;
- Lives or work in HPN's Service Area; and
- Works for an employer that meets the minimum employer contribution percentage for the applicable coverage as set forth in the Attachment A to the GEA.

❖ "**Eligible Family Member**" means a member of the Subscriber's family that is or becomes eligible to enroll for coverage under this Plan as a Dependent.

❖ "**Emergency Services**" means Covered Services provided for a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention at a Hospital or Emergency department could result in serious:
- Jeopardy to his health;
- Jeopardy to the health of an unborn child;
- Impairment of a bodily function; or
- Dysfunction of any bodily organ or part.

Emergency Services include items and services otherwise covered by HPN when provided by a Non-Plan Provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an inpatient or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

(a) The attending Emergency Physician or treating Provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network Provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
(b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
(c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
(d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
(e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

❖ "**Enrollment Date**" means the first day of coverage under this Plan or, if there is a Waiting Period, the first day of the Waiting Period. If an individual receiving benefits under the employer's Health Benefit Plan changes benefit packages, or if the employer changes Health Benefit Plan carriers, the individual's Enrollment Date does not change.

❖ "**ERISA**" means Employee Retirement Income Security Act of 1974, as amended, including regulations implementing the Act.

❖ **"Essential Benefits"** include the following: ambulatory services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services (including behavioral health treatment); prescription drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services; including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

❖ "**Evidence of Coverage**" or "**EOC**" means this document, including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Member's Enrollment Form, health statements, Member Identification Card, and all other applications received by HPN.

❖ "**Expedited Appeal**" means if a Member appeals a decision regarding a denied request for Prior Authorization (Pre-Service Claim) for an Urgent Care Claim, the Member or Member's Authorized Representative can request an Expedited Appeal, either orally or in writing. Decisions regarding an Expedited Appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

❖ **"Experimental or Investigational"** means medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time HPN makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information* (*AHFS DI*) under the therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIA, or class IIb; or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A or 2B.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to FDA oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical trials for which benefits are available as described herein.
- HPN may, as we determine, consider an otherwise Experimental or Investigational service to be a covered healthcare service for that illness or condition if:
  - The Member is not a participant in a qualifying clinical trial, as herein: and
  - The Member has an illness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, HPN must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that illness or condition.

❖ "**External Review**" means an independent review of an Adverse Benefit Determination conducted by an Independent Review Organization.

❖ **"Final Adverse Benefit Determination"** means the upholding of an Adverse Benefit Determination at the conclusion of the internal appeals process or an Adverse Benefit Determination in which the internal appeals process has been deemed exhausted.

External Review is only available for a Final Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service.

- **"Free Standing Diagnostic Center"** means a licensed establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient diagnostic services.

- **"Free Standing Emergency Facility"** means a facility, structurally separate and distinct from a hospital, which provides limited services for the treatment of a medical emergency and licensed as ascribed in NAC 449.61032 – NAC 449.61384.

- **"Gender Dysphoria"** means a disorder characterized by diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

- **"Generic Drug"** means an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.

- "**Genetic Disease Testing**" means the analysis of human DNA, chromosomes, proteins or other gene products to determine the presence of disease related genotypes, mutations, phenotypes or karyotypes for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risks, identification of carriers, monitoring, diagnosis or prognosis, but do not include tests conducted purely for research.

- "**Group**" means an employer or legal entity that has completed and signed the Group Enrollment Agreement and the Attachment A to the Group Enrollment Agreement (Group Application) with HPN for HPN to provide Covered Services.

- "**Group Enrollment Agreement**" or "**GEA**" means the agreement signed by HPN and Group that states the conditions for coverage, eligibility and enrollment requirements and premiums.

- "**Health Benefit Plan**" means a policy, contract, certificate or agreement offered by a carrier or similar agreement offered by an employer or other legal entity, to provide for, arrange for payment of, pay for or reimburse any of the costs of healthcare services. This term includes Short-Term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis. Health Benefit Plans do not include:
  - Coverage for accident only, dental only, vision only, disability income insurance, long-term care only insurance, hospital indemnity coverage or other fixed indemnity coverage, limited benefit coverage, specific disease/Illness coverage, credit-only insurance;
  - Coverage issued as a supplement to liability insurance;
  - Liability insurance, including general liability insurance and automobile liability insurance;
  - Workers' compensation insurance;
  - Coverage for medical payments under a policy of automobile insurance;
  - Coverage for on-site medical clinics; or
  - Medicare supplemental health insurance.

- "**Health Maintenance Organization**" or **"HMO"** means an organization that is formed in accordance with state law to provide managed healthcare services.

- "**Health Plan of Nevada**" or "**HPN**" means Health Plan of Nevada, Inc., a Nevada corporation licensed by the Nevada Insurance Commissioner under Nevada law. HPN is a federally qualified Health Maintenance Organization.

- "**HPN Reimbursement Schedule"** means the schedule showing the amount HPN will pay for Eligible Medical Expenses or the Recognized Amount, when applicable, to Providers. Eligible Medical Expenses or the Recognized Amount, when applicable, will be applicable to Non-Plan Providers including Non-Plan Facilities. HPN Reimbursement Schedule is based on:
  - The amount most consistently paid to the Provider; or
  - The amount paid to other Providers with the same or similar qualifications; or
  - The relative value and worth of the service compared to other services which HPN determines to be similar in complexity and nature with reference to other industry and governmental sources, examples of these sources include published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar services within the geographic market, a gap methodology, or Eligible Medical Expenses or the Recognized Amount, when applicable, could be based on a percentage of the provider's billed charge.

For Non-Plan Provider Emergency Services, HPN will pay the greater of:

- The amount we have negotiated with Plan Providers for the Emergency Services received (and if there is more than one amount, the median of the amounts); or
- 100% of the Eligible Medical Expenses or the Recognized Amount, when applicable, for Emergency Services provided by a Non-Plan Provider under your Plan; or
- The amount that would be paid for the Emergency Services under Medicare.

❖ "**Home Healthcare**" means healthcare services given by a Home Healthcare agency under a Physician's orders in the person's home. It is care given to persons who are homebound for medical reasons and physically not able to obtain necessary medical care on an outpatient basis. A Home Healthcare agency must be licensed by the state where it is located.

❖ "**Hospice**" means an establishment licensed by the state where it is located that furnishes a centrally administered program of palliative and supportive services. Such services are provided by a team of healthcare Providers and directed by a Physician. Services include physical, psychological, custodial and spiritual care for patients who are terminally ill and their families. For the purposes of this benefit only, "family" includes the immediate family, the person who primarily cared for the patient and other persons with significant personal ties to the patient, whether or not related by blood.

❖ "**Hospice Care Services**" means acute care provided by a Hospice if the Member has less than six (6) months to live as certified by the treating Physician, and the Member is not receiving or intending to receive any curative treatment. Care may be provided in the home, at a residential facility or at a medical facility at any time of the day or night. These services include bereavement care provided to the patient's family after the patient dies.

