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.
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, 2017

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, if we maintain a website for your particular health plan, 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.

• **For 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, call the phone number listed on your health plan ID card.

What Are Your Rights

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

- You have the right to ask to restrict uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.
- You have the right to ask to receive confidential Communications of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
• **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

• **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

• **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

• **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your plan website, such as [www.myHPOnline.com](http://www.myHPOnline.com) or [www.mySHLonline.com](http://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 on your health plan ID card or you may contact a Member Service Call Center Representative at 1-800-777-1840 (TTY 711).

• **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  Health Plan of Nevada/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.

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1This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD – Individual Practice Association, Inc.; Medica Health Plans of Florida, Inc.; Medica Healthcare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company; Unimerica Life Insurance Company of Nevada; Univera Life Insurance Company; Virginia Blue Cross and Blue Shield; Washington Blue Cross and Blue Shield; Wisconsin Blue Cross and Blue Shield; and the following health plans that are affiliated with UnitedHealth Group and Blue Cross and Blue Shield: Washington Blue Cross and Blue Shield (Washington, DC); West Virginia Blue Cross and Blue Shield; and Wisconsin Blue Cross and Blue Shield.
FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2017

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 Member Services at 1-800-777-1840 (TTY 711).

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2 For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 2, beginning on page six of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women’s and Children’s Health, LLC; AmeriChoice Health Services, Inc.; Connexionx HCI, LLC; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; LifePrint Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet,
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, 2017

The first part of this Notice, which provides our privacy practices for Medical Information (pages 1-5), 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

| Alcohol & Drug Abuse Information | 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. |
| Genetic Information | We are not allowed to use genetic information for underwriting purposes. |

### Summary of State Laws

| General Health Information | We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients. |
| HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions. | AR, CA, DE, NE, NY, PR, RI, VT, WA, WI |
| You may be able to restrict certain electronic disclosures of health information. | KY |
| We are not allowed to use health information for certain purposes. | NC, NV |
| We will not use and/or disclose information regarding certain public assistance programs except for certain purposes. | CA, IA |
| We must comply with additional restrictions prior to using or disclosing your health information for certain purposes. | KY, MO, NJ, SD |
| Prescriptions | We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients. |
| Communicable Diseases | We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients. |
| Sexually Transmitted Diseases and Reproductive Health | We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients. |
| Alcohol and Drug Abuse | We are allowed to use and disclose alcohol and drug abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients. |
## Summary of State Laws

