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.

PLAN BENEFIT INFORMATION

STATE PERSONNEL DIVISION - LAS VEGAS
10000330 A001
07012015

PROCESSED ON 06/03/2015 13:17 EDT
State of Nevada HPN Participants now have expanded statewide provider access through a special, limited network reciprocity arrangement between PEBP’s two HMO plans – HPN and Hometown Health (HTH). You can now access the HTH providers for urgently needed or emergent services while traveling in northern Nevada. Students away at school for a longer duration in northern Nevada may access HTH providers for certain routine, urgent and emergent services. This access is available subject to your applicable plan co-payments without balance billing from the HTH providers.

This expanded provider access will apply to “medically necessary” covered services which are determined according to the specific HMO plan provisions as outlined in the HPN Evidence of Coverage document. Please note that all applicable prior authorization requirements and referral guidelines will still apply as described in your HPN HMO plan documents.

Please remember that you still need to choose an HPN PCP as described in the HPN Provider Directory. If specialty care is needed, your PCP must refer you to a designated HPN specialist. **Failure to follow the requirements of this referral process will result in higher out-of-pocket costs to you. Visits to a specialist without the required referral will be denied by HPN, and you will be responsible for the costs.**

For the most up to date provider information, you can visit the on-line HMO provider directory website links at [www.pebp.state.nv.us](http://www.pebp.state.nv.us) or click the link button above.

If you have any questions regarding the statewide provider access arrangement, please contact the HPN Member Services Department at (702) 242-7300 or (800) 777-1840.
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.
MEDICAL INFORMATION PRIVACY NOTICE

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.

Effective January 1, 2015

We 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, we will post the revised notice on your health plan website, such as www.myHPNonline.com or www.mySHLonline.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.
- 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. “Highly confidential information” may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

  1. HIV/AIDS;
  2. Mental health;
  3. Genetic tests;
  4. Alcohol and drug abuse;
  5. Sexually transmitted diseases and reproductive health information; and
  6. Child or adult abuse or neglect, including sexual assault.

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. Attached to this notice is a “Federal and State Amendments” document.

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 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. You also may also obtain a copy of this notice on your health plan website, such as www.myHPNonline.com or www.mySHLonline.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 your health plan ID card or you may contact a Health Plan of Nevada/Sierra Health and Life Customer Call Center Representative at 1-800-777-1840, Monday through Friday, 8 a.m. to 5 p.m.

- Submitting a Written Request. Mail to us 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, at the following address:

  Health Plan of Nevada/Sierra Health and Life Member Services – Privacy Unit
  PO 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.
FINANCIAL INFORMATION PRIVACY NOTICE

Effective January 1, 2015

We 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 health plan ID card or contact the Health Plan of Nevada/Sierra Health and Life Customer Call Center Representative at 1-800-777-1840, Monday through Friday, 8 a.m. to 5 p.m.

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2 For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; 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.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.
UNITEDHEALTH GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES:
FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2015

The first part of this Notice, which provides our privacy practices for Medical Information (pages 1-4), describes how we
may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights
to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The
purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the
applicable federal or state law.

Summary of Federal Laws

<table>
<thead>
<tr>
<th>Alcohol &amp; Drug Abuse Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Genetic Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are not allowed to use genetic information for underwriting purposes.</td>
</tr>
</tbody>
</table>

Summary of State Laws

<table>
<thead>
<tr>
<th>General Health Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose general health information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
</tr>
</tbody>
</table>

| CA, NE, PR, RI, VT, WA, WI |

| HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions. |
| KY |

| You may be able to restrict certain electronic disclosures of health information. |
| NC, NV |

| We are not allowed to use health information for certain purposes. |
| CA, IA |

| We will not use and/or disclose information regarding certain public assistance programs except for certain purposes |
| KY, MO, NJ, SD |

| We must comply with additional restrictions prior to using or disclosing your health information for certain purposes |
| KS |

<table>
<thead>
<tr>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
</tr>
</tbody>
</table>

| CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY |

<table>
<thead>
<tr>
<th>Communicable Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
</tr>
</tbody>
</table>

| AZ, IN, KS, MI, NV, OK |

<table>
<thead>
<tr>
<th>Sexually Transmitted Diseases and Reproductive Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
</tr>
</tbody>
</table>

| CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY |

<table>
<thead>
<tr>
<th>Alcohol and Drug Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
</tr>
</tbody>
</table>

| AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI |

| Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information. |
| WA |

<table>
<thead>
<tr>
<th>Genetic Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are not allowed to disclose genetic information without your written consent.</td>
</tr>
</tbody>
</table>

| CA, CO, IL, KS, KY, LA, NY, RI, |
### Summary of State Laws

<table>
<thead>
<tr>
<th>Section</th>
<th>States/Provinces</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genetic Information</strong></td>
<td>AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT</td>
</tr>
<tr>
<td>Restrictions apply to the use, and/or the retention of genetic information.</td>
<td>FL, GA, IA, LA, MD, NM, OH, UT, VA, VT</td>
</tr>
<tr>
<td><strong>HIV / AIDS</strong></td>
<td>AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY</td>
</tr>
<tr>
<td>We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
<td>AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY</td>
</tr>
<tr>
<td>Certain restrictions apply to oral disclosures of HIV/AIDS-related information.</td>
<td>CT, FL</td>
</tr>
<tr>
<td>We will collect certain HIV/AIDS-related information only with your written consent</td>
<td>OR</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI</td>
</tr>
<tr>
<td>We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
<td>CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI</td>
</tr>
<tr>
<td>Disclosures may be restricted by the individual who is the subject of the information.</td>
<td>WA</td>
</tr>
<tr>
<td>Certain restrictions apply to oral disclosures of mental health information.</td>
<td>CT</td>
</tr>
<tr>
<td>Certain restrictions apply to the use of mental health information.</td>
<td>ME</td>
</tr>
<tr>
<td><strong>Child or Adult Abuse</strong></td>
<td>AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI</td>
</tr>
<tr>
<td>We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
<td>AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI</td>
</tr>
</tbody>
</table>
PREVENTIVE HEALTHCARE GUIDELINES

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 judgment 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.

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 Physicians (AAFP), and the American Academy of Pediatrics/Bright Futures.
## SECTION 1: GENERAL PREVENTIVE SCREENING TESTS AND EXAMS CHILDREN, TEENS AND ADULTS

<table>
<thead>
<tr>
<th>Item</th>
<th>Gender</th>
<th>Adults</th>
<th>Newborns, Children and/or Teens</th>
<th>Comments about screening test, Counseling, exam or shot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm Screening Test</td>
<td>Male: X</td>
<td>Female: Does not apply.</td>
<td>X</td>
<td>This screening test is only for adults. These interventions are only for adults.</td>
</tr>
<tr>
<td>Alcohol Misuse: Screening and Behavioral Counseling Intervention in Primary Care to Reduce Alcohol Misuse.</td>
<td>Male: X</td>
<td>Female: X</td>
<td>X</td>
<td>This screening test is a one time test for men between the ages of 65 to 75 years old who have ever smoked. These are screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.</td>
</tr>
<tr>
<td>Aspirin for the Prevention of Cardiovascular Disease (Counseling)</td>
<td>Male: X</td>
<td>Female: X</td>
<td>X</td>
<td>This promotes the use of aspirin for men age 45 to 79 years when the potential benefit outweighs the potential harm. This promotes the use of aspirin for women age 55 to 79 years when the potential benefit outweighs the potential harm.</td>
</tr>
<tr>
<td>Breast Cancer Screening: Screening Mammography</td>
<td>Male: Does not apply.</td>
<td>Female: X</td>
<td>X</td>
<td>The mammography screening test is recommended every 1 to 2 years for women aged 40 and older. Nevada Revised Statutes, NRS 695C.1735 (b) (c) state a baseline mammogram for women between the ages of 35 and 40; and an annual mammogram for women 40 years of age or older.</td>
</tr>
<tr>
<td>Breast Cancer Screening: Genetic Counseling and Evaluation for BRCA testing.</td>
<td>Male: Does not apply.</td>
<td>Female: X</td>
<td>X</td>
<td>This counseling is for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes.</td>
</tr>
<tr>
<td>Chemoprevention for Breast Cancer (Counseling)</td>
<td>Male: Does not apply.</td>
<td>Female: X</td>
<td>X</td>
<td>This discussion by a doctor focuses on the topic of chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Doctors should inform the patients of the potential benefits and harms of chemoprevention.</td>
</tr>
<tr>
<td>Item</td>
<td>Gender</td>
<td>Adults</td>
<td>Newborns, Children and/or Teens</td>
<td>Comments about screening test, Counseling, exam or shot</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening or Pap Smear</td>
<td>Does not apply.</td>
<td></td>
<td>X</td>
<td>A screening for cervical cancer in women ages 21 to 65 years with cytology (pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.</td>
</tr>
<tr>
<td>Chlamydia Infection Screening</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This screening test is for all sexually active non-pregnant women aged 24 and younger and older non-pregnant women at increased risk for infection. This screening is for all pregnant women aged 24 and younger and for older pregnancy women who are at increased risk. This screening is for all sexually active gay men, bisexual men, and other men who have sex with men.</td>
</tr>
<tr>
<td>Cholesterol Screening (Lipid Disorders Screening)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This screening test is only for adults. This screening test is for all men aged 35 and older and women aged 45 years old and older. Men between the ages of 20 to 35 years old and women between the ages of 20 to 45 years old if they are at increased risk for coronary heart disease. Screening is recommended every 5 years and shorter intervals for people who have lipid levels close to those warranting therapy.</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (Fecal Occult Blood Test, Sigmoidoscopy and Colonoscopy)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This screening test is only for adults. This screening test is for all adults at average risk beginning at 50 years of age and older. Screening test choices include a Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Testing (FIT) every year, a Sigmoidoscopy every 5 years, a FOBT plus flexible sigmoidoscopy every 5 years, or a colonoscopy every 10 years. For high risk individuals, testing should begin earlier than 50 years of age and/or these individuals should undergo screening more often with increased risk factors.</td>
</tr>
<tr>
<td>Contraceptive Methods (including sterilizations)</td>
<td>Does not apply.</td>
<td></td>
<td>X</td>
<td>For women, all FDA approved contraceptive methods, sterilization procedures and patient education and counseling (as prescribed)</td>
</tr>
<tr>
<td>Item</td>
<td>Gender</td>
<td>Adults</td>
<td>Newborns, Children and/or Teens</td>
<td>Comments about screening test, Counseling, exam or shot</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>--------</td>
<td>---------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Does not apply</td>
<td>X</td>
</tr>
<tr>
<td>Dental Caries: Prevention of Dental Caries in Preschool Children</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>X</td>
</tr>
<tr>
<td>Depression: Screening for Depression in adults</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This screening test is only for adults</td>
</tr>
<tr>
<td>Depression: Major Depressive Disorder in Children and Adolescents (Screening)</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>X</td>
</tr>
<tr>
<td>Diabetes Mellitus Screening (Type 2 Diabetes)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This screening test is only for adults</td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>Does not apply</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Healthy Diet: Behavioral Counseling in Primary Care to Promote a Healthy Diet</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This service is only for adults</td>
</tr>
<tr>
<td>Hearing Screening (newborn)</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>X</td>
</tr>
<tr>
<td>Hepatitis C Virus Infection Screening</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>High Blood Pressure: Screening for High Blood Pressure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This screening test is only for adults</td>
</tr>
<tr>
<td>Item</td>
<td>Gender</td>
<td>Adults</td>
<td>Newborns, Children and/or Teens</td>
<td>Comments about screening test, Counseling, exam or shot</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-----------------------------</td>
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<td>---------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HIV: Human Immunodeficiency Virus – Screening for Adolescents and Adults.</td>
<td>Male: X, Female: X</td>
<td>Adults: X</td>
<td>Newborns: X, Children and/or Teens: X</td>
<td>This screening is for all adults and adolescents at risk for human immunodeficiency virus (HIV) and for all pregnant women.</td>
</tr>
<tr>
<td>Human Papillomavirus DNA Testing</td>
<td>Does not apply</td>
<td>Adults: Does not apply</td>
<td>Newborns: X</td>
<td>This screening test is every 3 years for women who are 30 or older who have normal pap smear results.</td>
</tr>
<tr>
<td>Hypothyroidism Screening (newborn)</td>
<td>Male: X, Female: X</td>
<td>Adults: Does not apply</td>
<td>Newborns: X</td>
<td>This screening test is for all newborn infants from birth to 90 days old. This should be included in the metabolic screening panel.</td>
</tr>
<tr>
<td>Intimate Partner Violence: Screening for Intimate Partner Violence</td>
<td>Does not apply</td>
<td>Adults: X</td>
<td>Newborns: X, Children and/or Teens: X</td>
<td>This screening is for women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services.</td>
</tr>
<tr>
<td>Obesity: Screening for Obesity in Adults</td>
<td>Male: X, Female: X</td>
<td>Adults: X</td>
<td>Newborns: X</td>
<td>This screening is for all adults. Doctors should offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.</td>
</tr>
<tr>
<td>Obesity: Screening for Obesity in Children and Adolescents</td>
<td>Male: X, Female: X</td>
<td>Adults: Does not apply</td>
<td>Newborns: X</td>
<td>This screening is for children aged 6 years of age and older. Doctors should offer or refer to comprehensive intensive behavioral interventions to promote improvement in weight status.</td>
</tr>
<tr>
<td>Osteoporosis Screening</td>
<td>Does not apply</td>
<td>Adults: X</td>
<td>Newborns: X</td>
<td>This screening test is for all women age 65 years of age and older, and in younger women whose risk is ≥ that of a 65 year old white woman who has no additional risk factors.</td>
</tr>
<tr>
<td>Phenylketonuria (PKU) Screening</td>
<td>Male: X, Female: X</td>
<td>Adults: Does not apply</td>
<td>Newborns: X</td>
<td>This screening test is for all newborn infants from birth to 90 days old. This test is included in the metabolic screening panel.</td>
</tr>
<tr>
<td>Prevention of Falls in Community-Dwelling Older Adults</td>
<td>Male: X, Female: X</td>
<td>Adults: X</td>
<td>Newborns: X</td>
<td>The USPSTF recommends that exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.</td>
</tr>
<tr>
<td>Item</td>
<td>Gender</td>
<td>Adults</td>
<td>Newborns, Children and/or Teens</td>
<td>Comments about screening test, Counseling, exam or shot</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Prostate Cancer Screening (digital rectal exam or prostate specific antigen test)</td>
<td>X</td>
<td>Does not apply</td>
<td>X</td>
<td>This screening test is only for adults</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years. However, UnitedHealthcare concludes that prostate cancer screening is supported by clinical evidence and it is covered as a preventive service for males aged 40 and over.</td>
</tr>
<tr>
<td>Rubella Screening By History of Vaccination or by Serology.</td>
<td>Does not apply</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sexually Transmitted Infections: Behavioral Counseling to Prevent Sexually Transmitted Infections</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sickle Cell Disease Screening (newborn)</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>USPSTF recommends counseling children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.</td>
</tr>
<tr>
<td>Skin Cancer Prevention (counseling)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>All persons at increased risk for syphilis infection and all pregnant women.</td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. They also recommend that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.</td>
</tr>
<tr>
<td>Tobacco Use: Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This is only for adults</td>
</tr>
</tbody>
</table>