❖ "**Hospital**" means a facility that:

- Is licensed by the state where it is located and is Medicare-certified;
- Provides 24-hour nursing services by registered nurses (RNs) on duty or call; and
- Provides services under the supervision of a staff of one or more Physicians to diagnose and treat ill or injured bed patients hospitalized for surgical, medical or psychiatric conditions.

Hospital does not include:

- Ambulatory Surgical Facilities;
- Christian Science sanataria;
- Free Standing Emergency Facilities;
- health resorts;
- institutions for exceptional children;
- nursing homes;
- Residential Treatment Centers;
- Physician offices;
- private homes; or
- Skilled Nursing Facilities, places that are primarily for the care of convalescents.

❖ "**Illness**" means an abnormal state of health resulting from disease, sickness or malfunction of the body; or a congenital malformation, which causes functional impairment. For purposes of this EOC, Illness also includes sterilization or circumcision. Illness does not include any state of mental health or mental disorder other than Mental Illness as it is defined in this EOC.

❖ **"Independent Review Organization"** means an entity that:

- Conducts an independent External Review of an adverse determination; and
- Is certified by the Nevada Commissioner of Insurance

❖ "**Initial Enrollment Period**" means the period of time during which an eligible person may enroll under this Plan, as shown in the GEA signed by the Group.

❖ "**Injury**" means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.

❖ "**Inpatient**" means being confined in a Hospital, Skilled Nursing Facility or Residential Treatment Center as a registered bed patient under a Physician's order.

❖ **"Licensed Assistant Behavior Analyst"** means a person who holds current certification as a Board Certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

❖ **"Licensed Behavior Analyst"** means a person who holds current certification as a Board Certified Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and is licensed as a behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services.

❖ **"Mail Order Plan Pharmacy"** means a duly licensed pharmacy that has an independent contractor agreement with HPN to provide certain Covered Drugs to Members by mail.

❖ "**Managed Care Program**" means the process that determines Medical Necessity and directs care to the most appropriate setting to provide quality care in a cost-effective manner, including Prior Authorization of certain services.

❖ "**Manual Manipulation**" means the diagnosis, treatment or maintenance by a Practitioner for the treatment of:
- Musculoskeletal strain surrounding vertebra, spine, broken neck; or
- Subluxation of vertebra.

Manual Manipulation does not include diagnosis or treatment requiring general anesthesia, surgery or Hospital confinement.

❖ "**Medical Director**" means a Physician named by HPN to review use of health services by Members.

❖ "**Medically Necessary**" means a service or supply needed to improve a specific health condition or to preserve the Member's health and which, as determined by HPN is:
- Consistent with the diagnosis and treatment of the Member's Illness or Injury;
- The most appropriate level of service which can be safely provided to the Member; and
- Not solely for the convenience of the Member, the Provider(s) or Hospital.

In determining whether a service or supply is Medically Necessary, HPN may give consideration to any or all of the following:
- The likelihood of a certain service or supply producing a significant positive outcome;
- Reports in peer-review literature;
- Evidence based reports and guidelines published by nationally recognized professional organizations that include supporting scientific data;
- Professional standards of safety and effectiveness that are generally recognized in the United States for diagnosis, care or treatment;
- The opinions of independent expert Physicians in the health specialty involved when such opinions are based on broad professional consensus; or
- Other relevant information obtained by HPN.

When applied to Inpatient services, "Medically Necessary" further means that the Member's condition requires treatment in a Hospital rather than in any other setting. Services and accommodations will not automatically be considered Medically Necessary simply because they were prescribed by a Physician.

❖ "**Medically Necessary for External Review**" means healthcare services or products that a prudent Physician would provide to a patient to prevent, diagnose or treat an Illness, Injury or disease or any symptoms thereof that are necessary and:
- Provided in accordance with generally accepted standards of medical practice;
- Clinically appropriate with regard to type, frequency, extent, location and duration;
- Not primarily provided for the convenience of the patient, Physician or other Provider of healthcare;
- Required to improve a specific health condition of a Member or to preserve his existing state of health; and
- The most clinically appropriate level of healthcare that may be safely provided to the Member.

❖ "**Medicare**" means Medicare Part A and Medicare Part B healthcare benefits that a Member is receiving under Title XVIII of the Social Security Act of 1965 as amended.

❖ "**Member**" means a person who meets the eligibility requirements of Section 1., who has enrolled under this Plan and for whom premiums have been received and accepted by HPN.

❖ **"Mental Health Professional"** means any person qualified and licensed to provide assessments, diagnosis and therapy for mental health conditions or Substance-Related and Addictive Disorder.

❖ **"Mental Illness"** means a pathological state of mind producing clinically significant psychological or physiological symptoms together with impairment in one or more major areas of functioning where improvement can reasonably be anticipated with therapy. Mental Illness does not include any Severe Mental Illness as defined in the EOC and otherwise covered under the Severe Mental Illness Covered Services section, or any of the following when they represent the primary need for therapy:

- Behavior disorders;
- Chronic organic brain syndrome;
- Learning disabilities;
- Marital or family problems;
- Intellectual disability;
- Personality disorder; or
- Social, occupational, or religious maladjustment.

❖ **"Minimum Essential Coverage (MEC)"** means any insurance plan that meets the Affordable Care Act requirement for having health coverage. To avoid the penalty for not having insurance a person must be enrolled in a plan that qualifies as minimum essential coverage (sometimes called "qualifying health coverage"). Examples of plans that qualify include:

- Job-based plans;
- Marketplace plans;
- Medicare; and
- Medicaid & CHIP.

❖ "**Non-Medical 24-Hour Withdrawal Management**" means an organized residential service, including those defined in American Society of Addiction Medicine (ASAM) criteria, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

❖ **"Non-Plan Pharmacy"** means a duly licensed pharmacy that does not have an independent contractor agreement with HPN to provide Covered Drugs to Members.

❖ "**Non-Plan Provider**" means a Provider who does not have an independent contractor agreement with HPN.

❖ "**Occupational Illness or Injury**" means any Illness or Injury arising out of or in the course of employment for pay or profit.

❖ "**Open Enrollment Period**" means an annual thirty-one (31) day period of time during which Eligible Employees and their Eligible Family Members may enroll under this Plan without giving HPN evidence of good health.

❖ "**Orthotic Devices**" means an apparatus used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.

❖ "**Physician**" means anyone qualified and licensed to practice medicine and surgery by the state where the practice is located who has the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO). Physician also means Doctor of Dentistry, a Doctor of Podiatric Medicine or a Chiropractor when they are acting within the scope of their license.

❖ "**Physician-assisted Suicide**" means a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

❖ **"Physician Extender/Physician Assistant"** means a health care provider who is not a physician (MD/DO) but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.

❖ "**Placed (or Placement) for Adoption**" means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person ends upon the termination of such legal obligation.

- "**Plan**" means this Evidence of Coverage (EOC), including the Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Member's Enrollment Form, health statements, the Member Identification Card, and all other applications received by HPN.

- **"Plan Pharmacy"** is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide Covered Drugs to Members. Unless otherwise specified as Mail Order Plan Pharmacy herein, Plan Pharmacy services are retail services only and do not include Mail Order services.