<table>
<thead>
<tr>
<th>Category</th>
<th>States/Provinces</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.</strong></td>
<td>WA</td>
<td></td>
</tr>
<tr>
<td><strong>Genetic Information</strong></td>
<td>CA, CO, KS, KY, LA, NY, RI, TN, WY</td>
<td></td>
</tr>
<tr>
<td>We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
<td>AK, AZ, FL, GA, IL, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT</td>
<td></td>
</tr>
<tr>
<td>Restrictions apply to (1) the use, and/or (2) the retention of genetic information.</td>
<td>FL, GA, IA, LA, MD, NM, OH, UT, VA, VT</td>
<td></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, OR, PA, PR, RI, TX, VT, WV, WA, WI</td>
<td></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>WA, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, OR, PA, PR, RI, TX, VT, WV, WA, WI</td>
<td></td>
</tr>
<tr>
<td>Certain restrictions apply to oral disclosures of HIV/AIDS-related information.</td>
<td>CT, FL</td>
<td></td>
</tr>
<tr>
<td>We will collect certain HIV/AIDS-related information only with your written consent.</td>
<td>OR</td>
<td></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>
<td></td>
</tr>
<tr>
<td>Disclosures may be restricted by the individual who is the subject of the information.</td>
<td>WA</td>
<td></td>
</tr>
<tr>
<td>Certain restrictions apply to oral disclosures of mental health information.</td>
<td>CT</td>
<td></td>
</tr>
<tr>
<td>Certain restrictions apply to the use of mental health information.</td>
<td>ME</td>
<td></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>
<td></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>
<td></td>
</tr>
</tbody>
</table>
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.
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## 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>X, Does not apply</td>
<td>X</td>
<td>X</td>
<td>This screening test (ultrasound) is a one time test for men between the ages of 65 to 75 years old who have ever smoked.</td>
</tr>
<tr>
<td>Alcohol Misuse: Screening and Behavioral Counseling Intervention in Primary Care to Reduce Alcohol Misuse.</td>
<td>X, X, X</td>
<td>X</td>
<td>X</td>
<td>These are screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.</td>
</tr>
<tr>
<td>Breast Cancer Screening: Screening Mammography</td>
<td>Does not apply</td>
<td>X</td>
<td>X</td>
<td>The mammography screening test with or without clinical breast examination 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>Does not apply</td>
<td>X</td>
<td>X</td>
<td>This counseling is for women who have family members with breast, ovarian, tubal, or peritoneal cancer.</td>
</tr>
<tr>
<td>Breastfeeding: Primary Care Interventions to Promote Breastfeeding</td>
<td>Does not apply</td>
<td>X</td>
<td>X</td>
<td>Interventions included in primary care or OB visits during pregnancy and after birth to promote and support breastfeeding.</td>
</tr>
<tr>
<td>Chemoprevention for Breast Cancer (Counseling)</td>
<td>Does not apply</td>
<td>X</td>
<td>X</td>
<td>This discussion by a provider focuses on the topic of medications to reduce risk with women at high risk for breast cancer and at low risk for harmful events of these medications. The discussion should inform the patients of the potential benefits and harms of chemoprevention.</td>
</tr>
<tr>
<td>Cervical Cancer Screening or Pap Smear</td>
<td>Does not apply</td>
<td>X</td>
<td>X</td>
<td>A screening for cervical cancer in women ages 21 to 65 years (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 pap smear and human papillomavirus (HPV) testing every 5 years.</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>Chlamydia Infection Screening</td>
<td>Male</td>
<td></td>
<td></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. This screening is for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cholesterol Screening (Lipid Disorders Screening)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This screening test is for men aged 20-35 and women over age 20 that are at increased risk for coronary heart disease, and for all men aged 35 and older.</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (Fecal Occult Blood Test, Sigmoidoscopy or Colonoscopy)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>The screening test is for all adults aged 50-75 years. Screening can be done by an annual high-sensitivity fecal occult blood testing (FOBT) or, a sigmoidoscopy every 5 years with high-sensitivity FOBT every 3 years or, a screening colonoscopy every 10 years.</td>
</tr>
<tr>
<td>Contraceptive Methods (including sterilizations)</td>
<td>Does not apply</td>
<td>X</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>Depression: Screening for Depression in Adults</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>This screening test is only for adults to assure accurate diagnosis, effective treatment, and follow-up.</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 for adults who do not have symptoms and have a sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.</td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>Does not apply</td>
<td>X</td>
<td>X</td>
<td>This screening test is for all sexually active women, including pregnant women, if they are at increased risk for infection.</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 intensive behavioral dietary counseling is for adults with hyperlipidemia and other known risk factors for heart and diet-related chronic disease. This counseling can be delivered by primary care providers or by referral to other specialists, such as nutritionists or dietitians.</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>Hearing Screening (newborn)</td>
<td>Male</td>
<td>X</td>
<td>Does not apply</td>
<td>Newborns only</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This screening is for all newborn infants from birth to 90 days old.</td>
</tr>
<tr>
<td>hepatitis B Virus Infection Screening</td>
<td>Male</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This screening test is for all persons at high risk for infection.</td>
</tr>
<tr>
<td>hepatitis C Virus Infection Screening</td>
<td>Male</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This screening test is for all persons at high risk for infection. For persons born between 1945 and 1965, a one-time screening test should be offered.</td>
</tr>
<tr>
<td>High Blood Pressure: Screening for High Blood Pressure</td>
<td>Male</td>
<td>X</td>
<td>X</td>
<td>This screening test is only for adults</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This screening test is for adults 18 years of age and older and is included in a preventive care wellness examination.</td>
</tr>
<tr>
<td>HIV: Human Immunodeficiency Virus – Screening for Adolescents and Adults.</td>
<td>Male</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></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>Male</td>
<td>Does not apply</td>
<td>X</td>
<td>Does not apply</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This screening test is performed every 3 years for women who are 30 years or older and have normal pap smear results.</td>
</tr>
<tr>
<td>Hypothyroidism Screening (newborn)</td>
<td>Male</td>
<td>X</td>
<td>Does not apply</td>
<td>Newborns only</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This screening test is for all newborn infants from birth to 90 days old.</td>
</tr>
<tr>
<td>Intimate Partner Violence: Screening</td>
<td>Male</td>
<td>Does not apply</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This is to screen 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>Lung Cancer: Screening for Lung Cancer with Low-Dose Computer Tomography</td>
<td>Male</td>
<td>X</td>
<td>X</td>
<td>This screening test is only for adults</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This CT scan is an annual screening test for adults aged 55-80 years who have a 30 pack year smoking history and currently smoke or have quit within the past 15 years.</td>
</tr>
<tr>
<td>Metabolic Screening Panel (newborn)</td>
<td>Male</td>
<td>X</td>
<td>Does not apply</td>
<td>Newborns only</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This screening test is for all newborn infants from birth to 90 days old.</td>
</tr>
<tr>
<td>Obesity: Screening for Obesity in Adults</td>
<td>Male</td>
<td>X</td>
<td>X</td>
<td>This screening test is only for adults</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>X</td>
<td></td>
<td>This screening is for all adults. Patients with a body mass index (BMI) of 30 kg/m² or higher should be offered or referred to intensive counseling and behavioral interventions.</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>Obesity: Screening for Obesity in Children and Adolescents</td>
<td>Male</td>
<td>X</td>
<td>Female</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Newborns, Children and/or Teens</td>
<td>Does not apply</td>
<td>This screening is for children 6 years of age and older. Providers should offer or refer patients for intensive counseling and behavioral interventions.</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis Screening</td>
<td>Does not apply</td>
<td>X</td>
<td>X</td>
<td>This screening is for all women age 65 years of age and older, and in younger women whose risk is greater than or equal to that of a 65 year old white woman who has no additional risk factors.</td>
</tr>
<tr>
<td>Phenylketonuria (PKU) Screening</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>Newborns only</td>
</tr>
<tr>
<td>Prevention of Falls in Community-Dwelling Older Adults</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Community dwelling adults aged 65 and older at increased risk for falls should have exercise, physical therapy, and/or Vitamin D supplementation provided.</td>
</tr>
<tr>
<td>Prostate Cancer Screening (digital rectal exam or prostate specific antigen test)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>UnitedHealthcare covers prostate cancer screening 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>This screening test is for all women of childbearing age at their first clinical encounter.</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>High–intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.</td>
</tr>
<tr>
<td>Sickle Cell Disease Screening (newborn)</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>Newborns only</td>
</tr>
<tr>
<td>Skin Cancer Prevention (counseling)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Provide counseling to children, adolescents, and young adults with fair skin, aged 10 to 24 years about reducing exposure to ultraviolet radiation to prevent skin cancer.</td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>All persons at increased risk for syphilis infection and all pregnant women should be screened.</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>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>
<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>X</td>
</tr>
<tr>
<td>Screening for Visual Impairment in Children</td>
<td>X</td>
<td>X</td>
<td>Does not apply</td>
<td>X</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 and 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>
<tr>
<td>Screening</td>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia, Iron Deficiency Anemia Screening</td>
<td>This screening test is for pregnant women who do not have symptoms of anemia.</td>
<td></td>
<td></td>
<td></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 if later.</td>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational Diabetes Screening</td>
<td>This screening test is for asymptomatic women after 24 weeks of pregnancy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea 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>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV – Human Immunodeficiency Virus Infection Screening</td>
<td>This screening is for all pregnant women.</td>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td>This screening test is for all pregnant women.</td>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
<td></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 website at: www.cdc.gov.
2017 Recommended Immunizations for Children from Birth Through 6 Years Old

- **Birth**: HepB
- **1 month**: HepB, RV, DTaP, Hib
- **2 months**: HepB, RV, DTaP, Hib
- **4 months**: HepB, RV, DTaP, Hib
- **6 months**: HepB, RV, DTaP, Hib
- **12 months**: HepB, RV, DTaP, Hib
- **15 months**: HepB, RV, DTaP
- **18 months**: HepB, RV, DTaP
- **19–23 months**: HepB, RV
- **2–3 years**: HepB, RV
- **4–6 years**: HepB, RV

**Is your family growing?**

To protect your new baby and yourself against whooping cough, get a Tdap vaccine. The recommended time is the 27th through 36th week of pregnancy. Talk to your doctor for more details.

Shaded boxes indicate the vaccine can be given during the shown age range.

**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.

**FOOTNOTES:**
1. Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.
2. 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.
3. If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child’s doctor about additional vaccines he may need.

For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit www.cdc.gov/vaccines/parents

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

AMERICAN ACADEMY OF FAMILY PHYSICIANS

American Academy of Pediatrics

AMERICAN ACADEMY OF PEDIATRICS

DEDICATED TO THE HEALTH OF ALL CHILDREN™
2017 Vacunas recomendadas para niños, desde el nacimiento hasta los 6 años de edad

<table>
<thead>
<tr>
<th>Edad</th>
<th>Vacunas recomendadas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al nacer</td>
<td>HepB, DTaP, Hib, PCV, IPV</td>
</tr>
<tr>
<td>1 mes</td>
<td>HepB, RV, DTaP, Hib</td>
</tr>
<tr>
<td>2 meses</td>
<td>RV, DTaP</td>
</tr>
<tr>
<td>4 meses</td>
<td>RV, DTaP</td>
</tr>
<tr>
<td>6 meses</td>
<td>RV, DTaP</td>
</tr>
<tr>
<td>12 meses</td>
<td>HepB</td>
</tr>
<tr>
<td>15 meses</td>
<td>DTaP</td>
</tr>
<tr>
<td>18 meses</td>
<td>IPV</td>
</tr>
<tr>
<td>19-23 meses</td>
<td>Influenza (anual)</td>
</tr>
<tr>
<td>2-3 años</td>
<td>IPV</td>
</tr>
<tr>
<td>4-6 años</td>
<td>IPV</td>
</tr>
</tbody>
</table>

**NOTA:**
Si su hijo no recibió una de las dosis, no se necesita volver a empezar, sólo llévelo al pediatra para que le apliquen la siguiente. Consulte al médico de su hijo si tiene preguntas sobre las vacunas.