Updated as of April 18, 2014
<table>
<thead>
<tr>
<th>Item</th>
<th>Gender</th>
<th>Adults</th>
<th>Newborns, Children and/or Teens</th>
<th>Comments about screening test, Counseling, exam or shot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use: Primary Care Interventions to Prevent Tobacco Use in Children and Adolescents</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>It is recommended that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.</td>
</tr>
<tr>
<td>Screening for Visual Impairment in Children</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>This screening is done at least once between the ages of 3 and 5 years, to detect the presence of amblyopia, or its risk factors.</td>
</tr>
<tr>
<td>Wellness Examinations (Well baby, well child and well adult)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>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/diagnostic procedures. These include breastfeeding support and counseling, contraceptive methods counseling, domestic violence screening, annual HIV counseling, sexually transmitted infection counseling and well-woman visits.</td>
</tr>
<tr>
<td>Other Tests and Exams for Children From Birth to 21 Years.</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>Other tests and exams for children and teens from birth to 21 years include hearing tests, developmental/autism screening, lead screening, anemia screening, tuberculosis testing, dyslipidemia screening and the metabolic screening panel. 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.</td>
</tr>
</tbody>
</table>
## SECTION 2: PREVENTIVE SCREENING TESTS AND EXAMS

### PREGNANT WOMEN

<table>
<thead>
<tr>
<th>Screening</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse.</td>
<td>These screening and behavioral counseling interventions are to reduce alcohol misuse by pregnant women, in primary care settings.</td>
</tr>
<tr>
<td>Anemia, Iron Deficiency Anemia Screening</td>
<td>This screening test is for asymptomatic pregnant women.</td>
</tr>
<tr>
<td>Bacteriuria Screening</td>
<td>This screening test is for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit.</td>
</tr>
<tr>
<td>Breastfeeding Support, Supplies and Counseling</td>
<td>Includes comprehensive lactation support and counseling, from a trained provider, during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment, in conjunction with each birth.</td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>This screening test is for all pregnant women 24 years of age and younger and for older pregnant women who are at high risk.</td>
</tr>
<tr>
<td>Gestational Diabetes Screening</td>
<td>This screening test is for women who are 24 to 28 weeks pregnancy, and at the first prenatal visit for those who are high risk of development of gestational diabetes.</td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>This screening test is for all sexually active women, including pregnant women, if they are at increased risk for infection (i.e., if the woman is under 25 years of age or has other individual or population risk factors).</td>
</tr>
<tr>
<td>Hepatitis B Virus Infection Screening</td>
<td>This screening test is for all pregnant women at their first prenatal visit.</td>
</tr>
<tr>
<td>HIV – Human Immunodeficiency Virus Infection Screening</td>
<td>This screening is for all adults and adolescents at risk for human immunodeficiency virus (HIV), including pregnant women.</td>
</tr>
<tr>
<td>Rh Incompatibility Screening</td>
<td>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 to 48 weeks’ gestation, unless the biological father is known to be Rh (D) negative.</td>
</tr>
<tr>
<td>Rubella Screening By History of Vaccination or by Serology.</td>
<td>This screening test is for all women of childbearing age at their first clinical encounter.</td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td>This screening test is for all pregnant women.</td>
</tr>
<tr>
<td>Tobacco Use: Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women.</td>
<td>This counseling is to screen for tobacco use and provide augmented, pregnancy-tailored counseling for pregnant women who smoke.</td>
</tr>
<tr>
<td>Wellness Visits (pre-conception, prenatal &amp; postpartum)</td>
<td>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.</td>
</tr>
</tbody>
</table>
SECTION 3: IMMUNIZATIONS/SHOTS 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 Centers for Disease Control and Prevention (CDC). For more information, please go to the CDC web site at: www.cdc.gov.
2014 Recommended Immunizations for Children from Birth Through 6 Years Old

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Immunization Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>HepB, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>1 month</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>2 months</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>4 months</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>6 months</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>12 months</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>15 months</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>18 months</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>19-23 months</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>2-3 years</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>4-6 years</td>
<td>HepB, RV, DTaP, Hib, PCV, IPV</td>
</tr>
</tbody>
</table>

**Influenza (Yearly)**
- MMR
- Varicella
- HepA5

**FOOTNOTES:**
- Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting a flu vaccine for the first time and for some other children in this age group.
- Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high risk, should be vaccinated against HepA.

**NOTE:** If your child misses a shot, you don't need to start over. Just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

**SEE BACK PAGE FOR MORE INFORMATION ON VACCINE-PREVENTABLE DISEASES AND THE VACCINES THAT PREVENT THEM.**
# Vaccine-Preventable Diseases and the Vaccines that Prevent Them

<table>
<thead>
<tr>
<th>Disease</th>
<th>Vaccine</th>
<th>Disease spread by</th>
<th>Disease symptoms</th>
<th>Disease complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox</td>
<td>Varicella vaccine protects against chickenpox</td>
<td>Air, direct contact</td>
<td>Rash, tiredness, headache, fever</td>
<td>Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>DTaP* vaccine protects against diphtheria.</td>
<td>Air, direct contact</td>
<td>Sore throat, mild fever, weakness, swollen glands in neck</td>
<td>Swelling of the heart muscle, heart failure, coma, paralysis, death</td>
</tr>
<tr>
<td>Hib</td>
<td>Hib vaccine protects against <em>Haemophilus influenzae</em> type b.</td>
<td>Air, direct contact</td>
<td>May be no symptoms unless bacteria enter the blood</td>
<td>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</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>HepA vaccine protects against hepatitis A.</td>
<td>Direct contact, contaminated food or water</td>
<td>May be no symptoms; fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine</td>
<td>Liver failure, arthralgia (joint pain), kidney, pancreatic, and blood disorders</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>HepB vaccine protects against hepatitis B.</td>
<td>Contact with blood or body fluids</td>
<td>May be no symptoms; fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain</td>
<td>Chronic liver infection, liver failure, liver cancer</td>
</tr>
<tr>
<td>Flu</td>
<td>Flu vaccine protects against influenza.</td>
<td>Air, direct contact</td>
<td>Fever, muscle pain, sore throat, cough, extreme fatigue</td>
<td>Pneumonia (infection in the lungs)</td>
</tr>
<tr>
<td>Measles</td>
<td>MMR** vaccine protects against measles.</td>
<td>Air, direct contact</td>
<td>Rash, fever, cough, runny nose, pinkeye</td>
<td>Encephalitis (brain swelling), pneumonia (infection in the lungs), death</td>
</tr>
<tr>
<td>Mumps</td>
<td>MMR** vaccine protects against mumps.</td>
<td>Air, direct contact</td>
<td>Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain</td>
<td>Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness</td>
</tr>
<tr>
<td>Pertussis</td>
<td>DTaP* vaccine protects against pertussis (whooping cough).</td>
<td>Air, direct contact</td>
<td>Severe cough, runny nose, apnea (a pause in breathing in infants)</td>
<td>Pneumonia (infection in the lungs), death</td>
</tr>
<tr>
<td>Polio</td>
<td>IPV vaccine protects against polio.</td>
<td>Air, direct contact, through the mouth</td>
<td>May be no symptoms; sore throat, fever, nausea, headache</td>
<td>Paralysis, death</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>PCV vaccine protects against pneumococcus.</td>
<td>Air, direct contact</td>
<td>May be no symptoms, pneumonia (infection in the lungs)</td>
<td>Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>RV vaccine protects against rotavirus.</td>
<td>Through the mouth</td>
<td>Diarrhea, fever, vomiting</td>
<td>Severe diarrhea, dehydration</td>
</tr>
<tr>
<td>Rubella</td>
<td>MMR** vaccine protects against rubella.</td>
<td>Air, direct contact</td>
<td>Children infected with rubella virus sometimes have a rash, fever, swollen lymph nodes</td>
<td>Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects</td>
</tr>
<tr>
<td>Tetanus</td>
<td>DTaP* vaccine protects against tetanus.</td>
<td>Exposure through cuts in skin</td>
<td>Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever</td>
<td>Broken bones, breathing difficulty, death</td>
</tr>
</tbody>
</table>

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.
2014 Recommended Immunizations for Children from 7 Through 18 Years Old

<table>
<thead>
<tr>
<th>7-10 YEARS</th>
<th>11-12 YEARS</th>
<th>13-18 YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Tetanus, Diphtheria, Pertussis (Tdap) Vaccine</td>
<td>Tdap</td>
</tr>
<tr>
<td>MCV4</td>
<td>Human Papillomavirus (HPV) Vaccine (3 Doses)&lt;sup&gt;2&lt;/sup&gt;</td>
<td>HPV</td>
</tr>
<tr>
<td></td>
<td>Meningococcal Conjugate Vaccine (MCV4) Dose&lt;sup&gt;3&lt;/sup&gt;</td>
<td>MCV4 Dose&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Influenza (Yearly)&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Booster at age 16 years</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal Vaccine&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis A (HepA) Vaccine Series&lt;sup&gt;6&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis B (HepB) Vaccine Series</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inactivated Polio Vaccine (IPV) Series</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles, Mumps, Rubella (MMR) Vaccine Series</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Varicella Vaccine Series</td>
<td></td>
</tr>
</tbody>
</table>

These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine. These shaded boxes indicate the vaccine should be given if a child is catching up on missed vaccines. These shaded boxes indicate the vaccine is recommended for children with certain health conditions that put them at high risk for serious diseases. Note that healthy children can get the HepA series<sup>6</sup>. See vaccine specific recommendations at [www.cdc.gov/vaccines/pubs/ACIP-list.htm](http://www.cdc.gov/vaccines/pubs/ACIP-list.htm).

**FOOTNOTES**

1. Tdap vaccine is combination vaccine that is recommended at age 11 or 12 to protect against tetanus, diphtheria and pertussis. If your child has not received any or all of the DTaP vaccine series, or if you don’t know if your child has received these shots, your child needs a single dose of Tdap when they are 7-10 years old. Talk to your child’s health care provider to find out if they need additional catch-up vaccines.

2. All 11 or 12 year olds—both girls and boys— should receive 3 doses of HPV vaccine to protect against HPV-related disease. Either HPV vaccine (Cervarix<sup>®</sup> or Gardasil<sup>®</sup>) can be given to girls and young women; only one HPV vaccine (Gardasil<sup>®</sup>) can be given to boys and young men.

3. Meningococcal conjugate vaccine (MCV) is recommended at age 11 or 12. A booster shot is recommended at age 16. Teens who received MCV for the first time at age 13 through 15 years will need a one-time booster dose between the ages of 16 and 18 years. If your teenager missed getting the vaccine altogether, ask their health care provider about getting it now, especially if your teenager is about to move into a college dorm or military barracks.

4. Everyone 6 months of age and older—including preteens and teens— should get a flu vaccine every year. Children under the age of 9 years may require more than one dose. Talk to your child’s health care provider to find out if they need more than one dose.

5. Meningococcal Conjugate Vaccine (MCV3) and Pneumococcal Polysaccharide Vaccine (PPSV23) are recommended for some children 5 through 18 years old with certain medical conditions that place them at high risk. Talk to your healthcare provider about pneumococcal vaccines and what factors may place your child at high risk for pneumococcal disease.

6. Hepatitis A vaccination is recommended for older children with certain medical conditions that place them at high risk. HepA vaccine is licensed, safe, and effective for all children of all ages. Even if your child is not at high risk, you may decide you want your child protected against HepA. Talk to your healthcare provider about HepA vaccine and what factors may place your child at high risk for HepA.

For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit [http://www.cdc.gov/vaccines/teens](http://www.cdc.gov/vaccines/teens)
Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Diphtheria (Can be prevented by Tdap vaccine)
Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be passed from person to person by direct contact with droplets from an infected person's cough or sneeze. When people are infected, the diphtheria bacteria produce a toxin (poison) in the body that can cause weakness, sore throat, low-grade fever, and swelling glands in the neck. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In severe cases, the illness can cause coma, paralysis, and even death.

Hepatitis A (Can be prevented by HepA vaccine)
Hepatitis A is an infection in the liver caused by hepatitis A virus. The virus is spread primarily person-to-person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms include fever, tiredness, loss of appetite, nausea, abdominal discomfort, dark urine, and jaundice (yellowing of the skin and eyes). An infected person may have no symptoms, may have mild illness for a week or two, or may have severe illness for several months that requires hospitalization. In the US, about 100 people a year die from hepatitis A.

Hepatitis B (Can be prevented by HepB vaccine)
Hepatitis B is an infection of the liver caused by hepatitis B virus. The virus spreads through exchange of blood or other body fluids, for example, from sharing personal items, such as razors or during sex. Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rash, joint pain, and jaundice. The virus stays in the liver of some people for the rest of their lives and can result in severe liver diseases, including fatal cancer.

Human Papillomavirus (Can be prevented by HPV vaccine)
Human papillomavirus is a common virus. HPV is most common in people in their teens and early 20s. It is the major cause of cervical cancer in women and genital warts in women and men. The strains of HPV that cause cervical cancer and genital warts are spread during sex.

Influenza (Can be prevented by annual flu vaccine)
Influenza is a highly contagious viral infection of the nose, throat, and lungs. The virus spreads easily through droplets when an infected person coughs or sneezes and can cause mild to severe illness. Typical symptoms include a sudden high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Extreme fatigue can last from several days to weeks. Influenza may lead to hospitalization or even death, even among previously healthy children.

Measles (Can be prevented by MMR vaccine)
Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever can persist, rash can last for up to about 10 days, and coughing can last for about 10 to 14 days. Measles can also cause pneumonia, seizures, brain damage, or death.