- "**Plan Provider**" means a Provider who has an independent contractor agreement with HPN to provide certain Covered Services to Members. A Plan Provider's agreement with HPN may terminate, and a Member will be required to select another Plan Provider.

- "**Post-Service Claim**" means any Claim for Benefits under a Health Benefit Plan regarding payment of benefits that is not considered a Pre-Service Claim or an Urgent Care Claim.

- "**Practitioner**" means any person(s) qualified and licensed to practice the healing arts when they are acting within the scope of their license.

- "**Prescription Drug**" means a Federal legend drug or medicine that can only be obtained by a prescription order or that is restricted to prescription dispensing by state law. It also includes insulin and glucagon.

- **"Prescription Drug List (PDL)"** means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by HPN.

- "**Pre-Service Claim**" means any Claim for Benefits under a Health Benefit Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

- "**Primary Care Physician**" or "**PCP**" means a Plan Provider who has an independent contractor agreement with HPN to assume responsibility for arranging and coordinating the delivery of Covered Services to Members. A Primary Care Physician's agreement with HPN may terminate. In the event that a Member's Primary Care Physician's agreement terminates, the Member will be required to select another Primary Care Physician.

- "**Prior Authorization**" or "**Prior Authorized**" means a system that requires a Provider to get approval from HPN before providing non-emergency healthcare services to a Member for those services to be considered Covered Services. Prior Authorization is not an agreement to pay for a service.

- "**Procurement**" means obtaining Medically Necessary human organs or tissue for a Covered Transplant Procedure as determined by HPN and includes donor search, testing, removal, preservation and transportation of the donated organ or tissue. Procurement will also apply to medically appropriate donor testing services including, but not limited to, HLA typing, subject to any maximum procurement benefit amount. Procurement does not include maintenance of a donor while the Member is awaiting the transplant.

- "**Prosthetic Device**" means a non-experimental device that replaces all or part of an internal or external body organ or replaces all or part of the function of a permanently inoperative or malfunctioning internal or external organ.

- **"Provider"** means a:
  - Ambulatory Surgical Facility;
  - Dentist;
  - Hospital;
  - Physician;
  - Practitioner;
  - Podiatrist;
  - Skilled Nursing Facility;
  - Urgent Care Facility, or
  - Other person or organization licensed by the state where his/the practice is located to provide medical or surgical services, supplies, and accommodations acting within the scope of his/the license.

❖ **"Recognized Amount"** means the amount which the Copayment, Coinsurance and any applicable CYD, is based on for the below Covered Services when provided by Non-Plan Providers.

- Non-Plan Emergency Services.
- Non-Emergency Covered Services received at certain Network facilities by Non-Plan Providers, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

- An *All Payer Model Agreement* if adopted;
- State law; or
- The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a Non-Plan Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Services that use the Recognized Amount to determine the Member cost sharing may be higher or lower than if cost sharing for these Covered Services were determined based upon the Eligible Medical Expenses.

❖ **"Reference Product"** means a biological Prescription Drug.

❖ "**Referral**" means a recommendation for a Member to receive a service or care from another Provider or facility.

❖ **"Remote Physiologic Monitoring"** is the automatic collection and electronic transmission of patient physiological data that are analyzed and used by a licensed Physician or other qualified healthcare professional to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. The treatment plan will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiological Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiological Monitoring may not be used while the patient is Inpatient at a hospital or other facility. Use of multiple devices must coordinated by one Physician.

❖ **"Residential Treatment Center"** means a sub-acute facility or acute care facility which delivers twenty-four (24) hours/ seven (7) days a week assessment, diagnostic services and active behavioral health treatment to Members. The level of care and length of stay, in a facility with the appropriate licensure level, is authorized through the HPN Managed Care program.

❖ "**Retrospective**" or "**Retrospectively**" means a review of an event after it has taken place.

❖ "**Rider**" means a provision added to the Agreement or the EOC to expand benefits or coverage.

❖ **"Secretary**" means as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

❖ "**Service Area**" means the geographical area where HPN is licensed to operate. It is shown in Attachment B. Subscribers must live or work in the Service Area to be covered under this Plan. Dependent children that are covered under this Plan, due to a court order, do not have to reside within HPN's Service Area.

❖ **"Severe Mental Illness"** means any of the following Mental Illnesses that are biologically based and for which diagnostic criteria are prescribed in the Diagnostic and Statistical Manual of Mental Disorder (DSM), fourth edition, published by the American Psychiatric Association:

- Bipolar disorder;
- Major depressive disorders;
- Obsessive-compulsive disorder;
- Panic disorder;
- Schizoaffective disorder; and
- Schizophrenia.

❖ "**Short-Term**" means the time required for treatment of a condition that, in the judgment of the Member's PCP and HPN, is subject to significant improvement within sixty (60) consecutive calendar days from the first day of treatment.

❖ **"Short-Term Habilitation Services"** means occupational therapy, physical therapy and speech therapy prescribed by the Member's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Member prior to that Member developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

❖ "**Short-Term Rehabilitation**" means Inpatient or outpatient rehabilitation services which are provided within the applicable number of visits as set forth in the Plan's Attachment A Benefit Schedule. This includes speech therapy, occupational therapy and physical therapy.

❖ "**Skilled Nursing Care**" means services requiring the skill, training or supervision of licensed nursing personnel.

❖ "**Skilled Nursing Facility**" means a facility or distinct part of a facility that is licensed by the state where it is located to provide Skilled Nursing Care instead of Hospitalization and that has an attending medical staff consisting of one or more Physicians.

❖ **"Small Employer"** or small group means as ascribed in 42 U.S.C. § 18024(b)(2).

❖ "**Special Enrollee**" means an Eligible Employee or Eligible Family Member who applies for coverage during a Special Enrollment Period following a Special Enrollment Event.

❖ "**Special Enrollment Event**" means the occurrence of one of the events described below which allows an Eligible Employee and/or Eligible Family Member to enroll under this Plan during a Special Enrollment Period, as follows:

Special Enrollment Event Upon Loss of Coverage Under Another Health Benefit Plan. In the event of a loss of coverage under a Health Benefit Plan that is not COBRA continuation coverage, except where the loss of coverage is due to failure of the Eligible Employee or Eligible Family Member to pay premiums on a timely basis or termination of employment for cause. Loss of coverage under a Health Benefit Plan can be the result of:

- Legal separation, divorce, cessation of Dependent status, death, termination of employment (not for cause) or a reduction in hours of employment;
- Meeting or exceeding a lifetime Health Benefit Plan limit on all benefits under such coverage;
- Termination of employer contributions for the Eligible Employee or Eligible Family Member's coverage;
- Exhaustion of COBRA continuation coverage.

Note: Voluntary cancellation of healthcare coverage is not considered a Special Enrollment Event.

❖ "**Special Enrollment Period**" means the thirty-one (31)-day period following a Special Enrollment Event during which an Eligible Employee and/or any Eligible Family Members can enroll under this Plan.

❖ "**Specialist Physician**" or "**Specialist**" means a Plan Provider who has an independent contractor agreement with HPN to assume responsibility for the delivery of specialty medical services to Members. These specialty medical services include any Physician services not related to the ongoing primary care of a patient. A Specialist Physician's agreement with HPN may terminate. In the event that a Member's Specialist Physician's agreement terminates, another Specialist Physician will be selected for the Member if those services are still required.