**NOTAS A PIE DE PÁGINA:**
* Se recomiendan dos dosis con un intervalo de por lo menos cuatro semanas para los niños de 6 meses a 8 años que reciben por primera vez la vacuna contra la influenza y para otros niños en este grupo de edad.

5 Se requieren 2 dosis de la vacuna HepA para brindar una protección duradera. La primera dosis de la vacuna HepA se debe administrar durante los 12 y los 23 meses de edad. La segunda dosis se debe administrar 6 a 18 meses después. La vacuna HepA se puede administrar a todos los niños de 12 meses de edad o más para protegerlos contra la hepatitis A. Los niños y adolescentes que no recibieron la vacuna HepA y tienen un riesgo alto deben vacunarse contra la hepatitis A.

Si su hijo tiene alguna enfermedad que lo pone en riesgo de contraer infecciones o si va a viajar al extranjero, consulte al pediatra sobre otras vacunas que pueda necesitar.

Para más información, llame a la línea de atención gratuita 1-800-CDC-INFO (1-800-232-4636) o visite www.cdc.gov/vaccines/parents

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DEDICATED TO THE HEALTH OF ALL CHILDREN®
<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>Vacciella vaccine</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, paralyis, death</td>
</tr>
<tr>
<td>Hib</td>
<td>Hib vaccine protects against Haemophilus influenzae 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, epiglottis (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, arthritis (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>Influenza (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.
<table>
<thead>
<tr>
<th>Enfermedad</th>
<th>Vacuna</th>
<th>Enfermedad transmitida por</th>
<th>Signos y síntomas de la enfermedad</th>
<th>Complicaciones de la enfermedad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicela</td>
<td>Vacuna contra la varicela.</td>
<td>Aire, contacto directo</td>
<td>Sartrullido, cansancio, dolor de cabeza, fiebre</td>
<td>Ampollas infectadas, trastornos hemorrágicos, encefalitis (inflamación del cerebro), neumonía (infección en los pulmones)</td>
</tr>
<tr>
<td>Difteria</td>
<td>La vacuna DTaP® protege contra la difteria.</td>
<td>Aire, contacto directo</td>
<td>Dolor de garganta, fiebre moderada, debilidad, inflamación de los ganglios del cuello</td>
<td>Inflamación del músculo cardíaco, insuficiencia cardíaca, coma, parálisis, muerte</td>
</tr>
<tr>
<td>Hib</td>
<td>La vacuna contra la Hib protege contra Haemophilus influenzae serotipo b.</td>
<td>Aire, contacto directo</td>
<td>Puede no causar síntomas a menos que la bacteria entre en la sangre</td>
<td>Meningitis (infección en las membranas que recubren el cerebro y la médula espinal), discapacidad intelectual, epiglotitis (infección que puede ser mortal en la que se bloquea la tráquea y origina graves problemas respiratorios) y neumonía (infección en los pulmones), muerte</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>La vacuna HepA protege contra la hepatitis A.</td>
<td>Contacto directo, comida o agua contaminada</td>
<td>Puede no causar síntomas, fiebre, dolor de estómago, pérdida del apetito, cansancio, vómito, ictericia (coloración amarilla de la piel y los ojos), orina oscura</td>
<td>Insuficiencia hepática, artralgia (dolor en las articulaciones), trastorno renal, pancreático y de la sangre</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>La vacuna HepB protege contra la hepatitis B.</td>
<td>Contacto con sangre o líquidos corporales</td>
<td>Puede no causar síntomas, fiebre, dolor de cabeza, debilidad, vómito, ictericia (coloración amarilla de los ojos y la piel) dolor en las articulaciones</td>
<td>Infección crónica del hígado, insuficiencia hepática, cáncer de hígado</td>
</tr>
<tr>
<td>Influenza (gripe)</td>
<td>La vacuna influenza protege contra la gripe o influenza.</td>
<td>Aire, contacto directo</td>
<td>Fiebre, dolor muscular, dolor de garganta, tos, cansancio extremo</td>
<td>Neumonía (infección en los pulmones)</td>
</tr>
<tr>
<td>Sarampión</td>
<td>La vacuna MMR** protege contra el sarampión.</td>
<td>Aire, contacto directo</td>
<td>Sartrullido, fiebre, tos, moqueo, conjuntivitis</td>
<td>Encefalitis (inflamación del cerebro), neumonía (infección en los pulmones), muerte</td>
</tr>
<tr>
<td>Paperas</td>
<td>La vacuna MMR** protege contra las paperas.</td>
<td>Aire, contacto directo</td>
<td>Inflamación de glándulas salivales (debajo de la mandíbula), fiebre, dolor de cabeza, cansancio, dolor muscular</td>
<td>Meningitis (infección en las membranas que recubren el cerebro y la médula espinal), encefalitis (inflamación del cerebro), inflamación de los testículos o los ovarios, sordera</td>
</tr>
<tr>
<td>Tosferina</td>
<td>La vacuna DTaP® protege contra la tosferina (pertussis).</td>
<td>Aire, contacto directo</td>
<td>Tos intensa, moqueo, apnea (interrupción de la respiración en los bebés)</td>
<td>Neumonía (infección en los pulmones), muerte</td>
</tr>
<tr>
<td>Poliomielitis</td>
<td>La vacuna IPV protege contra la poliomielitis.</td>
<td>Aire, contacto directo, por la boca</td>
<td>Puede no causar síntomas, dolor de garganta, fiebre, náuseas, dolor de cabeza</td>
<td>Parálisis, muerte</td>
</tr>
<tr>
<td>Infección neumocócica</td>
<td>La vacuna PCV protege contra la infección neumocócica.</td>
<td>Aire, contacto directo</td>
<td>Puede no causar síntomas, neumonía (infección en los pulmones)</td>
<td>Bacteriemia (infección en la sangre), meningitis (infección en las membranas que recubren el cerebro y la médula espinal), muerte</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>La vacuna RV protege contra el rotavirus.</td>
<td>Por la boca</td>
<td>Diarrea, fiebre, vómito</td>
<td>Diarrea intensa, deshidratación</td>
</tr>
<tr>
<td>Rubéola</td>
<td>La vacuna MMR** protege contra la rubéola.</td>
<td>Aire, contacto directo</td>
<td>Los niños infectados por rubéola a veces presentan sartrullido, fiebre y ganglios linfáticos inflamados</td>
<td>Muy grave en las mujeres embarazadas; puede causar aborto espontáneo, muerte fetal, parto prematuro, defectos de nacimiento</td>
</tr>
<tr>
<td>Tétano</td>
<td>La vacuna DTaP® protege contra el tétano.</td>
<td>Exposición a través de cortaduras en la piel</td>
<td>Rigidez del cuello y los músculos abdominales, dificultad para tragar, espasmos musculares, fiebre</td>
<td>Fractura de huesos, dificultad para respirar, muerte</td>
</tr>
</tbody>
</table>