Meningococcal Disease (Can be prevented by MCV vaccine)
Meningococcal disease is caused by bacteria and is a leading cause of bacterial meningitis (infection around the brain and spinal cord) in children. The bacteria are spread through the exchange of nose and throat droplets, such as when coughing, sneezing or kissing. Symptoms include fever, vomiting, sensitivity to light, confusion and sleepiness. Meningococcal disease also causes blood infections. About one of every ten people who get the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous system, become developmentally disabled, or suffer seizures or strokes.

Mumps (Can be prevented by MMR vaccine)
Mumps is an infectious disease caused by the mumps virus, which is spread in the air by a cough or sneeze from an infected person. A child can also get infected with mumps in contact with a contaminated object, like a toy. The mumps virus causes fever, headaches, painful swelling of the salivary glands under the jaw, fever, muscle aches, tiredness, and loss of appetite. Severe complications for children who get mumps are uncommon, but can include meningitis infection of the covering of the brain and spinal cord, encephalitis (inflammation of the brain), permanent hearing loss, or swelling of the testes, which rarely can lead to sterility in men.

Pertussis (Whooping Cough) (Can be prevented by Tdap vaccine)
Pertussis is caused by bacteria spread through direct contact with respiratory droplets when an infected person coughs or sneezes. In the beginning, symptoms of pertussis are similar to the common cold, including runny nose, sneezing, and cough. After 1-2 weeks, pertussis can cause spells of violent coughing and choking, making it hard to breathe, drink, or eat. This cough can last for weeks. Pertussis is most serious for babies, who can get pneumonia, have seizures, become brain damaged, or even die. About two-thirds of children under 1 year of age who get pertussis must be hospitalized.

Pneumococcal Disease (Can be prevented by Pneumococcal vaccine)
Pneumonia is an infection of the lungs that can be caused by the bacteria called pneumococci. This bacteria can cause other types of infections too, such as ear infections, sinus infections, meningitis (infection of the covering around the brain and spinal cord), bacteremia and sepsis (blood stream infection). Sinus and ear infections are usually mild and are much more common than the more severe forms of pneumococcal disease. However, in some cases pneumococcal disease can be fatal or result in long-term problems, like brain damage, hearing loss and limb loss. Pneumococcal disease spreads when people cough or sneeze. Many people have the bacteria in their nose or throat at one time or another without being ill—this is known as being a carrier.

Polio (Can be prevented by PV vaccine)
Polio is caused by a virus that lives in an infected person's throat and intestines. It spreads through contact with the feces (stool) of an infected person and through droplets from a sneeze or cough. Symptoms typically include sudden fever, sore throat, headache, muscle weakness, and pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, up to 5% of children may die because they become unable to breathe.

Rubella (German Measles) (Can be prevented by MMR vaccine)
Rubella is caused by a virus that is spread through coughing and sneezing. In children rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but can be very serious to a baby in the womb. If a pregnant woman is infected, the result to the baby can be devastating, including miscarriage, serious heart defects, mental retardation and loss of hearing and eye sight.

Tetanus (Lockjaw) (Can be prevented by Tdap vaccine)
Tetanus is caused by bacteria found in soil. The bacteria enter the body through a wound, such as a deep cut. When people are infected, the bacteria produce a toxin (poison) in the body that causes serious, painful spasms and stiffness of all muscles in the body. This can lead to "locking" of the jaw so a person cannot open his or her mouth, swallow, or breathe. Complete recovery from tetanus can take months. Three of ten people who get tetanus die from the disease.

Varicella (Chickenpox) (Can be prevented by varicella vaccine)
Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough, sneeze. It can also spread from the blisters on the skin, either by touching them or by breathing in these viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache, and fever. Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), or even death.

If you have any questions about your child's vaccines, talk to your healthcare provider.
Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – United States, 2014.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are in bold.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19-23</th>
<th>2-3 yrs</th>
<th>4-6 yrs</th>
<th>7-10 yrs</th>
<th>11-12 yrs</th>
<th>13-15 yrs</th>
<th>16-18 yrs</th>
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<td>Rotavirus (RV) / RV1 (2-dose series); RSV (3-dose series)</td>
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<td>Tetanus, diphtheria, &amp; acellular pertussis* (Tdap; ≥7 yrs)</td>
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<td>Haemophilus influenzae type b (Hib)</td>
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<td>Pneumococcal conjugate† (PCV13)</td>
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<td>Pneumococcal polysaccharide (PPSV23)</td>
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<td>Influenza† (IIV; LAIV) 2 doses for some; See footnote 8</td>
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<tr>
<td>Human papillomavirus* (HPV2: females only, HPV4: males and females)</td>
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<td>Meningococcal† (Hib-MEnCY ≤6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)</td>
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This schedule includes recommendations in effect as of January 1, 2014. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online at (http://vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online at (http://www.cdc.gov/vaccines/recs/vacc-admin/contraindication.htm), or by telephone (800-CDC-INFO [800-232-4636]).

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/acip), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

NOTE: The above recommendations must be read along with the footnotes of this schedule.
Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2014

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

For vaccine recommendations for persons 19 years of age and older, see the adult immunization schedule.

Additional information

- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
- Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered >5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see MMWR, General Recommendations on Immunization and Reports / Vol. 60 / No. 2, Table 1. Recommended and minimum ages and intervals between vaccine doses available online at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
- Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destinations/list.


1. Hepatitis B (HepB) vaccine. (Minimum age: birth)
   Routine vaccination:
   At birth:
   - Administer monovalent HepB vaccine to all newborns before hospital discharge.
   - For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of the HepB series, at age 9 through 18 months (preferably at the next well-child visit).
   - If mother’s HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight. For infants weighing less than 2,000 g, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother’s HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HBIG for infants weighing 2,000 grams or more as soon as possible, but no later than age 7 days.

   Doses following the birth dose:
   - The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
   - Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0.1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
   - Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose at least 8 weeks after the second dose AND at least 16 weeks after the first dose. The final third or fourth dose in the HepB vaccine series should be administered no earlier than age 24 weeks.
   - Administration of a total of 4 doses of HepB vaccine is permitted when a combination vaccine containing HepB is administered after the birth dose.

   Catch-up vaccination:
   - Uncervaxed persons should complete a 3-dose series.
   - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
   - For other catch-up guidance, see Figure 2.

2. Rotavirus (RV) vaccine. (Minimum age: 6 weeks for both RV1 [Rotarix] and RV5 [Rotarix])
   Routine vaccination:
   Administer a series of RV vaccine to all infants as follows.
   1. If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
   2. If Rotarix is used, administer a 3-dose series at ages 2, 4, and 6 months.
   3. If any dose in the series was Rotarix or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

   Catch-up vaccination:
   - The maximum age for the first dose in the series is 14 weeks, 6 days; vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
   - The maximum age for the final dose in the series is 8 months, 0 days.
   - For other catch-up guidance, see Figure 2.

3. Diphtheria and tetanus toxoid and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks. Exception: DTaP-IPV [Kinrix]: 4 years)
   Routine vaccination:
   - Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 through 5 years.
   - The fourth dose may be administered as early as age 12 months, provided that at least 6 months have elapsed since the third dose.

   Catch-up vaccination:
   - The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 or 5 years.

   For other catch-up guidance, see Figure 2.

4. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for boosters; 11 years for Adacel)
   Routine vaccination:
   - Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
   - Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
   - Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks of gestation) regardless of time since prior Td or Tdap vaccination.

   Catch-up vaccination:
   - Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine for children 7 through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose at age 11 through 12 years should NOT be administered. To should be administered no later than age 10 years after the Tdap dose.
   - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoid (Td) booster doses every 10 years thereafter.

   Inactivated DTaP vaccine:
   - If administered inadvertently to a child aged 7 through 10 years may count as part of the catch-up series. Td dose may count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11 through 12 years.
   - If administered inadvertently to an adolescent aged 11 through 18 years, the dose should be counted as the adolescent Tdap booster.

   For other catch-up guidance, see Figure 2.

5. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks for PRP-T [ACTHIB, DTaP-IPV/Hib (Pentacel) and Hib-MonCV (MenHibrix)]: PRP-OMP [PedvaxHIB or COMVAX], 12 months for PRP-T [Hibrix])
   Routine vaccination:
   - Administer 2 to 3 doses Hib vaccine primary series and a booster dose (dose 3 or 4 depending on vaccine used in primary series) at age 12 through 15 months to complete a full 4-dose Hib vaccine series.
   - The primary series with ActHIB, MenHibrix, or Pentacel consists of 3 doses and should be administered at 2, 4, and 6 months of age. The primary series with PedvaxHIB or COMVAX consists of 2 doses and should be administered at 2 and 4 months of age; a dose at age 6 months is not indicated.
   - One booster dose (dose 3 or 4 depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months. An exception is Hibrix vaccine. Hibrix should only be used for the booster (final) dose in children aged 12 through 15 months who have received at least 1 prior dose of Hib-containing vaccine.
For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

5. *Hemophilus influenzae* type b (Hib) conjugate vaccine (cont’d)

Catch-up vaccination
- If dose 1 was administered at ages 12 through 14 months, administer a second (final) dose at least 8 weeks after dose 1, regardless of Hib vaccine used in the primary series.
- If the first 2 doses were PRP-OMP (PevaxHIB or ConVax), and were administered at age 11 months or younger, the third (final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 11 months or younger, the second dose is given between 12 through 14 months of age, a third (final) dose should be given 8 weeks later.
- If unvaccinated children aged 15 months or older, administer only 1 dose.
- For other catch-up guidance, see Figure 2. For catch-up guidance related to Men-ribix, please see the meningococcal vaccine footnotes and also MMWR March 22, 2013, 62(RR02):1-22, available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf.

**Vaccination of persons with high-risk conditions:**
- Children aged 12 through 59 months who are at increased risk for Hib disease, including chemotherapy recipients and those with anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, immunoglobulin deficiency, or early component complement deficiency, who have received either no doses or only 1 dose of Hib vaccine before 12 months of age, should receive 2 additional doses of Hib vaccine 8 weeks apart; children who received 2 doses of Hib vaccine before 12 months of age should receive 1 additional dose of Hib vaccine 8 weeks apart.
- For patients younger than 5 years of age undergoing chemotherapy or radiation treatment who received a Hib vaccine dose(s) within 14 days of starting therapy or during therapy, repeat the dose(s) at least 3 months following therapy completion.
- Recipients of hematopoietic stem cell transplant (HSCT) should be reimmunized with a 3-dose regimen of Hib conjugate vaccine starting 6 to 12 months after successful transplant, regardless of vaccination history; doses should be administered at 4-week intervals.
- A single dose of any Hib-containing vaccine should be administered to unimmunized* children and adolescents 15 months of age and older undergoing an elective splenectomy; if possible, vaccine should be administered at least 14 days before procedure.
- Hib vaccine is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized* persons aged 5 years or older who have anatomic or functional asplenia (including sickle cell disease and unvaccinated persons 5 through 18 years of age with human immunodeficiency virus (HIV) infection.

* Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine 14 months of age are considered unimmunized.

6. Pneumococcal vaccines (cont’d)
   - Administer 1 supplemental dose of PCV13 if 4 doses of PCV7 or other age-appropriate complete PCV7 series were received previously.
   - The minimum interval between doses of PCV (PCV7 or PCV13) is 8 weeks.
   - For children with a history of PPV23 vaccination, administer PPV23 at least 8 weeks after the last dose of PCV13.
   - For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies, HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease generalized malignancy; solid organ transplantation; or multiple myeloma.
   - If neither PCV13 nor PPV23 has been received previously, administer 1 dose of PCV13 now and 1 dose of PPV23 at least 8 weeks later.
   - If PCV13 has been received previously but PPV23 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PCV13.
   - If PPV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PPV23.
   - For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPV23, administer 1 dose of PPV23. If PCV13 has been received previously, then PPV23 should be administered at least 8 weeks after any prior PCV13 dose.
   - A single revaccination with PPV23 should be administered 5 years after the first dose to children with sickle cell disease or other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation, or multiple myeloma.

7. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

Routine vaccination
- Administer a 4-dose series of IPV at ages 2, 4, 6 through 18 months, and 4 through 6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

Catch-up vaccination
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
- If 4 or more doses are administered before age 4 years, an additional dose should be administered at ages 4 through 6 years (this dose should be administered at least 6 months after the previous dose).
- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered regardless of the child’s previous OPV or IPV history as recommended for U.S. residents aged 18 years or older.
- For other catch-up guidance, see Figure 2.

8. Influenza vaccine. (Minimum age: 6 months for inactivated influenza vaccine [IIV]; 2 years for live, attenuated influenza vaccine [LAIV])

Routine vaccination
- Administer influenza vaccine annually to all children beginning at age 6 months. For most healthy, nonpregnant persons aged 6 through 49 years, either LAIV or IIV may be used. However, LAIV should NOT be administered to any person, including 1) those with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 2) those who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see MMWR 2013; 62 (No. RR-71):1-43, available at http://www.cdc.gov/mmwr/pdf/rr/rr6207.pdf.

For children aged 6 months through 8 years:
- For the 2013–14 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses. For additional guidance, follow dosing guidelines in the 2013-14 ACIP influenza vaccine recommendations. MMWR 2013; 62 (No. RR-71):1-43, available at http://www.cdc.gov/mmwr/pdf/rr/rr6207.pdf.

For the 2014–15 season, follow dosing guidelines in the 2014 ACP Influenza vaccine recommendations.

For persons aged 9 years and older:
- Administer 1 dose.
For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html

9. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)
   Routine vaccination:
   • Administer ≥2 doses of MMR vaccine at ages 1 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   • Administer ≥1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (or 4 through 6 years) if the child remains in an area where disease risk is high, and the second dose at least 4 weeks later.
   • Administer ≥2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months, and the second dose at least 4 weeks later.
   Catch-up vaccination:
   • Ensure that all school-aged children and adolescents have ≥2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

10. Varicella (VAR) vaccine. (Minimum age: 12 months)
    Routine vaccination:
    • Administer ≥2 doses of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
    • For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

11. Hepatitis A (HepA) vaccine. (Minimum age: 12 months)
    Routine vaccination:
    • Initiate the 2-dose HepA vaccine series at 12 through 23 months; separate the 2 doses by 6 to 18 months.
    • Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
    • For any persons 2 years and older who have not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.
    Catch-up vaccination:
    • The minimum interval between the 2 doses is 6 months.
    Special populations:
    • Administer ≥2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection, men having sex with men, users of injection and non-injection illicit drugs, persons who work with HIV-infected primates or with HIV in a research laboratory; persons with clotting-factor disorders; persons with chronic liver disease; and persons who anticipate close, personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. The first dose should be administered as soon as the adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

12. Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for HPV2 [Gardasil] and HPV4 [Gardasil2])
    Routine vaccination:
    • Administer ≥3 doses of HPV vaccine on a schedule of 0, 1, 2, and 6 months to all adolescents aged 11 through 12 years. Either HPV2 or HPV4 may be used for females, and only HPV4 may be used for males.
    • The vaccine series may be started at age 9 years.
    • Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose 24 weeks after the first dose and 16 weeks after the second dose (minimum interval of 12 weeks).
    Catch-up vaccination:
    • Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if not previously vaccinated.
    • Use recommended routine dosing intervals (see above) for vaccine series catch-up.