❖ **"Specialty Drugs"** are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by HPN's P&T Committee that are either self-administered or administered by a healthcare Provider and used or obtained in either an outpatient or home setting.

❖ **"Step Therapy"** is a program for Members who take Prescription Drugs for an ongoing medical condition, such as arthritis, asthma or high blood pressure, which ensures the Member receives the most appropriate and cost-effective drug therapy for their condition. The Step Therapy program requires that before benefits are payable for a high cost Covered Drug that may have initially been prescribed, the Member try a lower cost first-step Covered Drug. If the prescribing Physician has documented with HPN why the Member's condition cannot be stabilized with the first-step Covered Drug, HPN will review a request for Prior Authorization to move the Member to a second-step drug, and so on, until it is determined by HPN that the prescribed Covered Drug is Medically Necessary and eligible for benefit payment.

❖ "**Subrogation**" means HPN's right to bring a lawsuit in the Member's name against any party whom the Member could have sued for reimbursement of covered medical expenses.

❖ "**Subscriber**" means an employee of the Group who meets the eligibility requirements of this EOC and who has enrolled under this Plan, and for whom premiums have been received and accepted by HPN.

❖ **"Substance-Related and Addictive Disorder"** as defined in the Diagnostic and Statistical Manual of Mental Disorder (DSM), fifth edition, is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. Substance-Related and Addictive Disorder treatment:

- Must be provided as a part of a treatment plan with clearly defined goals that are realistic and measurable. The plan must address significant impairment or deterioration in the Member's occupational or scholastic function, social function, or ability to provide self-care.
- Must be provided by state licensed professionals who are practicing within the scope of this licensure.

❖ **"Summary of Benefits" ("SBC")** means a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. The SBC helps consumers better understand the coverage they have and allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions and coverage limitations and exceptions. Members will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year and within seven business days of requesting a copy from their insurance issuer or group health plan.

❖ **"Telemedicine"** means the delivery of Covered Services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including facsimile or electronic mail. The term includes, without limitation, the delivery of services from a provider of health care to a patient at a different location through the use of:

- Synchronous interaction or an asynchronous system of storing and forwarding information; and
- Audio-only interaction, whether synchronous or asynchronous.

❖ **"Therapeutic Equivalent"** means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.

❖ "**Therapeutic Supply**" means the maximum quantity of supplies for which benefits are available for a single applicable Copayment or Coinsurance amount, if applicable, and may be less than but shall not exceed a thirty (30)-day supply.

❖ "**Totally Disabled**" means:

- The continuing inability of a Subscriber to substantially perform duties related to his employment or to work for pay, profit or gain at any job for which he is suited by reason of education, training or experience because of Illness or Injury; or
- The inability of a Dependent to engage in his regular and usual activities.

❖ **"Transitional Living"** means Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide twenty-four (24) hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria*, and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help with recovery.

❖ "**Transplant Benefit Period**" means the period beginning with the date the Member receives a written Referral from HPN for care in a Transplant Facility and ending on the first of the following to occur:
a. The date 365 days after the date of the transplant; or
b. The date when the Member is no longer covered under this Plan.

❖ "**Transplant Facility**" means a Hospital that has an independent contractor agreement or other contractual relationship with HPN to provide Covered Services to Eligible Members in connection with organ or tissue transplants related to a Covered Transplant Procedure as defined in this EOC. Non-Plan Hospitals do not have any contractual relationship with HPN to provide such services.

❖ **"Unproven"** in the context of **"**Experimental, Investigational or Unproven", means services, including medications and devices, regardless *of U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

HPN has a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, HPN will issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. The Member can view these policies at https://healthplanofnevada.com/Provider/Medical-Policies

NOTE: If a Member has a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment) HPN may, as we determine, consider an otherwise unproven service to be a covered healthcare service for that illness or condition. Prior to such a consideration, HPN must first establish that there is sufficient evidence to conclude that, even though Unproven, the service has significant potential as an effective treatment for that illness or condition.

❖ "**Urgent Care Claim**" means a Claim for Benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not Urgent Care Claims could seriously jeopardize the Member's life, health or the ability to regain maximum function by waiting for a routine appeal decision. An Urgent Care Claim also means a Claim for Benefits that, in the opinion of a physician with knowledge of the Member's medical conditions, would subject the Member to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for Prior Authorization of an Urgent Care service was denied, the Member could request an Expedited Appeal for the Urgent Care Claim.

❖ "**Urgent Care Facility**" means a facility equipped and operated mainly to give immediate treatment for an acute Illness or Injury.

❖ "**Urgently Needed Services**" means Covered Services needed to prevent a serious deterioration in a Member's health. While not as immediate as Emergency Services, these services cannot be delayed until the Member can see a Plan Provider.

❖ "**Waiting Period**" means the period of time established by the Group that must pass before coverage for an Eligible Employee or Eligible Family Member can become effective. If an Eligible Employee or Eligible Family Member enrolls as a Special Enrollee, any period before such Special Enrollment is not a Waiting Period.

RE: Notice of Transition of Care

Dear Customer/Client,

As required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260),* group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or heath care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits.

This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy, or would like help to find out if you are eligible for transition of care benefits, please call Member Services at the number on the back of your health plan ID card.

The Transition of Care form is available on your health plan's website under Health Plan Forms. If you need assistance filling out the form, please ask your provider's office.

Sincerely,
The Health Plan of Nevada and Sierra Health and Life Team

Health Plan of Nevada
A UnitedHealthcare Company

Attachment B

SERVICE AREA DESCRIPTION

To enroll in Health Plan of Nevada, you must work or reside in the Nevada Service Area:

Clark County (all zip codes)

Esmeralda County (all zip codes)

Lyon County (all zip codes)

Mineral County (all zip codes)

Nye County (all zip codes)

Washoe County (all zip codes)

Basic and Supplemental Health Services for Health Plan of Nevada, Inc.'s Service Area commenced in August 1982

Health Plan of Nevada
A UnitedHealthcare Company

HPN Solutions HMO 25 Direct Access - State of Nevada V2

Attachment A Benefit Schedule

Amounts which the Member is required to pay as shown below in the Benefit Schedule are based on Eligible Medical Expenses (EME) or the Recognized Amount, if applicable, as defined in the Evidence of Coverage.

The **Calendar Year Out of Pocket Maximum** is $5,000 per Member and $10,000 per family.

The Out Of Pocket Maximum does not include: 1) amounts charged for non-Covered Services, 2) amounts exceeding applicable Plan benefit maximums or EME payments; or, 3) penalties for not obtaining any required Prior Authorization or for the Member otherwise not complying with HPN's Managed Care Program.

Please note: For all Inpatient and Outpatient admissions, including those for Emergency or Urgent Care, in addition to specified surgical Copayment/Cost-share amounts, the Member is also responsible for all other applicable facility and professional Copayments/Cost-share as outlined in this Attachment A Benefit Schedule to the Evidence of Coverage (EOC).