* La vacuna DTaP® protege contra la difteria, el tétano y la neumonía.
** La vacuna MMR® protege contra el sarampión, las paperas y la rubéola.
### 2017 Recommended Immunizations for Children 7-18 Years Old

**Talk to your child’s doctor or nurse about the vaccines recommended for their age.**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Flu</th>
<th>Tdap</th>
<th>HPV</th>
<th>Meningococcal</th>
<th>Pneumococcal</th>
<th>Hepatitis B</th>
<th>Hepatitis A</th>
<th>Inactivated Polio</th>
<th>MMR</th>
<th>Chickenpox</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-8 Years</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>9-10 Years</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>11-12 Years</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>13-15 Years</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>16-18 Years</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**More Information:**
- Preteens and teens should get a flu vaccine every year.
- Preteens and teens should get one shot of Tdap at age 11 or 12 years.
- All 11-12 year olds should get 2-dose series of HPV vaccine at least 6 months apart. A 3-dose series is needed for those with weakened immune systems and those age 15 or older.
- All 11-12 year olds should get a single shot of a quadrivalent meningococcal conjugate vaccine (MenACWY). A booster shot is recommended at age 16.
- Teens, 16-18 years old, may be vaccinated with a MenB vaccine.

- **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.**
- **This shaded box indicates the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at www.cdc.gov/vaccines/pubs/AAP-ist.htm.**
- **This shaded box indicates the vaccine is recommended for children not at increased risk but who wish to get the vaccine after speaking to a provider.**
Información para los padres

2017: Vacunas recomendadas para los niños desde los 7 hasta los 18 años de edad

Hable con el médico o la enfermera de su hijo acerca de las vacunas recomendadas para su edad.

<table>
<thead>
<tr>
<th>Edad</th>
<th>Vacuna contra la influenza (gripe)</th>
<th>Vacuna Tdap (Tétanos, difteria, tosferina)</th>
<th>Vacuna contra el VPH (Virus del papiloma humano)</th>
<th>Vacuna antimeningocócica MenACWY</th>
<th>Vacuna neumocócica</th>
<th>Vacuna contra la hepatitis B</th>
<th>Vacuna contra la hepatitis A</th>
<th>Vacuna inactivadas contra la polio</th>
<th>Vacuna contra el sarampión, las paperas y la rubéola</th>
<th>Vacuna contra la varicela</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-8 Años</td>
<td>Los preadolescentes y adolescentes deben recibir una vacuna contra la influenza todos los años.</td>
<td>Los preadolescentes y adolescentes deben recibir una inyección de la vacuna Tdap a los 11 o 12 años de edad.</td>
<td>Todos los niños de 11 a 12 años deben recibir 2 dosis de la vacuna contra el VPH con un intervalo de por lo menos 6 meses. Aquellos con el sistema inmunológico debilitado y de 15 años de edad o más necesitan una serie de 3 dosis.</td>
<td>Todos los niños de 11 a 12 años deben recibir una dosis única de la vacuna antimeningocócica conjugada (MenACWY). Se recomienda una dosis de refuerzo a los 16 años.</td>
<td>Los adolescentes de 16 a 18 años pueden ser vacunados con la MenB.</td>
<td></td>
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<tr>
<td>9-10 Años</td>
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<tr>
<td>11-12 Años</td>
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<tr>
<td>13-15 Años</td>
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<tr>
<td>16-18 Años</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Además de las vacunas mencionadas, también se recomienda considerar las siguientes:
- Para el sarampión, las paperas y la rubéola, se recomienda una vacuna contra la rubéola a los 12 años de edad. Se debe administrar una segunda dosis a los 4-6 años de edad si no se administró una vacuna previa.
- Para la varicela, se recomienda una vacuna contra la varicela a los 12 años de edad.

Las casillas sombreadas indican cuándo se recomienda la vacuna para todos los niños, a menos que el médico le diga que su hijo no puede recibir en forma segura la vacuna.

Las casillas sombreadas indican que la vacuna debe administrarse a un niño que está poniéndose al día con las vacunas.

Las casillas sombreadas indican que la vacuna se recomienda para los niños con ciertas condiciones o situaciones de estilo de vida que los pone en mayor riesgo de enfermedades graves. Vea las recomendaciones específicas de las vacunas en [https://www.cdc.gov/vaccines/hcp/acip-recs/index.html](https://www.cdc.gov/vaccines/hcp/acip-recs/index.html) (en inglés).
Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Diphtheria (Can be prevented by Td vaccination)
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 bacteria can produce a toxin (poison) in the body that can cause a thick coating in the back of the nose or throat that makes it hard to breathe or swallow. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In serious cases, the illness can cause coma, paralysis, and even death.

Hepatitis A (Can be prevented by HepA vaccination)
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 can include fever, tiredness, poor appetite, vomiting, stomach pain, and sometimes jaundice (when skin and eyes turn yellow). An infected person may have no symptoms, may have mild illness for a week or two, may have severe illness for several months, or may rarely develop liver failure and die from the infection. In the U.S., about 100 people a year die from hepatitis A.

Hepatitis B (Can be prevented by HepB vaccination)
Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rash, joint pain, and jaundice. Symptoms of acute hepatitis B include fever, fatigue, loss of appetite, nausea, vomiting, pain in joints and stomach, dark urine, grey-colored stools, and jaundice (when skin and eyes turn yellow).

Human Papillomavirus (Can be prevented by HPV vaccination)
Human papillomavirus is a common virus. HPV is most common in people’s 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 vaccination)
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 vaccination)
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 a week, and coughing can last about 10 days. Measles can also cause pneumonia, seizures, brain damage, or death.

Meningococcal Disease (Can be prevented by meningococcal vaccination)
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 sudden onset of fever, headache, and stiff neck. Meningococcal bacteria also cause 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 systems, become developmentally disabled, or suffer seizures or strokes.

Mumps (Can be prevented by MMR vaccination)
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 by coming in contact with a contaminated object, like a toy. The mumps virus causes swollen salivary glands under the ears or jaw, fever, muscle aches, tiredness, abdominal pain, 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 results in decreased fertility.