13. Meningococcal conjugate vaccines. (Minimum age: 6 weeks for Hib-MenCY [MenHibrix], 9 months for MenACWY-D [Menactra], 2 months for MenACWY-CRM [Menveo])
    Routine vaccination:
    • Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a booster dose at 16 years.
    • Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive ≥2 doses primary series of Menactra or Menveo with at least 6 weeks between doses.
    • For children aged 2 months through 18 years with high-risk conditions, see below.
    Catch-up vaccination:
    • Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
    • If the first dose is the second dose at 11 through 12 years, a booster dose is administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
    • If the first dose is administered at age 16 years or older, a booster dose is not needed.
    • For other catch-up guidance, see Figure 2.

Vaccination of persons with high-risk conditions and other persons at increased risk of disease:
- Children with anatomic or functional asplenia (including sickle cell disease):
  1. For children aged <10 months of age, administer 4-dose infant series of Menilixib or Menveo at 2, 4, 6, and 12 through 15 months of age.
  2. For children aged 10 through 23 months who have not completed a series of Menilixib or Menveo, administer 2 primary doses of Menilixib or Menveo at least 3 months apart.
  3. For children aged ≥24 months and who have not received a complete series of Menilixib or Menveo, administer 2 primary doses of either Menilixib or Menveo at least 2 months apart.
- If Menilixib is administered to a child with asplenia (including sickle cell disease), do not administer Menilixib until 2 years of age and at least 4 weeks after the completion of all PCV13 doses.
- Children with persistent complement component deficiency:
  1. For children aged ≥10 months of age, administer a 4-dose infant series of either Menilixib or Menveo at 2, 4, 6, and 12 through 15 months of age.
  2. For children aged ≥7 through 23 months who have not initiated vaccination, two options exist depending on age and vaccine brand.
    a. For children who initiate vaccination with Menveo at 7 months through 23 months of age, a 2-dose series should be administered with the second dose at least 12 months of age and at least 3 months after the first dose.
    b. For children who initiate vaccination with Menilixib at 7 months through 23 months of age, a 2-dose series should be administered at least 3 months apart.
  c. For children aged >24 months and who have not received a complete series of Menilixib, Menveo, or Menactra, administer 2 primary doses of either Menilixib or Menveo at least 2 months apart.
  d. If Menilixib is administered to a child with asplenia (including sickle cell disease), do not administer Menilixib until 2 years of age and at least 4 weeks after the completion of all PCV13 doses.
  e. For children who travel to or reside in countries in which meningococcal disease is hyperendemic or endemic, including countries in the African meningitis belt or the HAJI, administer an age-appropriate formulation and series of Menilixib or Menveo for protection against serogroups A and W meningococcal disease. Prior to entry into the meningitis belt or the HAJI, it is not sufficient for children traveling to the meningitis belt or the HAJI because it does not contain serogroups A or W.
  f. For children at risk during a community outbreak attributable to a vaccine serogroup, administer or complete an age- and formulation appropriate series of Menilixib, Menactra, or Menveo.
  g. For other vaccination recommendations, refer to MMWR 2013;62(RR02):1-22.

Catch-up recommendations for persons with high-risk conditions:
  1. If Menilixib is administered to achieve protection against meningococcal disease, a complete age-appropriate series of Menilixib should be administered.
  2. If the first dose of Menilixib is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.
  3. For children who initiate vaccination with Menveo at 7 months through 9 months of age, a 2-dose series should be administered with the second dose at least 12 months of age and at least 3 months after the first dose.
  4. For other catch-up recommendations for these persons, refer to MMWR 2013;62(RR02):1-22.

For complete information on use of meningococcal vaccines, including guidance related to vaccination of persons at increased risk of infection, see MMWR March 22, 2012;62(RR02):1-22, available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf.
## 2014 Recommended Immunizations for Adults by Age

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>19-21 years</th>
<th>22-26 years</th>
<th>27-49 years</th>
<th>50-59 years</th>
<th>60-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza (Flu)</td>
<td></td>
<td></td>
<td></td>
<td>Get a flu vaccine every year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)</td>
<td></td>
<td></td>
<td></td>
<td>Get a Tdap vaccine once, then a Td booster vaccine every 10 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td></td>
<td></td>
<td></td>
<td>2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV Vaccine for Women</td>
<td></td>
<td></td>
<td></td>
<td>3 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV Vaccine for Men</td>
<td></td>
<td></td>
<td></td>
<td>3 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster (Shingles)</td>
<td></td>
<td></td>
<td></td>
<td>1 dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (PCV13)</td>
<td></td>
<td></td>
<td></td>
<td>1 dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (PPSV23)</td>
<td></td>
<td></td>
<td></td>
<td>1 or 2 doses</td>
<td></td>
<td>1 dose</td>
</tr>
<tr>
<td>Meningococcal</td>
<td></td>
<td></td>
<td></td>
<td>1 or more doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td>2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td>3 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenza type b (Hib)</td>
<td></td>
<td></td>
<td></td>
<td>1 or 3 doses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes:**

1. Influenza vaccine: There are several flu vaccines available—talk to your healthcare professional about which flu vaccine is right for you.
2. Td/Tdap vaccine: Pregnant women are recommended to get Tdap vaccine with each pregnancy in the third trimester to increase protection for infants who are too young for vaccination, but at highest risk for severe illness and death from pertussis (whooping cough). People who have not had Tdap vaccine since age 11 should get a dose of Tdap followed by Td booster doses every 10 years.
3. Varicella, HPV, MMR, Hepatitis A, Hepatitis B vaccine: These vaccines are needed for adults who didn’t get these vaccines when they were children.
4. HPV vaccine: There are two HPV vaccines, but only one, HPV (Gardasil®), should be given to men. Gay men or men who have sex with men who are 22 through 26 years old should get HPV vaccine if they haven’t already started or completed the series.
5. Zoster vaccine: You should get the zoster vaccine even if you’ve had shingles before.
6. MMR vaccine: If you were born in 1957 or after, and don’t have a record of being vaccinated or having had these infections, talk to your healthcare professional about how many doses you may need.
7. Pneumococcal vaccine: There are two different types of pneumococcal vaccines: PCV13 and PPSV23. Talk with your healthcare professional to find out if one or both pneumococcal vaccines are recommended for you.

If you are traveling outside of the United States, you may need additional vaccines. Ask your healthcare professional which vaccines you may need. For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit http://www.cdc.gov/vaccines
# 2014 Recommended Immunizations for Adults by Medical Condition

If you have this health condition,

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Pregnancy</th>
<th>Weakened Immune system (not human immunodeficiency virus [HIV])</th>
<th>HIV Infection</th>
<th>Kidney disease or poor kidney function</th>
<th>Asplenia (If you do not have a spleen or it does not work well)</th>
<th>Heart disease, chronic lung disease, chronic alcoholism</th>
<th>Diabetes (Type 1 and Type 2)</th>
<th>Chronic Liver Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza (Flu)</td>
<td>Get a flu vaccine every year</td>
<td>1 dose Tdap each pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)</td>
<td>1 dose Tdap each pregnancy</td>
<td>Get Tdap vaccine once, then a Td booster every 10 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>SHOULD NOT GET VACCINE</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV Vaccine for Women</td>
<td>3 doses through age 26 years</td>
<td>3 doses through age 26 years</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV Vaccine for Men</td>
<td>3 doses through age 26 years</td>
<td>3 doses through age 21 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster (Shingles)</td>
<td>SHOULD NOT GET VACCINE</td>
<td>1 dose for those 60 years and older</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td>SHOULD NOT GET VACCINE</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (PCV13)</td>
<td>1 dose</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (PPSV23)</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>1 or more doses</td>
<td>1 or more doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>2 doses</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3 doses</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib)</td>
<td>post-HCT recipient only</td>
<td>1 or 3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FOOTNOTES:**

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6. MMV vaccine if you were born in 1957 or after, and don’t have a record of being vaccinated or having had these infections, talk to your healthcare professional about how many doses you may need.
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If you are traveling outside of the United States, you may need additional vaccines. Ask your healthcare professional which vaccines you may need.

*For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit http://www.cdc.gov/vaccines*
Evidence Of Coverage

THIS EVIDENCE OF COVERAGE MAY CONTAIN A 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. This Plan is guaranteed renewable. This EOC may be terminated by HPN or the Group upon appropriate written notice in accordance with the GEA. 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 the 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. Words that are capitalized are defined in Section 13. - 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.
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Attachment A Benefit Schedule  
Attachment B Service Area  
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Riders, if applicable
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 concerning healthcare plans in Nevada.

**Hours of operation for the Division:**
Monday through Friday from 8 a.m. until 5 p.m., Pacific Standard Time (PST)
The Division is closed during state holidays.

**Contact information for the Division:**

<table>
<thead>
<tr>
<th>Carson City Office:</th>
<th>Las Vegas Office:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: (775) 687-0700</td>
<td>Phone: (702) 486-4009</td>
</tr>
<tr>
<td>Fax: (775) 687-0787</td>
<td>Fax: (702) 486-4007</td>
</tr>
<tr>
<td>1818 East College Pkwy., Suite 103</td>
<td>2501 East Sahara Ave., Suite 302</td>
</tr>
<tr>
<td>Carson City, NV 89706</td>
<td>Las Vegas, NV 89104</td>
</tr>
</tbody>
</table>

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:**
702-242-7300 or 1-800-777-1840
(Monday – Friday from 8:00 a.m. until 5:00 p.m., Pacific Standard 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:
A. Be a bona fide employee of the Group; and
B. Meet the following criteria:
   • Be employed full-time;
   • Be actively at work;
   • 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 actively at work 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 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.

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-one (31) 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.

HPN may require proof of continuing incapacity and dependency, but not more often than once a year after the first two (2) years beyond the date when the child reaches the limiting age. HPN’s determination of eligibility is final.

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.
• 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 which 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.
• 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 without giving evidence of good health.

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:
   - Violates or has violated any provision of the HPN EOC.
   - Misrepresents and/or fails to disclose a material fact which would affect coverage under this Plan.
   - Fails to follow HPN rules.
   - 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.

1. If a person applies to be a Member within thirty-one (31) days of the date he is first eligible to apply, coverage starts on the first day of the calendar month following the month when the Enrollment Form is received by HPN.

2. 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.

3. 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.

4. 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.

5. For a Special Enrollee, the Effective Date of Coverage is on the first day of the calendar month after an Enrollment Form is received, unless otherwise specified in the GEA.

6. 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.

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 thirty-one (31) days for newborn and adopted children.

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 contribution was due and not received by HPN.
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- 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 of the original Effective Date of Coverage and refund any applicable premium. 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 Member moves his primary residence outside HPN's Service Area. A Subscriber 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. HPN will request proof of the change of residence and/or place of work.
- On the date the GEA terminates for any reason, including but not limited to:
  1. Nonpayment of premiums.
  2. Failure to meet minimum enrollment requirements.
  3. HPN amends this EOC and the Group does not accept the amendment.

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. You 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.
   1. The Subscriber’s death.
   2. The Subscriber’s divorce or legal separation.
   3. The Subscriber becomes entitled to Medicare benefits under Part A, Part B, or both.
   4. 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.

d) 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.

e) 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 thirty (30) 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
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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 thirty (30) 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.

f) 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 thirty (30) 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.

g) 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 which does not include a Preexisting Condition clause that applies to the Subscriber or a Dependent.

• 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.

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

i) Plan Contact Information. For additional information about the Plan or your rights under COBRA continuation coverage, contact HPN’s Member Services Department by calling (702) 242-7300 or 1-800-777-1840.

j) 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
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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.
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 Copayment, Deductible 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 as defined in this EOC, or other Covered Services provided by a Non-Plan Provider that are Prior Authorized by HPN’s Managed Care Program including 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 form 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 or Hospice.
- Outpatient surgery provided in any setting, including technical and professional services.
- Diagnostic and Therapeutic Services.
- Home Healthcare Services.
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- All Inpatient and non-routine Outpatient non-Emergency Mental Health, Severe Mental Illness, and Substance Abuse Services, including
  - Intensive outpatient program treatment.
  - Outpatient electro-convulsive treatment.
  - Psychological testing.
  - Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- All Specialist visits or consultations.
- Prosthetic Devices, Orthotic Devices and Durable Medical Equipment.
- Courses of treatment, including allergy testing or treatment (e.g., skin, RAST); angioplasty; Home Healthcare Services; physiotherapy or Manual Manipulation; habilitative services and rehabilitation therapy (physical, speech, occupational).

4.5 Emergency Admission Notification

The Member must report all emergency admissions to the Member Services Department within 24 hours of admission or as soon as reasonably possible to authorize continued care at (702) 242-7300 or 1-800-777-1840.

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.

4.6 Independent Medical Review; Appeals Rights

HPN may require a Member to have an Independent Medical Review prior to issuing Prior Authorization for any medical benefits. In that case, only a Physician or Chiropractor who is certified to practice in the same field of practice as the primary treating Physician or Chiropractor or who is formally educated in that field will conduct the review.

The Independent Medical Review will include a physical exam of the Member and a personal review of all x-rays and reports made by the primary treating Physician or Chiropractor. A certified copy of all reports of findings will be sent to the primary treating Physician or Chiropractor and the Member within ten (10) business days after the review.

If the Member disagrees with the findings of the review, he must submit an appeal for binding arbitration to HPN within thirty (30) days after he receives the report. Please refer to the Appeals Procedures Section in this EOC for more information.