The Member is responsible for any/all amounts exceeding any stated maximum benefit amounts and/or any/all amounts exceeding the Plan's payment to Non-Plan Providers under this Plan. Further, such amounts do not accumulate to the calculation of the Calendar Year Out of Pocket Maximum.

IMPORTANT NOTE: This plan does not provide any services received from a Non-Plan Provider except for Emergency Services or Medically Necessary services that are not available through a Plan Provider.

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Medical Office Visits/Consultations and Visits in an Outpatient Setting (including Telemedicine Services)		
Primary Care Services		
• Convenient Care Facility	No	Member pays $15 per visit.
• Physician Extender or Assistant	No	Member pays $15 per visit.
• Physician	No	Member pays $25 per visit.
Specialist Services		
• With Referral	Yes	Member pays $25 per visit.
• Without Referral	No	Member pays $40 per visit.
Preventive Healthcare Services - For a complete list of Preventive Services, including all FDA approved contraceptives, go to http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/. If you have a question about whether or not a service is "Preventive", please contact the HPN Member Services Department (1-800-777-1840).	No	Member pays $0 per visit.
Diagnostic Breast Cancer Imaging	Yes	Member pays $0 per visit.

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Non-preventive Routine Lab and X-ray Services The Copayment/Cost-share is in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office or at an independent facility.	Yes	
• Lab		Member pays $0 per visit.
• X-Ray		Member pays $0 per visit.
Virtual Visits (Available through NowClinic or select contracted Providers)	No	Member pays $0 per visit.
Urgent Care Facility	No	Member pays $50 per visit.
Emergency Services		
• Emergency Room Facility (includes Physician Services)	No	Member pays $600 per visit; waived if admitted through a Hospital Emergency Room Facility.
• Hospital Admission - Emergency Stabilization (includes Physician Services) Applies until patient is stabilized and safe for transfer as determined by the attending Physician.	No	Member pays $600 per admission.
Ambulance Services		
• Emergency Transport	No	Member pays $0 per trip.
• Non-Emergency - HPN Arranged Transfers	Yes	Member pays $0.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)	Yes	Member pays $600 per admission.
• Physician Fees and Medical Services	Yes	Member pays $600 per admission.
Outpatient Hospital Facility Services	Yes	Member pays $350 per surgery.
Ambulatory Surgical Facility Services	Yes	Member pays $50 per surgery.
Anesthesia Services	Yes	Member pays $0 per surgery.
Physician Surgical Services - Inpatient and Outpatient		
• Inpatient Hospital Facility	Yes	Member pays $0 per surgery.
• Outpatient Hospital Facility	Yes	Member pays $0 per surgery.
• Ambulatory Surgical Facility	Yes	Member pays $0 per surgery.
• Physician's Office		
Primary Care Physician (Includes all physician services related to the surgical procedure)	No	Member pays $0 per visit.
Specialist (Includes all physician services related to the surgical procedure)		
• With Referral	Yes	Member pays $25 per visit.
• Without Referral	No	Member pays $45 per visit.

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Gastric Restrictive Surgery Services HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.		
• Physician Surgical Services	Yes	Member pays 50% of EME. Subject to maximum benefit.
• Physician's Office Visit	Yes	Member pays $25 per visit.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	Member pays $600 per admission.
• Physician Surgical Services - Inpatient Hospital Facility	Yes	Member pays $0 per surgery.
• Transportation, Lodging and Meals The maximum benefit per Member per Transplant Benefit Period for transportation, lodging and meals is $10,000. The maximum daily limit for lodging and meals is $200.	Yes	Member pays $0 per surgery. Subject to maximum benefit.
Post-Cataract Surgical Services		
• Frames and Lenses	Yes	Member pays $10 per pair of glasses. Subject to maximum benefit.
• Contact Lenses Benefit is limited to one (1) pair of Medically Necessary glasses or set of contact lenses as applicable per Member per surgery.	Yes	Member pays $10 per set of contact lenses. Subject to maximum benefit.
Home Healthcare Services (does not include Specialty Prescription Drugs)	Yes	Member pays $0 per visit.

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Hospice Care Services		
• Inpatient Hospice Facility	Yes	Member pays $600 per admission.
• Outpatient Hospice Services	Yes	Member pays $0 per visit.
• Inpatient and Outpatient Respite Services Benefits are limited to a combined maximum benefit of five (5) Inpatient days or five (5) Outpatient visits per Member per ninety (90) days of Home Hospice Care.	Yes	
◦ Inpatient		Member pays $600 per admission. Subject to maximum benefit.
◦ Outpatient		Member pays $25 per visit. Subject to maximum benefit.
• Bereavement Services Benefits are limited to a maximum benefit of five (5) group therapy sessions. Treatment must be completed within six (6) months of the date of death of the Hospice patient.	Yes	Member pays $25 per visit. Subject to maximum benefit.
Skilled Nursing Facility Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.	Yes	Member pays $600 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.
Residential Treatment Center	Yes	Member pays $600 per admission; waived if admitted from an acute care facility.
Manual Manipulation Applies to Medical-Physician Services and Chiropractic office visit. Subject to a maximum benefit of twenty (20) visits per Member per Calendar Year.		
• With Referral	Yes	Member pays $25 per visit. Subject to maximum benefit.
• Without Referral	No	Member pays $45 per visit. Subject to maximum benefit.

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Short-Term Habilitation Services (including but not limited to Physical, Speech and Occupational Therapy)		
• Inpatient Hospital Facility	Yes	Member pays $600 per admission. Subject to maximum benefit.
• Outpatient	Yes	Member pays $25 per visit. Subject to maximum benefit.
All Inpatient and Outpatient Short-Term Habilitation Services are subject to a combined maximum benefit of one hundred twenty (120)days/visits per Member per Calendar Year.		
Short-Term Rehabilitation Services (including but not limited to Physical, Speech and Occupational Therapy)		
• Inpatient Hospital Facility	Yes	Member pays $600 per admission. Subject to maximum benefit.
• Outpatient	Yes	Member pays $25 per visit. Subject to maximum benefit.
All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a combined maximum benefit of one hundred twenty (120)days/visits per Member per Calendar Year.		
Durable Medical Equipment Monthly rental or purchase at HPN's option. Purchases are limited to a single purchase of a type of DME, including repair and replacement, once every three (3) years.	Yes	Member pays $0. Subject to maximum benefit.
Genetic Disease Testing Services		
• Office Visit		
◦ With Referral	Yes	Member pays $25 per visit.
◦ Without Referral	No	Member pays $45 per visit.
• Lab Includes Inpatient, Outpatient and independent Laboratory Services.	Yes	Member pays 25% of EME.
Infertility Office Visit Evaluation Please refer to applicable surgical procedure Copayment/Cost-share and/or Coinsurance amount herein for any surgical infertility procedures performed.		
◦ With Referral	Yes	Member pays $25 per visit.
◦ Without Referral	No	Member pays $45 per visit.