Pertussis (Whooping Cough) (Can be prevented by Tdap vaccination)
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 half of children under 1 year of age who get pertussis must be hospitalized.

Pneumococcal Disease (Can be prevented by pneumococcal vaccination)
Pneumonia is an infection of the lungs that can be caused by the bacteria called pneumococcus. 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), and bacteremia (bloodstream infection). Sinus and ear infections are usually mild and are much more common than the more serious forms of pneumococcal disease. However, in some cases pneumococcal disease can be fatal or result in long-term problems, like brain damage and hearing 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 IPV vaccination)
Polio is caused by a virus that lives in an infected person’s throat and intestines. It spreads through contact with the stool of an infected person and through droplets from a sneeze or cough. Symptoms typically include sore throat, fever, tiredness, nausea, headache, or stomach pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, about 2 to 10 children out of 100 die because the virus affects the muscles that help them breathe.

Rubella (German Measles) (Can be prevented by MMR vaccination)
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 vaccination)
Tetanus is caused by bacteria found in soil, dust, and manure. The bacteria enter the body through a puncture, cut, or sore on the skin. When people are infected, the bacteria produce a toxin (poison) that causes muscles to become tight, which is very painful. Tetanus mainly affects the neck and 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. One to two out of 10 people who get tetanus die from the disease.

Varicella (Chickenpox) (Can be prevented by varicella vaccination)
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 the same air as an infected person. 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.
Enfermedades que se pueden prevenir con vacunas y las vacunas que las previenen

La difteria (Se puede prevenir con la vacuna DTP)

La difteria es una enfermedad muy contagiosa producida por una bacteria que afecta al sistema respiratorio, incluso los pulmones. La bacteria de la difteria se puede propagar de una persona a otra a través del contacto directo con las micro-gotas de la tos o el estornudo de una persona infectada. Cuando las personas están infectadas, estas bacterias pueden provocar una tos intensa y prolongada que puede durar hasta varias semanas. Los efectos de esta bacteria también pueden causar inflamación del moco del corazón, y, en algunos casos, falla cardíaca. En los casos graves, la enfermedad puede causar coma, parálisis y hasta la muerte.

La hepatitis A (Se puede prevenir con la vacuna HEP A)

La hepatitis A es una infección del hígado causada por el virus de la hepatitis A. El virus se transmite principalmente de persona a persona a través de la ruta fecal-oral. En otras palabras, el virus se puede recibir a partir del contacto con objetos, alimentos o bebidas contaminadas por las heces (esenciamento) de una persona infectada. Entre los síntomas se encuentran: fiebre, cansancio, pérdida del apetito, náuseas, malestar abdominal, ictericia (color amarillento de la piel y los ojos). Una persona infectada por el virus puede no tener síntomas, pero puede tener un caso leve de la enfermedad por una semana o dos, o puede tener un caso de la enfermedad por varios meses y en raras ocasiones presentar insuficiencia hepática y muerte de la infección. En los Estados Unidos, alrededor de 100 personas al año mueren en consecuencia de la hepatitis A.

La hepatitis B (Se puede prevenir con la vacuna HEP B)

La hepatitis B es una enfermedad que puede ser transmitida a través del contacto con objetos, alimentos o bebidas contaminadas por las heces (esenciamento) de una persona infectada. Entre los síntomas se encuentran: fiebre, cansancio, pérdida del apetito, náuseas, malestar abdominal, ictericia (color amarillento de la piel y los ojos). Una persona infectada por el virus puede no tener síntomas, pero puede tener un caso leve de la enfermedad por una semana o dos, o puede tener un caso de la enfermedad por varios meses y en raras ocasiones presentar insuficiencia hepática y muerte de la infección. En los Estados Unidos, alrededor de 100 personas al año mueren en consecuencia de la hepatitis A.

El virus del papiloma humano (Se puede prevenir con la vacuna HPV)

El virus del papiloma humano es un virus bastante común. El VPH es más común en las personas durante los años de la adolescencia y principios de la vida adulta. El VPH principal del cáncer del cuello del útero se encuentra en las mujeres y en las verrugas genitales tanto en los hombres como en las mujeres. Las vacunas del VPH que causan cáncer del cuello del útero y verrugas genitales se transmiten por contacto sexual (coto).

La influenza (Se puede prevenir con la vacuna annual contra la influenza)

La influenza es una infección viral de la nariz, la garganta y los pulmones que puede ser transmitida de una persona a otra a través del contacto directo con las micro-gotas de la tos o el estornudo de una persona infectada y puede causar una enfermedad que oscila de leve a grave. Entre los síntomas de la influenza se encuentran: fiebre, cansancio, malestar, esfumación, escalofríos, dolor de cabeza, dolor de garganta y dolor muscular. En los casos graves de la enfermedad, puede causar fiebre alta, dolor de cabeza, dolor de garganta y dolores musculares y de las articulaciones. La fatiga aguda puede durar de varios días a semanas. La influenza puede conllevar a la hospitalización o hasta causar la muerte, incluso en niños que anteriormente hayan sido sanos.

El sarampión (Se puede prevenir con la vacuna MMR)

El sarampión es una de las enfermedades virales más contagiosas que existen. El virus del sarampión se transmite mediante el contacto directo con las micro-gotas respiratorias suspendidas en el aire de una persona infectada. El sarampión es tan contagioso que el 90% de las personas que han estado en contacto con un sarampión puede resultar en una infección. Entre los síntomas comunes que se encuentran: fiebre, tos, ojos enrojecidos y fáskos. El sarampión puede ser perjudicial a largo plazo, puede durar alrededor de 10 días. El sarampión también puede causar neumonías, convulsiones, daños cerebrales o la muerte.

La enfermedad meningocócica (Se puede prevenir con la vacuna MEN)

La enfermedad meningocócica es causada por una bacteria y es la causa principal de la meningitis bacteriana (la infección de los meninges que cubren el cerebro y la espina dorsal) en los niños. Las bacterias se transmiten a través del intercambio de micro-gotas nasales y de la garganta al toser, estornudar y besar. Los síntomas incluyen apatía y fiebre, dolor de cabeza y rigidez de cuello. La enfermedad meningocócica también puede causar infecciones sanguíneas. Alrededor de una de cada diez personas que contraen la enfermedad mueren a consecuencia de ella. Los sobrevivientes de la enfermedad meningocócica pueden perder los brazos o las piernas, quedarse sordos, tener problemas en el sistema nervioso, tener discapacidades del desarrollo, sufrir convulsiones o daños cerebrales (apoplejías).

Las papeleras (Se puede prevenir con la vacuna MMR)

Las papeleras son una enfermedad infecciosa causada por el virus de las papeleras, el cual se transmite por el aire cuando una persona infectada tose o estornuda. Un niño también puede infectarse con las papeleras al estar en contacto con un objeto contaminado por el virus, como un juguete o por ejemplo. Las papeleras causan fiebre, dolores de cabeza, inflamación de las glándulas linfáticas y en algunos casos, fiebre alta, dolor de cabeza, dolor muscular, inflamación del cerebro (encefalitis), inflamación de las meninges (infección de la membrana que cubre el cerebro y la espina dorsal), encefalitis inflamatoria del cerebro, pérdida auditiva permanente, o inflamación de los testículos que en raras ocasiones puede generar esterilidad en los hombres.