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:
(a) Provided, prescribed or arranged by the Member's PCP;
(b) Specifically authorized through HPN's Managed Care Program;
(c) Received in HPN’s Service Area through a Plan Provider; and
(d) 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 EME 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 45th 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 address shown below. 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.

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

Phone:
(702) 242-7300
1-800-777-1840

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 applicable Copayments and benefit limitations for Covered Services. All Covered Services are subject to HPN’s Managed Care Program.

6.1 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 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 Expense 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 or Hospice Care Facility include:

• 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);
Evidence of Coverage

- 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.

6.2 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, subject to the maximum benefit limitation;
- anesthesia services;
- family planning services including sterilization procedures; and
- limited diagnostic and therapeutic infertility services determined to be Medically Necessary and Prior Authorized by HPN’s Managed Care Program. Covered Services do not include those services specifically excluded herein, but do include limited:
  1. Laboratory studies;
  2. Diagnostic procedures; and
  3. Artificial insemination services, up to six (6) cycles per Member per lifetime.

6.3 Specialty Services 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 PCP or the Medical Director for further evaluation of an Illness or Injury on an Inpatient or outpatient basis.

6.4 Preventive Healthcare Services

Covered Preventive Healthcare Services will be paid at 100% of Eligible Medical Expenses, without application of any Copayment, and/or Calendar Year Deductible and 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 www.myhpnonline.com located under the “Members & Guests” tab:

- 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 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.

6.5 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.

6.6 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 is necessary in order to perform radiation therapy.
Evidence of Coverage

6.7 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:

1. HPN will determine if the Member satisfies HPN’s Medically Necessary criteria before receiving benefits for transplant services.
2. HPN will provide a written Referral for care to a Transplant Facility.
3. 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.
- 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 EME incurred during the Transplant Benefit Period.

6.8 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.

6.9 Emergency 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 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.
Evidence of Coverage

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 condition which require Medically Necessary treatment, but not Emergency Services, include:

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

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 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.

(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 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 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.

**Telephone 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 Telephone 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.

6.10 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.

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

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.

6.12 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 mental retardation.

6.13 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.

6.14 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.

6.15 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 Copayments may apply to these Covered Services. Please refer to your Attachment A Benefit Schedule.

6.16 Prosthetic and Orthotic Devices

Covered Services include the following devices when received in connection with an Illness or Injury occurring after Member's Effective Date under this Plan 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.
6.17 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.

6.18 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;
- Intermittent positive pressure breathing machine;
- Hospital beds;
- 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.

6.19 Mental Health Services and Severe Mental Illness Services

All benefits for Mental Health and Severe Mental Illness Services are subject to HPN's Managed Care Program through Behavioral Healthcare Options and shown in the Attachment A Benefit Schedule.

Mental Health Services. When authorized by Behavioral Healthcare Options, Covered Services include evaluation, crisis intervention or psychotherapy only.

- Inpatient: Covered Services for the diagnosis and treatment of a Mental Illness.
- Outpatient: Outpatient evaluation and treatment of Mental Illness including individual and group psychotherapy sessions.

Severe Mental Illness Services. When authorized by HPN, Covered Services include Inpatient and outpatient treatment for Severe Mental Illness as defined in this EOC. Benefits for the treatment of Severe Mental Illness are subject to the benefit levels shown in the Attachment A Benefit Schedule.

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

6.20 Substance Abuse Services

All benefits for Inpatient Substance Abuse Services are subject to HPN's Managed Care Program through Behavioral Healthcare Options and listed in the Attachment A Benefit Schedule.

- Inpatient: when there has been a history of multiple outpatient treatment failures or when outpatient treatment is not feasible, services for diagnosis and medical treatment for alcoholism and abuse of drugs.
- Outpatient: services for the diagnosis, medical treatment and rehabilitation, including individual, group, and family counseling, and outpatient detoxification services for recovery from the effects of alcoholism and abuse of drugs.
- Detoxification: treatment for withdrawal from the physiological effects of alcohol and drug abuse. Inpatient detoxification is considered appropriate treatment only for
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6.21 Mastectomy Reconstructive Surgical Services

Benefits are available for Subscribers and their enrolled Dependents for Mastectomy Reconstructive Surgery. Mastectomy Reconstructive Surgery is the surgical procedure performed following a mastectomy on one or both breasts to re-established symmetry between the two breasts. Such surgery includes, but is not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy.

The following services received in connection with Mastectomy Reconstructive Surgical Services are Covered Services subject to the terms and conditions of this EOC:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending Physician and the patient.

The first three (3) years after mastectomy:

Benefits for reconstructive surgery, including complications relating to the reconstructive surgery, performed while the patient is covered under this Plan, and within the three (3) years immediately following a mastectomy that was covered under this Plan, will be paid at the same level as would have been provided at the time of the mastectomy.

Benefits for reconstructive surgery performed within three (3) years following a mastectomy that was covered under this Plan, while the patient is no longer covered by HPN under this Plan, will be paid at the same level as would have been provided at the time of the mastectomy except that no coverage will be provided for any complications relating to the reconstructive surgery.

More than three (3) years after mastectomy:

Benefits for reconstructive surgery performed more than three (3) years following a mastectomy that was covered under this Plan (if the patient is still covered by HPN under this Plan) will be paid subject to all of the terms, conditions and exclusions contained in the EOC at the time of the reconstructive surgery.

No benefits will be paid for reconstructive surgery performed, or any complications relating to the reconstructive surgery, more than three (3) years following a mastectomy that was covered under this Plan if the patient is no longer covered by HPN under this Plan.

6.22 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.

6.23 Self-Management and Treatment of Diabetes


NOTE: All inpatient and non-routine Outpatient non-emergency Mental Health, Severe Mental Illness or Substance Abuse require Prior Authorization by BHO. Members must contact Behavioral Health Care Options (BHO) at (702) 364-1484 or 1-800-873-2246, for assistance in scheduling their first appointment in order to verify that any requested Mental Health, Severe Mental Illness or Substance Abuse services are Covered Services under the Plan, and that such Covered Services will be obtained at the appropriate level of care in order to be eligible for full benefit payment. A BHO coordinator will either assist in scheduling the appointment or will make a referral to the appropriate Plan Provider based on the service requested and the associated level of acuity. If the Member is unable to contact BHO due to an emergency admission, the Member must contact BHO as soon as reasonably possible following the emergency admission to obtain Prior Authorization of any needed follow up care.

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 Substance Abuse facility for non-emergency treatment without Prior Authorization, Member will be responsible for the cost of services received.
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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.

6.24 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 that provided by a Plan anesthesia Provider only during procedures performed by an educationally qualified Specialist in pediatric dentistry, or other 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.

6.25 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 40kg/m2; or
- Have a BMI greater than 35kg/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 three (3) 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.

6.26 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.

6.27 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
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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 (AHRO);
  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 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 the State 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.
Evidence of Coverage

6.28 Medical Supplies

Medical Supplies are routine supplies that are customarily used during the course of treatment for an Illness or Injury. Medical Supplies include, but are not limited to the following:
- Catheter and catheter supplies – Foley 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, lambs wool pads, sterile solutions, ointments, sterile applicators, sterile gloves;
- Elastic stockings;
- Enemas and douches;
- IV supplies;
- Sheets and bags;
- Splints and slings;
- Surgical face masks; and
- Syringes and needles.

6.29 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.

6.30 Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). 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 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 Members who have either of the following:
- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

6.31 Autism Spectrum Disorder

Covered Services include Medically Necessary services that are generally recognized and accepted procedures for screening, diagnosing and treating Autism Spectrum Disorders for Members under the age of 18 or, if enrolled in high school, until such Member reaches the age of 22. Covered Services must be provided by a duly licensed physician, psychologist or Behavior Analyst (including an Assistant Behavior Analyst and/or Certified Autism Behavior Interventionist) 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 do not include services provided by:
- an early intervention agency or school for services delivered through early intervention, or
- school services.

6.32 Habilitative Services

Benefits are provided for Habilitative Services provided on an outpatient basis 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 or Investigational.

Coverage for Habilitative 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 Habilitative Services. A service that does not help the Member to meet functional goals in a treatment plan within a prescribed time frame is not a 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.
Evidence of Coverage

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 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.

7.6 Personal comfort, hygiene or convenience items such as a hospital television, telephone, or private room when not Medically Necessary. 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.

7.7 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.

7.8 Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function. 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.

7.9 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, GIFT and 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;
- Sonohysterography;
- Monitoring of ovarian response to stimulants;
- CT or MRI of sella turcica unless elevated prolactin level;
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- Evaluation for sterilization reversal;
- Laparoscopy;
- Ovarian wedge resection;
- Removal of fibroids, uterine septae and polyps;
- Open or laparoscopic resection, fulguration, or removal of endometrial implants;
- Surgical lysis of adhesions;
- Surgical tube reconstruction.

7.10 Reversal of surgically performed sterilization or subsequent resterilization.

7.11 Elective abortions.

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

7.13 Any services or supplies rendered in connection with Member acting as or utilizing the services of a surrogate mother.

7.14 Third-party physical exams 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.

7.15 Venipuncture (drawing of blood for laboratory tests).

7.16 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.

7.17 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.
- Any and all services or supplies treatments, laboratory tests or x-rays received by the donor in connection with the transplant (including donor search, donor transportation, testing, registry and retrieval/harvesting costs) and costs related to cadaver or animal retrieval or maintenance of a donor for such retrieval.
- Any and all Hospital, Physician, laboratory or x-ray services in any way related to any excluded transplant service, procedure or treatment.

7.18 Treatment of:
- Marital or family problems;
- Occupational, religious, or other social maladjustments;
- Chronic behavior disorders;
- Codependency;
- Impulse control disorders;
- Organic disorders;
- Learning disabilities or mental retardation or any Severe Mental Illness as defined in the EOC and otherwise covered under the Severe Mental Illness Covered Services section.

For purposes of this Exclusion,

- “chronic” means any condition existing for more than six (6) months.
- Counseling and other forms of cognitive and behavioral therapy is excluded in connection with the treatment of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD). This section is not meant to exclude an evaluation for a diagnosis of ADD or ADHD, or to exclude any corresponding outpatient prescription drugs (if otherwise available under the outpatient Prescription Drug Benefit Rider if applicable to your Plan) when prescribed by a treating Plan Provider, nor is this meant to exclude an evaluation for the diagnosis of any other co-morbid issues.

7.19 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.

7.20 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.

7.21 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.

7.22 Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.
• Bone anchored hearing aids are excluded except when either of the following applies:
  • For Member’s with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
  • For Member’s with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Also excluded is more than one bone anchored hearing aid per Member who meets the above coverage criteria during the entire period of time the Member is enrolled under the Plan, as well as repairs and/or replacements for a bone anchored hearing aid for Member’s who meet the above coverage criteria, other than for malfunctions.

7.23 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; electrodagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile or gerovital.

7.24 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.

7.25 Acupuncture or Hypnosis.
7.26 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.
7.27 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.
7.28 Travel and accommodations, whether or not recommended or prescribed by a Provider, other than as specifically covered in this Plan.
7.29 Outpatient Prescription Drugs, nutritional supplements, vitamins, herbal medicines, appetite suppressants, Specialty drugs, and other over-the-counter drugs, except as specifically covered in the outpatient Prescription Drug Benefit Rider, if applicable to your Plan. This includes drugs and supplies for a patient’s use after discharge from a Hospital. Drugs and medicines approved by the FDA for experimental or investigational use or any drug that has been approved by the FDA for less than one (1) year unless Prior Authorized by HPN.
7.30 Care for conditions that federal, state or local law requires to be treated in a public facility.
7.31 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.
7.32 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.
7.33 Special formulas, food supplements other than as specifically covered in this EOC or special diets on an outpatient basis.
7.34 Services, supplies or accommodations provided without cost to the Member or for which the Member is not legally required to pay.
7.35 Milieu therapy, biofeedback, behavior modification, sensitivity training, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcoosis, narcosynthesis, rolffing, residential treatment, vocational
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7.36 Experimental or investigational treatment or devices as determined by HPN.

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

7.38 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.

7.39 Any services given by a Provider to himself or to members of his family.

7.40 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.

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

7.42 Telemetry readings, EKG interpretations when billed separately from the EKG procedure. Arterial blood gas interpretations when billed separately from the procedure.

7.43 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.

7.44 Autologous blood donations.

7.45 Healthcare services or supplies required as a result of an attempt to commit, or committing a felony by the Member.

7.46 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.

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

7.48 Services and materials resulting from failure to comply with professionally prescribed treatment.

7.49 Services or materials provided as a result of a self-inflicted injury or illness.

7.50 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.

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 tells you how other health insurance you may have affects your coverage under this Plan.

9.1 The Purpose of COB

Coordination of Benefits (COB) is intended to help contain the cost of providing healthcare coverage. When an individual person has dual coverage through HPN and another healthcare plan, the COB guidelines outlined in this Section apply. The COB guidelines explain how, in a dual healthcare coverage situation, benefits are coordinated or shared by each plan.

9.2 Benefits Subject to COB

All of the healthcare benefits provided under this EOC are subject to this Section. The Member agrees to permit HPN to coordinate its obligations under this EOC with payments under any other Group Health Benefit Plan that covers the Member.

9.3 Definitions

Some words in this Section have a special meaning to meet the needs of this Section. These words and their meaning when used are:

(a) “Plan” will mean an entity providing Group healthcare benefits or services by any of the following methods:

1. Insurance or any other arrangement for coverage for individuals whether on an insured or uninsured basis, including the following:

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a. Hospital indemnity benefits with regard to the amount in excess of $30 per day.

b. Hospital reimbursement type plans which permit the insured person to elect indemnity benefits at the time of claim.

2. Service plan contracts, group practice, individual practice and other prepayment coverage.

3. Any coverage for students that is sponsored by, or provided through, school or other educational institutions, other than accident coverage for grammar school or high school students that the parent pays the entire premium.

4. Any coverage under labor management trusteed plans, union welfare plans, employer organization plans, employee benefit plans, or employee benefit organization plans.

5. Coverage under a governmental program, including Medicare and workers’ compensation plans.

The term “Plan” will be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(b) “Allowable Expense” means the Eligible Medical Expense for Medically Necessary Covered Services. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be an Allowable Expense and a benefit paid.

(c) “Claim Determination Period” means the Calendar Year.

(d) “Primary Plan” means a Plan that, in accordance with the rules regarding the order of benefits determination, provides benefits or benefit payments without considering any other Plan.