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Medical Supplies (Obtained outside of a medical office visit)	Yes	Member pays $0.
Other Diagnostic and Therapeutic Services The Copayment/Cost-share amounts are in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office or at an independent facility.		
• Anti-cancer drug therapy, non-cancer related drug therapy or other Medically Necessary therapeutic drug services.	Yes	Member pays $25 per day.
• Dialysis	Yes	Member pays $25 per day.
• Therapeutic Radiology	Yes	Member pays $25 per day.
• Complex Allergy Diagnostic Services (including RAST) and Serum Injections	Yes	Member pays $25 per visit.
• Otologic Evaluations	Yes	Member pays $25 per visit.
• Other complex diagnostic imaging services including: CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; and complex neurological or psychiatric testing or therapeutic services.	Yes	Member pays $100 per test or procedure.
• Positron Emission Tomography (PET) scans	Yes	Member pays $100 per test or procedure.
Prosthetic Devices Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.	Yes	Member pays $750 per device. Subject to maximum benefit.
Orthotic Devices Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.	Yes	Member pays $50 per device. Subject to maximum benefit.

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Self-Management and Treatment of Diabetes		
• Education and Training	No	Member pays $25 per visit.
• Supplies (except for Insulin Pump Supplies)	No	Member pays $5 per therapeutic supply.
Insulin Pump Supplies	Yes	Member pays $10 per therapeutic supply.
• Equipment (except for Insulin Pump)	Yes	Member pays $20 per device.
Insulin Pump	Yes	Member pays $100 per device.
Special Food Products and Enteral Formulas	Yes	Member pays $0.
Temporomandibular Joint Treatment	Yes	Member pays 50% of EME.
Mental Health and Severe Mental Illness Services		
• Inpatient Hospital Facility	Yes	Member pays $600 per admission.
• Outpatient Office-based Individual and Group Therapy, and Medical Management Treatment (including Telemedicine Services)	No	Member pays $25 per visit.
• All other Outpatient Treatment (including Telemedicine Services)	Yes	Member pays $25 per visit.
Substance-Related and Addictive Disorder Services		
• Inpatient Hospital Facility	Yes	Member pays $600 per admission.
• Outpatient Office-based Individual and Group Therapy, and Medical Management Treatment (including Telemedicine Services)	No	Member pays $25 per visit.
• All other Outpatient Treatment (including Telemedicine Services)	Yes	Member pays $25 per visit.
Hearing Aids Purchases are limited to a single purchase of a type of Hearing Aid per hearing impaired ear, including repair and replacement, once every three (3) years.	Yes	Member pays $0. Subject to maximum benefit.
Applied Behavioral Analysis (ABA) for the treatment of Autism Limited to one thousand five hundred (1,500) total hours of therapy per Member per Calendar Year.	Yes	Member pays $25 per visit. Subject to maximum benefit.

The Member's Tier I Copayment/Cost-share will not be more than 50% of the allowed cost of providing any single service or supplying an item to a Member, after the deductible, if applicable, has been met. A Member may not contribute any more than the individual CYD amount toward the family CYD amount. A Member may not contribute any more than the individual Calendar Year Out of Pocket Maximum toward the family Calendar Year Out of Pocket Maximum amount.

[(1)]Referral or Prior Auth. Required – Except as otherwise noted and, with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness and Substance-Related and Addictive Disorder Services, all Covered Services not provided by the Member's Primary Care Physician require a Referral or a Prior Authorization in the form of a written referral authorization from HPN. Please refer to your HPN Evidence of Coverage for additional information.

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

P.O. Box 15645, Las Vegas, NV 89114-5645

Domestic Partner Rider

This Domestic Partner Rider when attached to the Health Plan of Nevada ("HPN") Evidence of Coverage ("EOC") amends the document to include Dependent coverage for a Subscriber's Domestic Partner. The enrollment of a Subscriber's Domestic Partner is subject to the eligibility and enrollment requirements contained herein. Dependent coverage for a Subscriber's Domestic Partner is subject to the conditions, limitations and exclusions contained in the EOC, the Attachment A Benefit Schedule and any applicable Endorsements or Riders.

To be eligible to enroll as a Subscriber's Domestic Partner under this Rider, a person must on the date of enrollment meet the following criteria:

a. provide proof of cohabitation; and

b. have attained the age of consent in his state of residence; and

c. not be related by blood in any manner that would bar marriage in the state of the Domestic Partnership; and

d. have a committed and personal relationship and be considered part of the Subscriber's family, and

e. not currently be a party to a valid marriage or a Domestic Partnership with anyone other than the Subscriber; and

f. have registered as the Subscriber's Domestic Partner using the Declaration of Domestic Partnership form from the Nevada Secretary of State's office as proof of the Domestic Partner relationship or using the equivalent form of registration documentation from the state in which the Domestic Partnership is registered.

The Plan will require a notarized copy of the required registration documentation as proof of the Domestic Partner relationship.

A Domestic Partner's dependent children are eligible for coverage when meeting the Eligible Dependent criteria as set forth in the EOC and any applicable Endorsements.

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Real Appeal Rider

This Rider is a supplement to your Health Plan of Nevada, Inc. ("HPN") Evidence of Coverage ("EOC") and Attachment A Benefit Schedule and amends your coverage to include benefits for virtual obesity counseling services for eligible Members through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services. Unless otherwise specifically stated, these provisions are effective on the first day of the new or renewing Plan Year or the Effective Date of Coverage.

Real Appeal
Benefits are provided for Real Appeal, which provides a virtual lifestyle intervention for weight-related conditions to eligible Members. The goal is to help those at risk from obesity-related diseases. Real Appeal is designed to support Members thirteen (13) years of age or older.

This intensive multi-component behavioral intervention provides fifty-two (52) weeks of support. This support includes one-on-one coaching and online group participation, with supporting video content delivered by a live virtual coach. The experience will be personalized for each individual through an introductory online session.

These covered health care services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools –
    - Personal one-on-one coaching;
    - Group support sessions;
    - Educational videos;
    - Tailored informational kits;
    - Integrated web platform; and
    - Mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like additional information regarding these covered health care services, you may contact us through www.realappeal.com, https://member.realappeal.com or Member Services at the number shown on your ID card.

Health Plan of Nevada
A UnitedHealthcare Company

State of Nevada
4-Tier Outpatient Prescription Drug Rider to the HPN Group Evidence of Coverage

THIS PRESCRIPTION DRUG BENEFIT RIDER CONTAINS A CALENDAR YEAR DEDUCTIBLE ("CYD")	
The Prescription Drug Calendar Year Deductible (CYD) applies to Tier IV	
$100 Prescription Drug Calendar Year Deductible per Member not to exceed $200 for all Members in a Family.	
Plan Retail Prescription Drug Benefits	
Prescription Drug Tier	**Tier I HMO Plan Benefit**
Tier I	Member pays $10 Copayment per Designated Plan Pharmacy Therapeutic Supply.
Tier II	Member pays $40 Copayment per Designated Plan Pharmacy Therapeutic Supply.
Tier III	Member pays $75 Copayment per Designated Plan Pharmacy Therapeutic Supply.
Tier IV (Specialty Drugs)	After CYD, Member pays 20% of EME per Designated Plan Pharmacy Therapeutic Supply.
Prescription Drug Products from a Mail Order Network Pharmacy or 90 Day Retail Plan Network Pharmacy Member pays up to 2.5 times the applicable Tier Cost-share per Pharmacy Therapeutic Supply.	
Please refer to the HPN Prescription Drug List (PDL) for the listing of Covered Drugs and for any Covered Drugs requiring Prior Authorization and/or Step Therapy as outlined in the HPN EOC.	