La tifosioma (Se puede prevenir con la vacuna TOS)

La tifosioma es una enfermedad causada por una bacteria que se transmite a través del contacto directo con las micro-gotas respiratorias de una persona infectada al toser o estornudar. Al principio, los síntomas de la tos o la fiebre son similares a los del sarampión, entre ellos: fiebre alta, escalofríos, dolor de cabeza, dolor de garganta, dolor muscular y dolores de las articulaciones. La fiebre aguda puede durar de varios días a semanas. La tifosioma es una enfermedad muy grave para los bebés, quienes pueden tener neumonía, convulsiones, daños cerebrales, e incluso, morir. Alrededor de dos tercios de los niños menores de 1 año de edad que se contagian de la tifosioma tienen que hospitalizados.

La enfermedad neumocócica (Se puede prevenir con la vacuna neumocócica)

La enfermedad neumocócica es la infección de los pulmones que puede ser causada por la bacteria llamada neumococo. Esta bacteria también puede causar otros tipos de infección, como infección de oído, sinusitis, meningitis (infección del cerebro y la médula espinal) y bacteriemia (infección del torrente sanguíneo). Las infecciones de los senos nasales y del oído normalmente son leves y son mucho más comunes que las formas más graves de la enfermedad neumocócica. Sin embargo, en algunos casos la enfermedad neumocócica puede ser mortal o derivar en problemas de salud a largo plazo como daño cerebral y pérdida auditiva. La enfermedad neumocócica se transmite cuando las personas infectadas tosen o estornudan. Sin embargo, muchas personas tienen la bacteria en la nariz o la garganta en un momento a otro sin estar enfermas, eso se conoce por el nombre de portador de la enfermedad.

La polio (Se puede prevenir con la vacuna IPV)

La polio es una enfermedad causada por un virus que vive en la garganta o los intestinos de una persona infectada. Se transmite a través del contacto con las heces (esenciamento) de una persona infectada y a través de las micro-gotas de un estornudo o tos. Entre los síntomas más comunes se encuentran fiebre, dolor de garganta, dolor de cabeza, debilidad y malestar abdominal. En alrededor del 5% de las personas, la polio puede causar parálisis. Entre las personas que resultan paralizadas, hasta el 9% de los niños pueden morir porque no pueden respirar.

La rubéola (Se puede prevenir con la vacuna MMR)

La rubéola es una enfermedad causada por un virus que se transmite a través de la tos y el estornudo. En los niños, la rubéola normalmente causa una enfermedad leve con fiebre, inflamación de las glándulas y un sarpullido que dura alrededor de 3 días. La rubéola rara veces causa una enfermedad grave o complicaciones en los niños, pero puede ser muy grave para un bebé en el vientre. Si una mujer embarazada se contagia de la enfermedad, el resultado de la misma en el bebé puede ser devastador, como entre ellos aborto espontáneo, defectos cardíacos graves, retardo mental y pérdida de la audición de la vista.

El tétanos (Se puede prevenir con la vacuna TIG)

El tétanos es una enfermedad causada por bacterias que se encuentran en la tierra. La bacteria ingresa al cuerpo a través de una herida, tal como una cortada profunda. Cuando las personas se infectan, la bacteria produce una toxina (veneno) en el cuerpo que causa inflamación de los músculos del cuerpo. El tétanos afecta principalmente el cuello y el abdomen. Esto puede llevar al lenguaje mudo y a la parálisis que la persona no puede abrir la boca, ni respirar. La desviación total del tétanes puede tomar meses. Alrededor de dos de cada 10 personas que contában el tétanos mueren a causa de la enfermedad.

La varicela (Se puede prevenir con la vacuna contra la varicela)

La varicela es una enfermedad causada por el virus de la varicela-zóster. La varicela es altamente contagiosa y se transmite con mucha facilidad a partir de las personas infectadas. El virus se puede transmitir a partir de la tos o el estornudo. También se puede transmitir a partir de las amapolas en la piel; ya sea al tocarse o al respirar estas partículas virales. Entre los síntomas más comunes de la varicela se encuentran: sarpullido con picazón y ampollas, cansancio, dolor de cabeza y fiebre. Normalmente, la varicela es una enfermedad leve, pero puede conllevar a infecciones de la piel, neumonía, encefalitis (infección del cerebro) o incluso la muerte.

Consulte al médico si tiene alguna pregunta acerca de las vacunas de su hijo.
### INFORMATION FOR ADULT PATIENTS

#### 2017 Recommended Immunizations for Adults: By Age

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Flu Influenza</th>
<th>Td/Tdap Tetanus, diphtheria, pertussis</th>
<th>Shingles Zoster</th>
<th>Pneumococcal PCV13</th>
<th>Pneumococcal PPSV23</th>
<th>Meningococcal MenACWY or MPSV4</th>
<th>Meningococcal MenB</th>
<th>HPV Human papillomavirus for women</th>
<th>HPV Human papillomavirus for men</th>
<th>Chickenpox Varicella</th>
<th>Hepatitis A</th>
<th>Hepatitis B</th>
<th>Hib Haemophilus influenzae type b</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 - 21 years</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Blue</td>
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<td>22 - 26 years</td>
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<tr>
<td>27 - 59 years</td>
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<td>60 - 64 years</td>
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<td>65+ years</td>
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</tbody>
</table>

**More Information:**
- You should get a flu vaccine every year.
- You should get a Tdap booster every 10 years. You also need 1 dose of Tdap. Women should get a Tdap vaccine during each pregnancy to help protect the baby.
- You should get shingles vaccine even if you have had shingles before.
- You should get 1 dose of PCV13 and at least 1 dose of PPSV23 depending on your age and health condition.
- You should get this vaccine if you did not get it when you were a child.

**Recommended For You:** This vaccine is recommended for you unless your healthcare professional tells you that you do not need it or should not get it.

**May Be Recommended For You:** This vaccine is recommended for you if you have certain risk factors due to your health condition or other. Ask your healthcare professional to see if you need this vaccine.

If you are traveling outside the United States, you may need additional vaccines. Ask your healthcare professional about which vaccines you may need at least 6 weeks before you travel.