(e) “Secondary Plan” means a Plan that in accordance with the rules regarding the order of benefit determination, may reduce its benefits or benefit payments and/or recover from the Primary Plan benefit payments.

9.4 When COB Applies

COB applies when a Member covered under this Plan is also entitled to receive payment for or provision of some or all of the same Covered Services from another Plan.
9.5 Determination Rules

The rules establishing the order of benefit determination are:

(a) Non-Dependent or Dependent. A Plan that covers the person as a Subscriber is primary to a Plan that covers the person as a Dependent.

(b) Dependent Child of Parents Not Separated or Divorced. Except as stated in 10.5(c) below, when this Plan and another Plan cover the same child as a Dependent of different parents:
   1. The Plan of the parent whose birthday falls earlier in the Calendar Year is primary to the Plan of the parent whose birthday falls later in the year.
   2. If both parents have the same birthday, the Plan that has covered a parent for a longer period of time is primary.
   3. If the other Plan does not have the rule described in (1) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(c) Dependent Child of Separated or Divorced Parents. If two (2) or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
   1. If there is a court decree that would establish financial responsibility for the medical, dental or other healthcare expenses with respect to the child, the benefits of a Plan that covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan that covers the child as a Dependent child;
   2. Second, the Plan of the parent with custody of the child;
   3. Third, the Plan of the spouse (stepparent) of the parent with custody of the child;
   4. Finally, the Plan of the parent not having custody of the child.

(d) Active/Inactive Subscriber. A Plan that covers a person as a Subscriber who is neither laid-off nor retired (or that Subscriber's Dependents) is primary to a Plan that covers that person as a laid-off or retired Subscriber (or that Subscriber's Dependents). If the other Plan does not have this rule, and if as a result, the Plans do not agree on the order of benefits, this rule (d) is ignored.

(e) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the Plan that covered the person for a longer period of time is primary to the Plan which covered that person for the shorter time period.

Two consecutive Plans shall be treated as one Plan if:
   1. That person was eligible under the second Plan within 24 hours after the termination of the first Plan;
   2. There was a change in the amount or scope of a Plan's benefits or there was a change in the entity paying, providing or administering Plan benefits; or
   3. There was a change from one type of Plan to another (e.g., single employer to multiple employer Plan).

(f) If No COB Provision. If another Plan does not contain a provision coordinating its benefits with those of this Plan, the benefits of such other Plan will be considered primary.

9.6 How COB Works

Plans use COB to decide which healthcare coverage programs should be the Primary Plan for the Covered Service. If the Primary Plan payment is less than the charge for the Covered Service, then the Secondary Plan will apply its Allowable Expense to the unpaid balance. Benefits payable under another Plan include the benefits that would have been payable if the Member had filed a claim for them.

9.7 Right to Receive and Release Information

In order to decide if this COB Section (or any other Plan's COB Section) applies to a claim, HPN (without the consent of or notice to any person) has the right to the following:

(a) Release to any person, insurance company or organization, the necessary claim information.
(b) Receive from any person, insurance company or organization, the necessary claim information.
(c) Require any person claiming benefits under this Plan to give HPN any information needed by HPN to coordinate those benefits.

9.8 Facility of Payment

If another Plan makes a payment that should have been made by HPN, then HPN has the right to pay the other Plan any amount necessary to satisfy HPN's obligation. Any amount paid shall be deemed to be benefits paid under this Plan, and to the extent of such payments, HPN shall be fully discharged from liability under this Plan.
9.9 Right to Recover Payment

If the amount of benefit payment exceeds the amount needed to satisfy HPN's obligation under this section, HPN has the right to recover the excess amount from one or more of the following:

(a) Any persons to or for whom such payments were made.
(b) Any group insurance companies or service plans.
(c) Any other organizations.

9.10 Failure to Cooperate

If a Member fails to cooperate with HPN’s administration of this section, the Member may be responsible for the expenses for the services rendered and if legal action is taken, a court could make the Member responsible for any legal expense incurred by HPN to enforce its rights under this section.

Member cooperation includes the completion of the necessary paperwork that would enable HPN to collect payment from the Primary Plan for services. Any benefits paid to the Member in excess of actual expenses must be refunded to HPN.

SECTION 10. Subrogation

If a Member's Illness or Injury is caused by a third party, and the Member has the right to recover damages from that third party, HPN will provide or make payment for Covered Services related to such Illness or Injury. Acceptance of such Covered Services or payment shall constitute consent to the provisions of this section.

10.1 Member Reimbursement Obligation

If a Member receives payment for medical services and supplies from a third party through a suit or settlement, the Member will be obligated to reimburse HPN for either the actual cost incurred by HPN or the reasonable value of services for benefits provided under this Plan for such services and supplies, but no more than the amount the Member recovers.

10.2 HPN’s Right of Recovery

HPN shall place a lien on all funds recovered by the Member either the actual cost incurred by HPN or the reasonable value for the services and supplies provided to the Member. HPN may give notice of that lien to any party who may have contributed to the loss.

HPN has the right to be subrogated to the Member's rights to the extent of the benefits payable for Covered Services received under this Plan. This includes HPN's right to bring suit against a third party in the Member's name.

10.3 Member Cooperation

The Member must take such action, furnish such information and assistance, and execute such instruments as HPN may require to facilitate enforcement of its rights under this provision. The Member shall take no action prejudicing the rights and interests of HPN under this provision.

Any Member who fails to cooperate in HPN's administration of this section shall be responsible for the actual cost of the services rendered in connection with the Illness or Injury caused by a third party.


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 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.

11.3 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.
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11.4 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.

11.5 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.

11.6 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.

11.7 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.

11.8 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.

11.9 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.

11.10 Clerical Error

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

11.11 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.

11.12 Overpayments

HPN has the right to correct and/or collect benefit payments for healthcare services made in error. Hospitals, Physicians, Providers, and/or Members have the responsibility to return any overpayments or incorrect payments to HPN. HPN has the right to offset any such overpayment against any future payments.

11.13 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.

11.14 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.
11.15 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 contacting the Member Services Department at (702) 242-7300 or 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.

11.16 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 Expense for such services.

11.17 Gender References

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

11.18 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.

11.19 Availability of Providers

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

11.20 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.

### 11.21 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.

### 11.22 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.

### 11.23 Failure to Obtain Prior Authorization

All requests for Prior Authorization must be initiated by the Member’s Physician. 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 provided the Member’s request for Prior Authorization is received by an employee or department of the Plan customarily responsible for handling benefit matters and the original request specifically named the Member, a specific medical condition or symptom, and a 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.

### 11.24 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.

### 11.25 Notification of an Adverse Benefit Determination

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

SECTION 12. 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.

Please see the Glossary Terms Section herein for a description of the terms used in this section.

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 in writing and reviewed by the Grievance Review Committee. The 2nd Level Formal Appeal is voluntary for all Adverse Benefit Determinations.

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.

12.1 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.
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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.

12.2 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 in Section 12.1. 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
P.O. Box 15645
NV017-3020
Las Vegas, NV 89114-5645
Fax: 1-702-266-8813

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 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 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.
12.3 Expedited 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 three (3) days of the oral notification.

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.

12.4 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 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, Post-Service, and Urgent Care Claims for Benefits.

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 one at a time mutually convenient to 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
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- 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:

1. The specific reason or reasons for upholding the Adverse Benefit Determination;
2. Reference to the specific Plan provisions on which the benefit determination is based; and
3. A statement describing any additional voluntary levels of appeal.
4. 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.

### 12.5 Arbitration of Disputes of an Independent Medical Review

If the Member is dissatisfied with the findings of an Independent Medical Review, the Member shall have the right to have the dispute submitted to binding arbitration before an arbiter under the commercial arbitration rules applied by the American Arbitration Association. This review is in place of HPN’s Appeals Procedures.

The arbiter will be selected by mutual agreement of HPN and the Member. The cost and expense of the arbitration shall be paid by HPN. The decision of the arbiter shall be binding upon the Member and HPN.

### 12.6 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.

Additionally, as per applicable law and regulations, the notice will provide the Member the information outlined in Section 12.2 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 below 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 for Consumer Health Assistance
555 East Washington Avenue #4800
Las Vegas NV 89101
(702) 486-3587
(888) 333-1597

The determination of an IRO concerning an External Review in favor of the Member of an adverse determination is final, conclusive and binding. 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.

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12.6.a 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 and 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, that 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.

12.6.b Expedited External Review

A request for an Expedited External Review may be submitted to OCHA 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.

12.7 Request for an External Review Due to Denial of Experimental or Investigational 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 or investigational, is available in limited circumstances as outlined in the following sections.
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#### 12.7.a 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.

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.

#### 12.7.b 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 or investigational, 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 that such service or treatment would be significantly less effective if not promptly initiated. Upon receipt of such request and proof, the 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.

12.8 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 13. Glossary

13.1 “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; or a determination that a benefit is experimental, investigational, 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.

13.2 “Ambulance” means a ground or air vehicle licensed to provide Ambulance services.

13.3 “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.

13.4 “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.

13.5 “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.

13.6 “Autism Spectrum Disorders” means a neurobiological medical condition including, but not limited to, autistic disorder, Asperger’s Disorder and Pervasive Developmental Disorder not otherwise specified.

13.7 “Benefit Schedule” means the brief summary of benefits, limitations and Copayments given to the Subscriber by HPN. It is Attachment A to this EOC.

13.8 “Calendar Year” means January 1 through December 31 of the same year.

13.9 “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.

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;
- 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.

13.10 “Certified Autism Behavior Interventionist” means a person who is certified as an Autism Behavior Interventionist by the Board of Psychological Examiners and who provides Behavior Therapy under the supervision of:
- A licensed psychologist;
- A Licensed Behavior Analyst; or
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3. A Licensed Assistant Behavior Analyst.

13.12 “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).


13.14 “Coinsurance” means the percentage of the charges billed or the percentage of Eligible Medical Expenses, 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.)

13.15 “Contract Year” means the twelve (12) months beginning with and following the Effective Date of the Group Enrollment Agreement (GEA).

13.16 “Convenient Care Facility” means a facility that provides services for Medically Necessary, non-urgent or non-emergent injuries or illnesses. Examples of such conditions include:
   1. diagnostic laboratory services;
   2. general health screenings;
   3. minor wound treatment and repair;
   4. minor illnesses (cold/flu);
   5. treatment of burns and sprains;
   6. blood pressure checks

13.17 “Copayment” or “Cost-share” means the amount the Member pays when a Covered Service is received.

13.18 “Covered Services” means the health services, supplies and accommodations for which HPN pays benefits under this Plan.

13.19 “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.

13.20 “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.
   • Training or assistance in personal hygiene.
   • Other forms of self-care.
   • Supervisory care by a Physician in a custodial facility to meet regulatory requirements.

13.21 “Deductible” means the portion of Eligible Medical Expenses 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.)

13.22 “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.

13.23 “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.

13.24 “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.

13.25 “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.

13.26 “Eligible Employee” means a natural person that:
   A. Is a bona fide employee of the Group; and
   B. Meets the following criteria:
      • Is employed full-time;
      • Is actively at work;
      • 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.

The term includes a sole proprietor or a partner of a partnership, if the sole proprietor or partner is included as an Eligible Employee under a Health Benefit Plan of a Small Employer.

13.27 “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.

13.28 “Emergency Services” means Covered Services provided after the sudden onset of a medical or dental condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention 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.

13.29 “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.


13.31 “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.

13.32 “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.

13.33 “Expeditied 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.

13.34 “External Review” means an independent review of an Adverse Benefit Determination conducted by an Independent Review Organization.

13.35 “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.

13.36 “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.

13.37 “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.

13.38 “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.

13.39 "Habilitative 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.

13.40 "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.

13.41 "Health Maintenance Organization" or "HMO" means an organization that is formed in accordance with state law to provide managed healthcare services.

13.42 "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.

13.43 "HPN Reimbursement Schedule" means the schedule showing the amount HPN will pay for Eligible Medical Expenses (EME) to Providers. EME 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 Expense 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 Expense 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.

13.44 "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.

13.45 "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,
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13.46  **“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.

13.47  **“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:
- residential or nonresidential treatment facilities;
- health resorts;
- nursing homes;
- Christian Science sanatorium;
- institutions for exceptional children;
- Skilled Nursing Facilities, places that are primarily for the care of convalescents;
- clinics;
- Physician offices;
- private homes; or
- Ambulatory Surgical Facilities.

13.48  **“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.

13.49  **“Independent Medical Review”** means an independent evaluation of the medical or chiropractic care of a Member that must include a physical examination of the Member unless he is deceased, and a personal review of all x-rays and reports by a certified Physician or Chiropractor who is formally educated in the applicable medical field.

13.50  **“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

13.51  **“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.

13.52  **“Injury”** means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.

13.53  **“Inpatient”** means being confined in a Hospital or Skilled Nursing Facility as a registered bed patient under a Physician's order.

13.54  **“Licensed Assistant Behavior Analyst”** means a person who holds current certification or meets the standards to be certified 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 Board of Psychological Examiners and who provides Behavioral Therapy under the supervision of a Licensed Behavior Analyst or psychologist.

13.55  **“Licensed Behavior Analyst”** means a person who holds current certification or meets the standards to be certified as a board certified Behavior Analyst or a board certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and whom the Board of Psychological Examiners licenses as a Behavior Analyst.

13.56  **“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.

13.57  **“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.
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Manual Manipulation does not include diagnosis or treatment requiring general anesthesia, surgery or Hospital confinement.

13.58 "Medical Director" means a Physician named by HPN to review use of health services by Members.

13.59 "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.

13.60 "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.

13.61 "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.

13.62 "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.

13.63 "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:
- Marital or family problems;
- Social, occupational, or religious maladjustment;
- Behavior disorders;
- Impulse control disorders;
- Learning disabilities;
- Mental retardation;
- Chronic organic brain syndrome;
- Personality disorder; or
- Transsexualism, psychosexual identity disorder, psychosexual dysfunction of gender dysphoria.

13.64 "Non-Plan Provider" means a Provider who does not have an independent contractor agreement with HPN.

13.65 "Occupational Illness or Injury" means any Illness or Injury arising out of or in the course of employment for pay or profit.
13.66 “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.

13.67 “Orthotic Devices” means an apparatus used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.

13.68 “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.

13.69 “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.

13.70 “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.

13.71 “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.

13.72 “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.

13.73 “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.

13.74 “Practitioner” means any person(s) qualified and licensed to practice the healing arts when they are acting within the scope of their license.