This Prescription Drug Benefit Rider is issued in consideration of: (a) Group's election of coverage under this Rider, (b) your eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Prescription Drug Benefit Rider is a supplement to your Evidence of Coverage (EOC) and Attachment A Benefit Schedule issued by Health Plan of Nevada, Inc., and amends your coverage to include benefits for Covered Drugs. This coverage is subject to the applicable terms, conditions, limitations and exclusions contained in your HPN EOC and herein.

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.

Health Plan of Nevada
A UnitedHealthcare Company

Vision Care Services Rider to the HPN Evidence of Coverage

Option 6: 12/12/24/10-10-100

The Vision Care Services Rider is issued in consideration of: (a) the Groups's election of coverage under this Rider, (b) the Member's eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Rider is a supplement to the Health Plan of Nevada ("HPN") Evidence of Coverage ("EOC") and Attachment A Benefit Schedule and amends your coverage to include benefits for Vision Care Services.

SECTION 1. Vision Care Services

Subject to definitions, terms and conditions in the EOC, a Member is entitled to receive the vision care services set forth in this Rider. The Member shall be entitled to vision care services only if a Plan Provider prescribes Lenses and Frames and the prescription was ordered while the Member was enrolled in HPN.

Covered Services and Limitations	Copayment
Vision Examination One (1) vision examination by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be provided each twelve (12) consecutive calendar month period.	$10 copay for each examination by a Plan Provider. Subject to limitation.
Lenses (Plastic) One (1) pair of Lenses will be provided during any \twelve (12) consecutive calendar month period, when a prescription change is determined Medically Necessary by a Plan Provider. Lenses are limited to single vision, bifocal, trifocal, lenticular and other complex Lenses.	$10 copay for one pair of Lenses (Plastic). Subject to limitation.
Frames Expenses incurred in connection with Frames, from an approved frame selection will be considered covered vision expenses once during each twenty-four (24) consecutive calendar month period. Charges for Frames in excess of the maximum allowance shall be the responsibility of the Subscriber. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.	$100 maximum allowance for Frames. Subject to limitation.
Contact Lenses Expenses incurred in connection with the purchase of one (1) pair of Contact Lenses prescribed by a Plan Provider may be considered covered vision expense on the condition that the Subscriber elects to receive an allowance for the purchase of such Contact Lenses in lieu of all other vision benefit once during any twelve (12) consecutive month period (with the exception of the annual vision examination which shall continue to be available). Charges for Contact Lenses in excess of the Maximum allowance shall be the responsibility of the Subscriber. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.	$250 maximum allowance for medically necessary Contact Lenses. Subject to limitation. $115 maximum allowance for conventional or disposable Contact Lenses. Subject to limitation.

Vision Care Service Rider

SECTION 2. Exclusions

This section tells you what services and supplies are not covered under the Evidence of Coverage. The following services and resulting complications are excluded from coverage hereunder.

2.1 Any services and supplies not provided for in the EOC, not Medically Necessary as defined by the EOC or not required in accordance with the accepted standards of vision practice of the community.

2.2 Services provided by non-participating vision care providers.

2.3 Charges for services by a vision Plan Provider to his or her Dependents.

2.4 Charges for care or services and supplies provided before the Effective Date or after the termination date of the Evidence of Coverage.

2.5 Services or materials that are experimental, investigational or unproven.

2.6 Services or materials provided under Workers' Compensation or Employer's Liability laws.

2.7 Services provided or paid for by governmental agency or under any governmental program or law**,** except charges which the member is legally obligated to pay.

2.8 Services performed for cosmetic purposes or to correct congenital malformations.

2.9 Services and materials resulting from failure to comply with professionally prescribed treatment.

2.10 Services or materials provided as a result of a self-inflicted injury or illness.

2.11 Two pairs of eyeglasses in lieu of bifocals.

2.12 Visual therapy.

2.13 Replacement of lost or stolen eyewear.

SECTION 3. Limitations

3.1 The following options are excluded from coverage hereunder; however, if the Member wishes to pay the full cost of any option, it will be made available by the Plan Provider. The Plan Provider will maintain a schedule listing the full cost of these options:

- Oversize Lenses;
- Cost of Frames in excess of Frames allowance;
- Tinted of photochromic Lenses;
- Coated Lenses;
- Cosmetic Contact Lenses
- No-line bifocal Lenses;
- Plastic multi-focal Lenses;
- Two pairs of Lenses and Frames in lieu of bifocal Lenses and Frames; or
- All prescription sunglasses.

SECTION 4. General Provisions

4.1 This Rider shall be effective on the effective date of the EOC.

4.2 This Rider shall terminate upon termination of the EOC and under the same terms and conditions specified in the EOC. Upon such termination, Member shall cease to be entitled to any benefits provided in this Rider.

4.3 Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions agreements or limitations of the EOC, other than as set forth in this Rider.

SECTION 5. Glossary

This section tells you meanings of some of the more important words in the Evidence of Coverage. Please read it carefully. It will help you to understand the rest of the Evidence of Coverage.

- **"Blended Lenses"** means bifocals which do not have a visible dividing line.
- **"Calendar Year"** means January 1 through December 31 of the same year.
- **"Coated Lenses"** means a substance which is added to a finished lens on one or both surfaces.
- "**Contact Lenses"** means ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Plan Provider to be fitted directly to the patient's eyes.
- **"Course of Treatment"** means an interdependent series of Medically Necessary Covered Services prescribed by a Vision Provider to correct a specific optical condition.
- **"Eligible Vision Expenses" (EVE)** means the maximum allowable amount the Company will pay for a particular Covered Service as determined by the Company in accordance with the HPN Reimbursement Schedule. Vision Plan Providers have agreed to accept the HPN Reimbursement Schedule as payment in full for Covered Services, less any applicable Copayment. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.
- **"Frames"** mean standard eyeglass Frames adequate to hold two Lenses.
- **"Injury"** means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.
- **"Lenses"** mean ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Vision Plan Provider to be fitted into frames.
- **"Medically Necessary"** means any vision care services or supplies required to preserve the Member's visual health and which, as determined by the Company's Managed Care Program and or Medical Director, are:
  - Consistent with the symptoms or diagnosis and treatment of the Member's vision deficiency;
  - Appropriate with regard to standards of good vision practice; and
  - Not solely for the convenience of the Member or Provider; and
  - The most appropriate supply or level of service which can be provided to the Member.

  Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by a Provider. The Company may consult with professional consultants, or other appropriate sources for recommendations regarding the services or supplies the Member receives are Medically Necessary.
- **"Non-Plan Vision Provider"** means a Vision Provider who does not have an independent contractor agreement with HPN.
- "**Occupational Illness or Injury**" means any Illness or Injury arising out of or in the course of employment for pay or profit.
- **"Orthoptics"** means the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Vision Care Service Rider

- **"Oversize Lenses"** means larger than standard lens blank, to accommodate prescriptions.
- **"Photochromic Lenses"** means lenses which change color with intensity of sunlight.
- **"Plano Lenses"** means lenses which have no refractive power.
- "**Prior Authorization**" or "**Prior Authorized**" means a system that requires a Provider to get approval from HPN before providing non-emergency healthcare services to a Member for those services to be considered Covered Services. Prior Authorization is not an agreement to pay for a service.
- **"Professional Service"** means examination, material selection, fitting of glasses, related adjustments, etc.
- **"Tinted Lenses"** means lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc.).
- **"Vision Plan Provider**" means a Provider who has an independent contractor agreement with HPN to provide certain Covered Services to Members. A Vision Plan Provider's agreement with HPN may terminate, and a Member will be required to select another Vision Plan Provider.

Advance Directives

DURABLE POWER OF ATTORNEY

DECLARATION OF LIVING WILL

NOTE: This document is not intended as a substitute for legal advice. You should seek qualified legal guidance to assist you in completing and executing an Advance Directive in accordance with the law.

Introduction

There may come a time when you will be seriously injured or become gravely ill and unable to make healthcare decisions for yourself. You may wish to choose in advance what kinds of treatments are administered and whether or not life support systems should be maintained or withdrawn.

Most states allow a competent adult to execute a document which allows him or her to accept or refuse treatment in the event that he or she has a terminal condition and is not able to make decisions for himself or herself. Many states do not specify the particular form that a directive must follow to be effective, but you should check the laws in your own state to be sure. However, we have included information for you on where you can get forms which may be available.

Glossary

Advance Directive - an instruction, such as a Declaration/Living Will or Durable Power of Attorney for Healthcare Decisions, to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

Attorney In Fact - a person authorized by another to act in his place either for some particular purpose, as to do a particular act, or for the transaction of business in general which is not of a legal nature.

Life-sustaining Treatment - a medical procedure or intervention that uses mechanical or other artificial means to sustain, restore or supplant a vital function. It only artificially postpones the moment of death of a patient in a Terminal Condition whose death is imminent or will result within a relatively short time without the application of the procedure. The term does not include the administration of medication or the performance of a medical procedure considered to be necessary to provide comfort or care, or to alleviate pain.

Terminal Condition - an incurable and irreversible condition caused by injury, disease or illness that would result in death without the application of life-sustaining procedures, according to reasonable medical judgement. The application of life-sustaining procedures serves only to postpone the moment of the patient's death.

Types of Advance Directives

A ***Declaration/Living Will*** is one type of Advance Directive. A Declaration/Living Will directs your attending physician to withdraw treatment that only prolongs a Terminal Condition. To be valid under law, a Declaration/Living Will must be signed by you as the declarant and must also be signed by two witnesses who 1) are not related to you by blood or marriage, 2) are not mentioned in your will and 3) would have no claim on your estate.

In addition the Declaration/Living Will may not be witnesses by your physician or by anyone working for your physician. If you are in a healthcare facility at the time you sign the Declaration/Living Will, you may not use as a witness any other patient, or employee of the facility if they are involved in providing direct patient care to you or are directly involved in the financial affairs of the facility. The signatures of the witnesses do not have to be notarized to make the Declaration/Living Will a valid legal document.

A ***Durable Power of Attorney for Healthcare Decisions*** may also be executed. This document allows you to appoint someone to make a variety of healthcare decisions for you should you become unable to do so. Requirements under the law are very specific for properly executing this document, and you should seek qualified legal guidance to assist you in completing and executing an Advance directive in accordance with the law.

Advance Directives as Part of your Permanent Medical Record

Once you have executed an Advance Directive of any kind, please notify your physician and provide a copy of it to him or her so that it may be made a part of your permanent medical record.

Upon learning of the existence of an Advance Directive, a physician must make reference to the fact that you have an Advance Directive in your permanent medical record.

Frequently Asked Questions

How long is an Advance Directive valid?

Generally, any Advance Directive is effective until it is revoked. You may want to consider initialing and dating your Advance Directive periodically to show that it still expresses your wishes. You may revoke your Advance Directive at any time and in any manner, without regard to your mental or physical condition. A revocation is effective when your attending physician or other healthcare provider receives notice of the revocation from you or from a witness to the revocation. Pursuant to the law, to the extent that a Durable Power of Attorney for Healthcare or Declaration/Living Will conflicts with a directive or treatment decision executed under the law, the instrument executed later in time controls.

What will happen if I become terminally ill and I am unable to make healthcare decisions by myself, yet I haven't executed an Advance Directive?

In preparation for this possibility, you should, at the very least, make your wishes known to those you love. Laws in your state may give a "surrogate decision maker" the authority to consent to the withholding or withdrawal of life-sustaining treatment for you. (This consent must be in writing and attested by two witnesses.)

A "surrogate decision maker" is, in order of authority;

- your spouse;
- your adult child or, if you have more than one child, a majority of the adult children who are reasonably available to consult;
- your parents;
- your adult sibling or, if you have more than one adult sibling, a majority of the adult siblings who are reasonably available to consult;
- or your nearest other adult relative by blood or adoption who is reasonably available to consult.

If a class of "surrogate decision makers" entitled to consent is not reasonably available to consult and competent to decide, or declines to decide, the next class is authorized to make the decision. An equal division in a class does not authorize the next class to decide.

What if my doctor objects to the withholding or withdrawal of life-sustaining treatment?

Healthcare providers have varying beliefs regarding the implementation of an individual's Advance Directive. An attending physician or other provider of healthcare who is unwilling to honor your Advance Directive must take all reasonable steps as promptly as possible to transfer your care to another physician or healthcare provider.

How will my execution of an Advance Directive affect my health and life insurance policies?

The making of an Advance Directive does not affect the sale, purchase or issuance of a life insurance or annuity policy, nor does it affect the terms of an existing policy. It also cannot be prohibited or required as a condition of being insured for, or receiving, healthcare.

What are our policies on the administration of life-sustaining treatment?

As a company we are committed to the preservation of life and the alleviation of suffering. If, however, you wish to have life-sustaining treatment withheld or withdrawn in the event you become terminally ill, we will make every effort to see that your wishes are honored. If you have already executed an Advance Directive, please give a copy to your doctor(s) to be placed in your medical record.

Where can I obtain a Declaration/Living Will or Durable Power of Attorney for Healthcare Decisions form?

Forms are available from a variety of sources, including some physicians, attorneys, and healthcare facilities.

Once you have completed an Advance Directive, discuss your decisions with your family, next of kin, or other responsible parties, and give your attorney and each one of your doctors a copy to be placed in all of your medical records. It is also advisable to keep a copy with you at all times.

Conclusion

It is difficult for people to make good decisions when they are under pressure or emotional strain, particularly in areas where there are no clear-cut answers about life-sustaining treatment. These issues require a great deal of discussion and careful thought. The information provided here
has been presented in the hope that you will discuss it with your doctor and others and come to a decision that is right for you or someone you love.