For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines).
## Información para pacientes adultos

**2017 - Vacunas recomendadas para adultos según la edad**

<table>
<thead>
<tr>
<th>Edad</th>
<th>Influenza (grippe)</th>
<th>Td/Tdap</th>
<th>Culebrilla</th>
<th>Antineumocócica</th>
<th>Antimeningocócica</th>
<th>MMR</th>
<th>VPH</th>
<th>Varicela</th>
<th>Hepatitis A</th>
<th>Hepatitis B</th>
<th>Hib</th>
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<tbody>
<tr>
<td>19 - 21 años</td>
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<td>22 - 26 años</td>
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<td>27 - 59 años</td>
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<td>60 - 64 años</td>
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</tbody>
</table>

### Más información

- **Usted debe recibir la vacuna contra la influenza todos los años.**
- **Usted debe recibir una dosis de tétanos de la TD cada 10 años. También necesita 1 dosis de la TdAP. Las mujeres deben recibir una dosis de la PCV13 y el mumps 1 dosis de la PPSV23 dependiendo de su edad y estado de salud.
- **Usted debe recibir 1 dosis de la MMR y el varicela para mujeres.**
- **Usted debe recibir esta vacuna si no la recibió cuando era niño.**
- **Usted debe recibir la vacuna contra el VPH si no ha completado la serie y es una mujer de hasta 25 años o un hombre de hasta 21 años.**

### Recomendada para usted:
Esta vacuna se recomienda para usted a menos que su profesional de salud le diga que no la necesita o no debe vacunarse.

### Puede ser recomendada para usted:
Esta vacuna se recomienda para usted, si tiene ciertos factores de riesgo debido a su estado de salud o otros. Habla con su profesional de salud para saber si necesita esta vacuna.

Si va a viajar fuera de los Estados Unidos, puede que necesite vacunas adicionales. Al menos 6 semanas antes de su viaje, pregúnte a su profesional de salud cuáles vacunas puede necesitar.

Para obtener más información, llame al 1-800-CDC-INFO (1-800-232-4636) o visite www.cdc.gov/espanol/vacunas
### 2017 Recommended Immunizations for Adults: By Health Condition

#### 2017 Immunization Schedule

**If you have this health condition, talk to your healthcare professional about these vaccines.**

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Flu Influenza</th>
<th>Td/Tdap</th>
<th>Tetanus, diphtheria, pertussis</th>
<th>Shingles Zoster</th>
<th>Pneumococcal</th>
<th>Meningococcal</th>
<th>MMR</th>
<th>HPV</th>
<th>Chickenpox Varicella</th>
<th>Hepatitis A</th>
<th>Hepatitis B</th>
<th>Hib Hemophrophilus influenza type b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
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<td>Weakened Immune System</td>
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<td>HIV: CD4 count less than 200</td>
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<td>HIV: CD4 count 200 or greater</td>
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<td>Kidney disease or poor kidney function</td>
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<td>Asplenia (if you do not have a spleen or if it does not work well)</td>
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<td>Heart disease</td>
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<tr>
<td>Chronic lung disease</td>
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<td>Chronic alcoholism</td>
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<td>Diabetes (Type 1 or Type 2)</td>
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<td>Chronic Liver Disease</td>
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</table>

**More Information:**

- **Recommended For You:** This vaccine is recommended for you unless your healthcare professional tells you that you do not need it or should not get it.
- **May Be Recommended For You:** This vaccine is recommended for you if you have certain other risk factors due to your age, health condition or other. Talk to your healthcare professional to see if you need this vaccine.
- **You Should Not Get This Vaccine:**

---

You should get this vaccine if you did not get it when you were a child.

---

For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit www.cdc.gov/vaccines
INFORMACIÓN PARA PACIENTES ADULTOS 2017 - Vacunas recomendadas para adultos según el estado de salud

Si usted tiene esta afección o estado de salud, hable con su profesional de salud acerca de estas vacunas:

<table>
<thead>
<tr>
<th>Condición</th>
<th>Influenza (gripe)</th>
<th>Td/Tdap</th>
<th>Culebrilla Herpes Zóster</th>
<th>Antineumocócica</th>
<th>Antimeningocócica</th>
<th>MMR</th>
<th>Sarampión, parotiditis, rubéola</th>
<th>VPH</th>
<th>Varicela</th>
<th>Hepatitis A</th>
<th>Hepatitis B</th>
<th>Hib</th>
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<tbody>
<tr>
<td>Embarazo</td>
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<td>Sistema inmunológico debilitado</td>
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<td>Vírus de CD4 es menos de 200</td>
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<tr>
<td>Vírus de CD4 es 200 o más</td>
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<td></td>
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<tr>
<td>Enfermedad renal o funcionamiento renal deficiente</td>
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<tr>
<td>Asplenia (si usted no tiene bazo o si este no funciona a bien)</td>
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<tr>
<td>Enfermedad cardíaca, enfermedad pulmonar crónica, alcoholismo crónico</td>
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<tr>
<td>Diabetes (tipo 1 o tipo 2)</td>
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<tr>
<td>Enfermedad hepática crónica</td>
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</tbody>
</table>

Más información:
- Usted debe recibir la vacuna contra la influenza todos los años.
- Usted debe recibir una dosis de Td/Tdap al final de la edad de la Tierra. Las mujeres deben recibir la vacuna Tdap durante el embarazo.
- Usted debe recibir una dosis de la PCV13 y al menos 1 dosis de la PPSV23 dependiendo de su edad y afección o estado de salud.
- Usted debe recibir esta vacuna si no la recibió cuando era niño.

Recomendada para usted: Esta vacuna se recomienda para usted a menos que su profesional de salud le diga que no la necesita o no debe vacunarse.

Puede ser recomendada para usted: Esta vacuna se recomienda para usted si tiene ciertos factores de riesgo debido a su estado de salud o otros. Habla con su profesional de salud para saber si necesita esta vacuna.

Para obtener más información, llame al 1-800-CDC-INFO (1-800-232-4636) o visite www.cdc.gov/espanol/vacunas

U.S. Department of Health and Human Services Centers for Disease Control and Prevention
2017 Prescription Drug Endorsement

To the Health Plan of Nevada, Inc. Prescription Drug Rider

This Endorsement is a supplement to your Health Plan of Nevada, Inc. (“HPN”) Prescription Drug Rider. These provisions are effective immediately.

Prescription Drug Riders

1. Add the following to the Limitations Section

- Benefits are available for refills of Covered Drugs, including prescription eye drops, only when dispensed as ordered by a duly licensed health care provider. Refills are provided once a given amount of the Covered Drug is used through the course of therapy; amounts vary by the type of Covered Drug. Refill dates of Covered Drugs can be aligned so that drugs that are refilled at the same frequency can be refilled concurrently.
2017 Benefit Schedule Endorsement

To the Health Plan of Nevada, Inc. (“HPN”) Evidence of Coverage

This Endorsement is a supplement to your Health Plan of Nevada, Inc. (“HPN”) Evidence of Coverage (EOC). These provisions are effective January 1, 2017.

Attachment A Benefit Schedule

1. **Add** Residential Treatment Centers as follows:
   - HMO – Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.
   - POS - Subject to a combined Tier I, II and III maximum benefit of one hundred (100) days per Member per Calendar Year.