13.75 “Prescription Drug” means any required by federal law or regulation to be dispensed only by a prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.

13.76 “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.

13.77 “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.

13.78 “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.

13.79 “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.

13.80 “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.

13.81 “Provider” means a:
- Hospital,
- Skilled Nursing Facility,
- Urgent Care Facility,
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- Ambulatory Surgical Facility,
- Physician,
- Practitioner,
- dentist,
- podiatrist, or
- other person or organization licensed by the state where his practice is located to provide medical or surgical services, supplies, and accommodations acting within the scope of his license.

13.82 “Referral” means a recommendation for a Member to receive a service or care from another Provider or facility.

13.83 “Retransplant” means the retransplantation of a previously transplanted organ or tissue.

13.84 “Retrospective” or “Retrospectively” means a review of an event after it has taken place.

13.85 “Rider” means a provision added to the Agreement or the EOC to expand benefits or coverage.

13.86 “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.

13.87 “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), published by the American Psychiatric Association:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder.

13.88 “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.

13.89 “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.

13.90 “Skilled Nursing Care” means services requiring the skill, training or supervision of licensed nursing personnel.

13.91 “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.

13.92 “Special Enrollee” means an Eligible Employee or Eligible Family Member who applies for coverage during a Special Enrollment Period following a Special Enrollment Event.

13.93 “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.

13.94 “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.
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13.95 “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.

13.96 “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.

13.97 “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.

13.98 “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.

13.99 “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.

13.100 “Telemedicine” means certain Covered Services for diagnosis and treatment of low acuity medical conditions delivered to HPN Members through the use of interactive audio, video, or other telecommunications or electronic technology by a contracted HPN Telemedicine Provider listed as such in the HPN Provider Directory at a site other than the site at which the patient is located. Telemedicine is available in all states where HPN contracted Telemedicine Providers offer telemedicine services. Telemedicine does not include the use of standard telephone calls, facsimile transactions or e-mail messaging and is only available through designated providers listed as Telemedicine Providers in the HPN Provider Directory.

13.101 “Therapeutic Supply” is 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.

13.102 “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.

13.103 “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:
- the date 365 days after the date of the transplant;
- the date when the Member is no longer covered under this Plan, whichever is earlier.

13.104 “Transplant Facility” means a Hospital that has an independent contractor agreement or other contractual relationship with HPN to provide Covered Services related to a Covered Transplant Procedure as defined in this EOC. Non-Plan Hospitals do not have agreements with HPN to provide such services.

13.105 “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
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Care service was denied, the Member could request an Expedited Appeal for the Urgent Care Claim.

13.106 “Urgent Care Facility” means a facility equipped and operated mainly to give immediate treatment for an acute Illness or Injury.

13.107 “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.

13.108 “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.
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 Areas commenced in August 1982.
**Health Plan of Nevada**
A UnitedHealthcare Company

**HPN Solutions HMO 15 V2**

Attachment A Benefit Schedule

The Calendar Year Out of Pocket Maximum is $6,000 per Member and $12,000 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.

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required*</th>
<th>Tier I HMO Plan Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Office Visits and Consultations in a Medical Office Setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Primary Care Services</td>
<td>No</td>
<td>Member pays $5 per visit.</td>
</tr>
<tr>
<td>Convenient Care Facility</td>
<td></td>
<td>Member pays $5 per visit.</td>
</tr>
<tr>
<td>Physician Extender or Assistant</td>
<td></td>
<td>Member pays $15 per visit.</td>
</tr>
<tr>
<td>Physician</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>• Specialist Services</td>
<td>No</td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td><strong>Preventive Healthcare Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Services include various recommended exams, immunizations, diagnostic tests and screenings. Refer to the HPN Preventive Guidelines on the HPN website (<a href="http://www.healthplanofnevada.com">www.healthplanofnevada.com</a>) located under the “Members &amp; Guests” tab or contact the Member Services Department (702-242-7300) for the complete list of covered Adult and Pediatric Preventive Services and Immunizations. These guidelines are updated in accordance with the Federal Government standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Lab and X-ray services provided and billed by the Physician’s office.</strong> (Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician’s office.)</td>
<td>Yes</td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td>• Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• X-Ray</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Benefit Schedule

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required*</th>
<th>Tier I HMO Plan Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telemedicine Services</strong> <em>(Only available through select Providers.)</em></td>
<td>No</td>
<td>Member pays $5 per visit.</td>
</tr>
<tr>
<td><strong>Laboratory Services – Outpatient</strong> <em>Performed at an independent facility.</em></td>
<td>Yes</td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td><strong>Routine Radiological and Non-Radiological Diagnostic Imaging Services</strong> <em>Performed at a Free-Standing Diagnostic Center.</em></td>
<td>Yes</td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgent Care Facility</td>
<td>No</td>
<td>Member pays $30 per visit.</td>
</tr>
<tr>
<td>• Emergency Room Visit</td>
<td>No</td>
<td>Member pays $150 per visit; waived if admitted.</td>
</tr>
<tr>
<td>• Hospital Admission – Emergency Stabilization <em>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</em></td>
<td>No</td>
<td>Member pays $300 per admission.</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency Transport</td>
<td>No</td>
<td>Member pays $0 per trip.</td>
</tr>
<tr>
<td>• Non-Emergency – HPN Arranged Transfers</td>
<td>Yes</td>
<td>Member pays $0.</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Facility Services</strong> <em>Elective and Emergency Post-Stabilization Admissions</em></td>
<td>Yes</td>
<td>Member pays $300 per admission.</td>
</tr>
<tr>
<td><strong>Outpatient Surgery at a Hospital Facility</strong></td>
<td>Yes</td>
<td>Member pays $50 per surgery.</td>
</tr>
<tr>
<td><strong>Ambulatory Surgical Facility Services</strong></td>
<td>Yes</td>
<td>Member pays $50 per surgery.</td>
</tr>
<tr>
<td><strong>Anesthesia Services</strong></td>
<td>Yes</td>
<td>Member pays $0 per surgery.</td>
</tr>
<tr>
<td><strong>Physician Surgical Services – Inpatient and Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient or Outpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $0 per surgery.</td>
</tr>
<tr>
<td>• Ambulatory Surgical Facility</td>
<td>Yes</td>
<td>Member pays $0 per surgery.</td>
</tr>
<tr>
<td>• Physician’s Office Primary Care Physician (Includes all physician services related to the surgical procedure)</td>
<td>No</td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td>• Specialist (Includes all physician services related to the surgical procedure)</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
</tbody>
</table>
## Covered Services and Limitations

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Referral or Prior Auth. Required*</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastric Restrictive Surgery Services</td>
<td>Yes</td>
<td>HPN pays 50% of EME. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Physician Surgical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Office Visit</td>
<td></td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>Organ and Tissue Transplant Surgical Services</td>
<td>Yes</td>
<td>Member pays $300 per admission.</td>
</tr>
<tr>
<td>• Inpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $0 per surgery.</td>
</tr>
<tr>
<td>• Physician Surgical Services – Inpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $0. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Transportation, Lodging and Meals</td>
<td>Yes</td>
<td>Member pays $0.</td>
</tr>
<tr>
<td>- 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Procurement</td>
<td>Yes</td>
<td>HPN pays 50% of EME. Subject to maximum benefit.</td>
</tr>
<tr>
<td>- Benefits for procurement procedures and/or services are limited to those deemed by HPN to be Medically Necessary and appropriate for an approved Organ Transplant in a single Transplant Benefit Period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Retransplantation Services</td>
<td>Yes</td>
<td>HPN pays 50% of EME. Subject to maximum benefit.</td>
</tr>
<tr>
<td>- Benefits are limited to one (1) Medically Necessary Retransplantation per Member per type of transplant.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Cataract Surgical Services</td>
<td>Yes</td>
<td>$10 per pair of glasses. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Frames and Lenses</td>
<td>Yes</td>
<td>$10 per set of contact lenses. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Contact Lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Benefits are limited to one (1) Medically Necessary pair of glasses or set of contact lenses as applicable per Member per surgery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Healthcare Services (does not include Specialty Prescription Drugs)</td>
<td>Yes</td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td>- Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drugs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Covered Services and Limitations

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required*</th>
<th>Tier I HMO Plan Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospice Facility</td>
<td>Yes</td>
<td>Member pays $300 per admission.</td>
</tr>
<tr>
<td>• Outpatient Hospice Services</td>
<td>Yes</td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td>• Inpatient and Outpatient Respite Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Yes</td>
<td>Member pays $300 per admission. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bereavement Services</td>
<td>Yes</td>
<td>Member pays $15 per visit.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td>Subject to maximum benefit.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>Yes</td>
<td>Member pays $300 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.</td>
</tr>
<tr>
<td>Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Manual Manipulation</strong></td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>Applies to Medical-Physician Services and Chiropractic office visit. Subject to a maximum benefit of sixty (60) visits per Member per Calendar Year.</td>
<td></td>
<td>Subject to maximum benefit.</td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation and Habilitative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $300 per admission. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>All Inpatient and Outpatient Short Term Rehabilitation and Habilitative Services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.</td>
<td></td>
<td>Subject to maximum benefit.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>Yes</td>
<td>Member pays $100 or 50% of EME of purchase or monthly rental price, whichever is less. Subject to maximum benefit.</td>
</tr>
<tr>
<td>Monthly rental or purchase at HPN’s option. Purchases are limited to a single purchase of a type of DME, including repair and replacement, every three (3) years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Services and Limitations</td>
<td>Referral or Prior Auth. Required*</td>
<td>Tier I HMO Plan Provider Benefit</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Genetic Disease Testing Services</strong></td>
<td>Yes</td>
<td>Member pays $25 per visit. HPN pays 75% of EME.</td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • Lab  
  *Includes Inpatient, Outpatient and independent Laboratory Services.* | | |
| **Infertility Office Visit Evaluation** | Yes | Member pays $25 per visit. |
| *Please refer to applicable surgical procedure Copayment/Cost-share herein for any surgical infertility procedures performed.* | | |
| **Medical Supplies** | Yes | Member pays $0. |
| **Other Diagnostic and Therapeutic Services** | Yes | |
| *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.* | | Member pays $15 per day. |
| • Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services. | | |
| • Dialysis | | Member pays $15 per day. |
| • Therapeutic Radiology | | Member pays $15 per day. |
| • Allergy Testing and Serum Injections | | Member pays $15 per visit. |
| • Otologic Evaluations | | Member pays $15 per visit. |
| • Other complex diagnostic imaging services such as CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services. | | Member pays $15 per test or procedure. |
| • Positron Emission Tomography (PET) scans | | Member pays $475 per test. |
| **Prosthetic Devices** | Yes | Member pays $750 per device. Subject to maximum benefit. |
| *Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.* | | |
| **Orthotic Devices** | Yes | Member pays $50 per device. Subject to maximum benefit. |
| *Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.* | | |
## Covered Services and Limitations

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required*</th>
<th>Tier I HMO Plan Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Management and Treatment of Diabetes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Education and Training</td>
<td>No</td>
<td>Member pays $15 per visit.</td>
</tr>
<tr>
<td>• Supplies (except for Insulin Pump Supplies)</td>
<td>No</td>
<td>Member pays $5 per therapeutic supply.</td>
</tr>
<tr>
<td>Insulin Pump Supplies</td>
<td>Yes</td>
<td>Member pays $10 per therapeutic supply.</td>
</tr>
<tr>
<td>• Equipment (except for Insulin Pump)</td>
<td>Yes</td>
<td>Member pays $20 per device.</td>
</tr>
<tr>
<td>Insulin Pump</td>
<td>Yes</td>
<td>Member pays $100 per device.</td>
</tr>
<tr>
<td>Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Special Food Products and Enteral Formulas</strong></td>
<td>Yes</td>
<td>Member pays $0. Subject to maximum benefit.</td>
</tr>
<tr>
<td>Special Food Products only are limited to a maximum benefit of one (1) thirty (30) day therapeutic supply per Member four (4) times per Calendar Year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Treatment</strong></td>
<td>Yes</td>
<td>HPN pays 50% of EME.</td>
</tr>
<tr>
<td><strong>Mental Health and Severe Mental Illness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $300 per admission.</td>
</tr>
<tr>
<td>• Outpatient Treatment</td>
<td>Yes</td>
<td>Member pays $15 per visit.</td>
</tr>
<tr>
<td><strong>Substance Abuse Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $300 per admission.</td>
</tr>
<tr>
<td>• Outpatient Treatment</td>
<td>Yes</td>
<td>Member pays $15 per visit.</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>Yes</td>
<td>Member pays $100 or 50% of EME of purchase price, whichever is less. Subject to maximum benefit.</td>
</tr>
<tr>
<td>Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Applied Behavioral Analysis (ABA) for the treatment of Autism</strong></td>
<td>Yes</td>
<td>Member pays $15 per visit. Subject to maximum benefit.</td>
</tr>
<tr>
<td>Limited to two hundred fifty (250) visits not to exceed seven hundred fifty (750) total hours of therapy per Member per Calendar Year.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A Member’s 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.

Please note: For all Inpatient and Outpatient admissions, including those for Emergency or Urgent Care, in addition to specified surgical Copayment/cost-share amounts, Member is also responsible for all other applicable facility and professional Copayments/cost-share as outlined in the Attachment A Benefit Schedule.

Member is responsible for any and 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.

*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 Abuse 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.
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.
State of Nevada Gender Identity Disorder Treatment Rider

Lifetime Maximum Benefit: Unlimited

This Rider is a supplement to the Health Plan of Nevada, Inc. (HPN) Evidence of Coverage (EOC) and Attachment A Benefit Schedule and amends your coverage to include benefits for Gender Identity Disorder Treatment. Gender Identity Disorder is also referred to as: sex transformation, sex change, sex reversal, gender change, intersex surgery, transsexual surgery, transgender surgery and sex or gender reassignment.

This coverage is subject to the applicable terms, conditions, limitations and exclusions contained in your HPN EOC and herein.

SECTION 1. Covered Services

All covered Sex Transformation services are subject to the provisions of HPN’s Managed Care Program and all other terms and provisions of the HPN EOC.

Covered Services include limited benefit coverage for Prior Authorized medical treatment for Transgender Services as follows:

1. **Psychotherapy.** Benefit coverage includes Transgender and associated co-morbid psychiatric diagnoses provided as any other outpatient Mental Health Service under the Plan.

2. **Continuous Hormone Replacement Therapy.** Benefit coverage includes eligible prescription hormones injected by a medical Provider during an office visit. The Member must meet all of the following eligibility qualifications for hormone replacement (in addition to the Plan’s overall eligibility requirements as shown in Section 1. of the EOC):
   - Be at least 18 years or older for hormones to change physical characteristics; and
   - Demonstrate knowledge of what hormones medically can and cannot do and their social benefits and risks; and
   - The Member must meet the definition of Transgender; and
   - Initial hormone replacement therapy must be preceded by:
     a. A documented real-life experience (living as the other gender) of at least three (3) months prior to the administration of hormones; or
     b. A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three (3) months).

Benefits for oral and self-injectable hormone replacement treatment therapies are only payable when such therapies are obtained from a Designated Plan Pharmacy and as set forth in the applicable provisions of your HPN Outpatient Prescription Drug Benefit Rider to the HPN EOC. Please refer to your HPN Outpatient Prescription Drug Benefit Rider for applicable coverage and exclusion terms.

3. **Laboratory Testing.** Benefit coverage includes laboratory testing to monitor continuous hormone replacement therapy provided as any other outpatient diagnostic service under the Plan.
4. **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:

- Complete hysterectomy;
- Orchiectomy;
- Penectomy;
- Vaginoplasty;
- Clitoroplasty;
- Labiaplasty;
- Salpingo-oophorectomy;
- Mediodioplasty;
- Scrotoplasty;
- Urethroplasty;
- Placement of testicular prosthesis;
- Phalloplasty;
- Thyroid chondroplasty (removal of the Adam’s Apple);
- Bilateral mastectomy; and
- Augmentation mammoplasty (including breast prosthesis if necessary) if the Physician prescribing hormones and the surgeon have documentation that breast enlargement after undergoing hormone therapy for eighteen (18) months is not sufficient for comfort in the social role.

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

1. The surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender identity disorder;

2. The treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH) standards;

3. The Member must be age eighteen (18) years or older for irreversible surgical interventions;

4. The Member must complete twelve (12) months of continuous hormone therapy for those without contraindications;

5. The Member must complete twelve (12) months of successful continuous full time real life experience in the desired gender;

6. The Member must meet the definition of Transgender;

HPN makes no representation or warranty as to the medical competence or ability of any Gender Identity Disorder 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 Identity Disorder Treatment Center/Facility or its respective staff or Physicians

### Section 2. Limitations.

2.1 Prior Authorization is required.

2.2 Gender Identity Disorder Treatment Services are covered under the Tier I HMO benefit.

2.3 Benefits are limited to one sex transformation reassignment per lifetime, which may include several staged procedures.

2.4 Sterilization surgery is not required in order to receive the covered services under this Rider.

2.5 Copayment amounts paid by the Member do not accumulate to the calculation of the Calendar Year Copayment Maximum.

### SECTION 3. Exclusions

3.1 Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;

3.2 Sperm preservation in advance of hormone treatment or gender surgery;
Gender Identity Disorder Treatment Rider

3.3 Cryopreservation of fertilized embryos;

3.4 Surgical treatment not Prior Authorized by HPN;

3.5 Voice modification surgery;

3.6 Facial feminization surgery, including but not limited to: facial bone reduction, face “lift”, facial hair removal and certain facial plastic reconstruction;

3.7 Suction-assisted lipoplasty of the waist;

3.8 Rhinoplasty, blepharoplasty, blepharoptosis and brow ptosis repair, unless Medically Necessary and Prior Authorized;

3.9 Surgical or hormone treatment on Members under eighteen (18) years of age;

3.10 Drugs for hair loss or growth;

3.11 Drugs for sexual performance or cosmetic purposes (except for hormone therapy described in Section 1.2, herein);

3.12 Voice therapy;

3.13 Services that exceed the maximum dollar limit of this Rider; and

3.14 Transportation, meals, lodging or other similar expenses.

SECTION 4. Glossary

4.1 “Gender Identity Disorder” means a condition characterized by the following diagnostic criteria:

a. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex);

b. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex;

c. The disturbance is not concurrent with a physical intersex condition;

d. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
GENDER IDENTITY DISORDER TREATMENT
BENEFIT SCHEDULE

Lifetime Maximum Benefit: Unlimited

<table>
<thead>
<tr>
<th>Gender Identity Disorder Treatment Covered Services and Limitations</th>
<th>Prior Auth Required</th>
<th>Tier I HMO Benefit (Member is responsible for all amounts exceeding EME)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
<td>Yes</td>
<td>50% of EME. Subject to maximum benefit.</td>
</tr>
<tr>
<td>Physician Services and Physician Consultations</td>
<td>Yes</td>
<td>50% of EME. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Office Visit</td>
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<tr>
<td>• Office Consultation</td>
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<td>• Inpatient Visit</td>
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<tr>
<td>• Inpatient Consultation</td>
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</tbody>
</table>

IMPORTANT NOTE: Copayment amounts paid by the Member do not accumulate to the calculation of the Calendar Year Copayment Maximum.
3-Tier Outpatient Prescription Drug Rider to the HPN Group Evidence of Coverage

Please refer to the HPN Prescription Drug List (PDL) for the listing of Covered Drugs.

Plan Retail Prescription Drug Benefits

**Tier I:** Member pays
$7 Copayment per Designated Plan Pharmacy Therapeutic Supply

**Tier II:** Member pays
$35 Copayment per Designated Plan Pharmacy Therapeutic Supply

**Tier III:** Member pays
$55 Copayment per Designated Plan Pharmacy Therapeutic Supply

Plan Mail Order Prescription Drug Benefit

Member pays:

2.5 times the applicable Tier Copayment per Plan Mail Order Pharmacy Therapeutic Supply

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.

SECTION 1. Obtaining Covered Drugs

Benefits for Covered Drugs are payable under the terms of this Rider subject to the following conditions:

- **A Designated** Plan Pharmacy must dispense the Covered Drug, except as otherwise specifically provided in Section 1.2 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

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.
applicable Tier I, II or III benefit level. 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 have an arrangement to provide those Covered Drugs.

1.1 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.

(a). Tier I – is the low cost option for Covered Drugs.
(b). Tier II – is the midrange cost option for Covered Drugs.
(c). Tier III – is the high cost option for Covered Drugs.
(d). Mandatory Generic benefit provision applies when:
   • a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The Member will pay the Covered Copayment plus the difference between the Eligible Medical Expenses (“EME”) of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Designated Plan Pharmacy for each Therapeutic Supply.

(e). When a Drug is dispensed through the Mail Order Plan Pharmacy, the applicable Tier I, Tier II, or Tier III Mail Order Plan Pharmacy benefit tier will apply per Therapeutic Supply.

1.2 Emergency or Urgently Needed Services Prescription Drugs

(a). 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 Copayment amount subject to the applicable Tier I, Tier II or Tier III benefit.

(b). 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 Section 1.3 below.

1.3 Non-Plan Pharmacy Benefit Payments

(a). In order that claims for Covered Drugs obtained at a Non-Plan Pharmacy 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.

(b). Benefit payments are subject to the limitations and exclusions set forth in the HPN EOC and this Rider as follows:

1. When any Covered Drug is dispensed, the benefit payment will be subject to HPN’s EME and the applicable Tier I, II or III Copayment amount. 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 EME of the Generic Covered Drug less the applicable tier copayment. The Member is responsible for any amounts exceeding HPN’s benefit payment.

3. No benefits are payable if HPN’s EME of the Covered Drug is less than the applicable Copayment.

1.4 Mail Order Plan Pharmacy Benefit Payments

(a). Benefits for Covered Drugs are available when dispensed by an HPN Mail Order Plan Pharmacy subject to the applicable Tier I, Tier II or Tier III Mail Order benefit.

(b). Information on how to obtain Mail Order Drugs is provided in the Mail Order Brochure provided after enrollment with HPN.

SECTION 2. Limitations

2.1 Prior Authorization or Step Therapy may be required for certain Covered Drugs.

2.2 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.

2.3 Benefits for prescriptions for Mail Order Drugs submitted following HPN’s receipt of notice of individual’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 individual.

2.4 Benefits are not payable if you are directed to a Designated Plan Pharmacy and you choose not to obtain your Covered Drug from that Designated Plan Pharmacy.

2.5 If HPN determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Plan Pharmacies may be limited. If this happens, HPN may require you to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if you use the assigned single Plan Pharmacy. If you do not make a selection within thirty-one (31) days of the date you are notified, then HPN will select a single Plan Pharmacy for you.

SECTION 3. Exclusions

No benefits are payable for the following drugs, devices and supplies as well as for any complications resulting from their use except when prescribed in connection with the treatment of Diabetes:

3.1 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.

3.2 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.

3.3 Devices of any type, including those prescribed by a licensed Provider, except for prescription contraceptive devices.
3.4 Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

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

3.6 Medications used for cosmetic purposes.

3.7 Prescription Drug Products when prescribed to treat infertility.

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

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

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

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

3.12 Prescription Drugs dispensed prior to the Member’s Effective Date of coverage or after Member’s termination date of coverage under the Plan.

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

3.14 Drugs 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.

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

3.16 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.

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

3.18 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.

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

3.20 Medical supplies unless listed on the PDL or Prior Authorized by HPN.

3.21 Coverage for Prescription Drugs for the amount dispensed (days’ supply or quantity limit) which exceeds the supply limit.

3.22 Coverage for Prescription Drugs for the amount dispensed (days’ supply or quantity limit) which is less than the minimum supply limit.

3.23 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).

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

3.25 Experimental or 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.

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

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

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

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

3.30 Unit dose packaging of Prescription Drugs.

SECTION 4. Glossary

4.1 “Brand Name Drug” is a Prescription Drug which is marketed under or protected by:
  • a registered trademark;
  • or a registered trade name;
  • or a registered patent.

4.2 “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.

4.3 “Covered Drug” is 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, subject to 3.16 herein;
  • 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.

4.4 “Copayment” means the amount the Member pays when a Covered Service is received.

4.5 “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 Rider, 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.

4.6 “Dispensing Period” as established by HPN means 1) a predetermined period of time; or 2) a period of time up to a
PRESCRIPTION DRUG RIDER

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.

4.7 “Eligible Medical Expense (EME)” for purposes of this Rider, means the Plan Pharmacy’s contracted cost of the Covered Drug to HPN but not more than the actual charge to the Member.

4.8 “Generic Drug” is an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.

4.9 “Mail Order Plan Pharmacy” is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide certain Tier I, Tier II and Tier III Drugs to Members by mail.

4.10 “Non-Plan Pharmacy” is a duly licensed pharmacy that does not have an independent contractor agreement with HPN to provide Covered Drugs to Members.

4.11 “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.

4.12 Prescription Drug List (PDL)” means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by HPN.

4.13 “Prescription Drug” is any drug required by federal law or regulation to be dispensed upon written prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.

4.14 “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.

4.15 “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.

4.16 “Therapeutic Equivalent” means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.

4.17 “Therapeutic Supply” is the maximum quantity of a Covered Drug for which benefits are available for the applicable Drug Fee or the applicable Coinsurance amount and may be less than but shall not exceed a 30-day retail supply or 90-day mail order supply.

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.

HPN may periodically change the placement of a Prescription Drug among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

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. As a result of such changes, you may be required to pay more or less for that Prescription Drug.
Vision Care Services Rider
Option 6: 12/12/24/10-10-100

The Member Handbook and Evidence of Coverage ("EOC") between the Group and Health Plan of Nevada, Inc. (HPN), to which this Vision Care Services Rider ("Rider") is attached and incorporated therein, is amended to include the following vision care services:

SECTION 1. Vision Care Services

Subject to all 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) Lenses and Frames are prescribed by a Plan Provider and (b) the prescription was ordered while the Member was enrolled in HPN.

1.1 Examination
One 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 12 consecutive calendar month period.

1.2 Lenses
One pair of Lenses will be provided during any 12 consecutive calendar month period, without charge, if a prescription change is determined to be Medically Necessary by a Plan Provider. Lenses are limited to single vision, bifocal, trifocal, lenticular and other complex Lenses.

1.3 Frames
Expenses incurred in connection with Frames, from an approved frame selection, will be considered covered vision expenses once during each 24 consecutive calendar month period, up to a maximum allowance of $100.00. Charges for Frames in excess of the maximum allowance shall be the responsibility of the Member. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.

1.4 Contact Lenses
Contact Lenses will be provided if a Member’s visual acuity cannot be corrected to 20/70 in the better eye except for the use of Contact Lenses. In such event, Contact Lenses will be provided once during any 12 consecutive calendar month period. Contact Lenses are limited to single vision spherical Lenses. Such Covered Expenses shall be subject to a maximum allowance of $250.00. Charges for Contact Lenses in excess of the maximum allowance shall be the responsibility of the Member. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.

In addition, expenses incurred in connection with the purchase of one pair of Contact Lenses prescribed by a Plan Provider may be considered covered vision expenses, regardless of any visual acuity correction standards described above, on the condition that the Member elects to receive an allowance for the purchase of such Contact Lenses in lieu of all other vision benefits described in this Rider once during any 12 consecutive month period (with the exception of the annual vision examination which shall continue to be
available). Such Covered Expenses shall be subject to a maximum allowance of $115. Charges for Contact Lenses in excess of the maximum allowance shall be the responsibility of the Member. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.

1.5 Copayments

Examination: A Copayment of $10.00 is required for each vision examination by a licensed Plan Provider.

Plastic Lenses: A Copayment of $10.00 is required for Plastic Lenses, including Single Vision, Bifocal, Trifocal or Lenticular.

SECTION 2. Exclusions

In addition to any other applicable exclusions in the EOC, benefits shall not be provided for:

1. Lenses, Frames and/or Contact Lenses not prescribed by a Plan Provider;
2. Lenses, Frames and/or Contact Lenses prescribed:
   a) before the effective date of coverage, or
   b) after termination of coverage;
3. replacement of Lenses, Frames and/or Contact Lenses which are lost or broken;
4. orthoptics or vision training;
5. medical or surgical treatment of the eyes;
6. services or materials provided under Workers’ Compensation; and
7. eye examinations required as a condition of employment or by a government body.

SECTION 3. Limitations

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 frame allowance;
- tinted or 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.


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

"Contact Lenses" shall mean 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.

"Frames" shall mean standard eyeglass Frames adequate to hold two Lenses.

"Lenses" shall mean ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Plan Provider to be fitted into Frames.

"Plan Provider" means an ophthalmologist or optometrist who has agreed under an independent contract to provide vision care services to Members.