2. **Amend** the combined maximum benefit for Short-Term Rehabilitation/Habilitation Services by separating the benefits as follows:
   - All Inpatient and Outpatient Short-Term **Habilitation** Services are subject to a combined maximum benefit of sixty (60) days/visits per Member per Calendar Year.
   - All Inpatient and Outpatient Short-Term **Rehabilitation** Services are subject to a combined maximum benefit of sixty (60) days/visits per Member per Calendar Year.

3. **Amend** the maximum benefit for ABA Therapy Services as follows:
   - **FROM:** Limited to two hundred fifty (250) visits not to exceed seven hundred fifty (750) total hours of therapy per Member per Calendar Year.
   - **TO:** Limited to one thousand five hundred (1,500) total hours of therapy per Member per Calendar Year.
Evidence Of Coverage

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

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

Health Plan of Nevada, Inc. (“HPN”), and the Group have agreed to all of the terms of this EOC, and the EOC has been incorporated by reference into the Group Enrollment Agreement (“GEA”) entered into by HPN and Group. HPN or the Group, upon appropriate written notice in accordance with the GEA, may terminate this EOC. 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. Please read them carefully and keep them in a safe place. 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 B Service Area  
Endorsements, if applicable  
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:

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

Las Vegas Office:
Phone: (702) 486-4009
Fax: (702) 486-4007
2501 East Sahara Ave., Suite 302
Las Vegas, NV 89104

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

1-800-992-0900 Please listen to the greeting and select the appropriate prompt.

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

Address:

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

Phone:

1-877-545-7378
(Monday – Friday from 8:00 a.m. until 5:00 p.m., Pacific 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 be an employee of the enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the policy and meets the following criteria:
- Be employed full-time;
- Be in an active employment status;
- Work at least the minimum number of hours per week indicated by the Group in its Attachment A to the Group Enrollment Agreement (GEA);
- Meet the applicable waiting period indicated by the Group in its Attachment A to the GEA;
- Enroll during an enrollment period;
- Live or work in HPN’s Service Area; and
- Work for an employer that meets the Minimum Employer Contribution Percentage for the applicable coverage as set forth in the Attachment A to the GEA.

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

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

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

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

1.2 Who Is Not Eligible

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

1.3 Changes In Eligibility Status

It is the Subscriber's responsibility to give HPN written notice within thirty-one (31) days of changes that affect his Dependent’s eligibility. Changes include, but are not limited to:
- Reaching the limiting age.
- Ceasing to satisfy the mental or physical handicap requirements.
- Death.
- Divorce.
- Transfer of residence or work outside HPN’s Service Area.
Evidence of Coverage

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

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

1.4 Enrollment

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

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

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

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

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

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

1.5 Effective Date of Coverage

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

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

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

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

- An adopted child is covered for the first thirty-one (31) days from birth only if the adoption has been legally completed before the child’s birth. A child Placed for Adoption at any other age is covered for the first thirty-one (31) days after the Placement for Adoption. Coverage continues after the applicable thirty-one (31) day period only if the Subscriber enrolls the child as a Dependent and pays any premium within sixty (60) days following the placement of the child in the Subscriber’s home. In the event adoption proceedings are terminated, coverage of a child Placed for Adoption ends on the date the adoption proceedings are terminated.

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

- For a Special Enrollee, 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.

- 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.
Evidence of Coverage

- Subscriber must give HPN a copy of the certified birth certificate, decree of adoption, or certificate of Placement for Adoption for coverage to continue after sixty (60) days for newborn and adopted children.

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.
- 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.
- The end of the month in which a Dependent Child under permanent legal guardianship turns age 19 unless the Child is unmarried and either resides with the Subscriber or is enrolled as a full-time student at an accredited institution.
- On the date the GEA terminates for any reason, including but not limited to:
  1. Nonpayment of premiums.
  2. Failure to meet minimum enrollment requirements.
  3. HPN amends this EOC and the Group does not accept the amendment.

2.2 Termination by the Subscriber

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

2.3 Reinstatement

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

2.4 Retroactive Termination

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

2.5 Effect of Termination

No benefits will be paid under this Plan by HPN for services provided after termination of a Member's coverage under this Plan. The Member will be responsible for payment of medical services and supplies incurred after the Effective Date of the termination of this Plan and/or the GEA.
SECTION 3. Continuation of Coverage

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

3.1 COBRA

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

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

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

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

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

b) A Dependent who would lose coverage under this Plan due to any of the qualifying events shown below has the right to elect COBRA continuation coverage. Such coverage may continue for up to thirty-six (36) months.

   i) The Subscriber’s death.
   ii) The Subscriber’s divorce or legal separation.
   iii) The Subscriber becomes entitled to Medicare benefits under Part A, Part B, or both.
   iv) A Dependent no longer qualifies as a Dependent child as provided in Section 1. of this EOC.

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

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

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

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.
Evidence of Coverage

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 sixty (60) days of the election; or
- Timely premium payments are not made as described in 3.1(f).

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

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

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

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

2. **Second Qualifying Event Extension.** If a second qualifying event occurs while receiving eighteen (18) months of COBRA continuation coverage, an enrolled spouse and Dependent children can qualify for eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan.

   This extension may be available to the spouse and any Dependent children receiving COBRA continuation coverage if the Subscriber or former Subscriber:
   - dies;
   - becomes entitled to Medicare benefits (under Part A, Part B, or both);
   - gets divorced or legally separated; or
   - if the Dependent child no longer qualifies as a Dependent child as provided in Section 1. of this EOC.

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 sixty (60) days after the Social Security Administration’s determination.
- Any Subscriber, Dependent or any representative designated or authorized to act on behalf of the Subscriber or Dependent may provide the notice and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of the Subscriber and all Dependents with respect to the qualifying event.

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

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

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

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

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

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

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

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

**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.
Evidence of Coverage

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

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

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

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

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

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

a. the 24-month period beginning on the date on which the Subscriber’s absence from work begins; or

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

   (1) If the Subscriber served in the uniformed services and is absent from work for less than thirty-one (31) days:
      (a) 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
      (b) 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.

   (2) 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.

   (3) 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.

   (4) 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.

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• The date the Subscriber no longer resides or works within the HPN Service Area or a Dependent no longer resides within the HPN Service Area.

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

3.4 Non-Election

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

### 4.4 Services Requiring Prior Authorization

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

- Non-emergency Inpatient admissions and extensions of stay in a Hospital, Skilled Nursing Facility, Residential Treatment Center or Hospice.
- Outpatient surgery provided in any setting, including technical and professional services.
- Diagnostic and Therapeutic Services.
- Home Healthcare Services.
- All Inpatient and non-routine Outpatient non-Emergency Mental Health, Severe Mental Illness, and Substance 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; and habilitative and rehabilitation therapy (physical, speech, occupational).

### 4.5 Emergency Admission Notification

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

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.
Evidence of Coverage

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:

1-877-545-7378

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, Residential Treatment Center or Hospice Care Facility.

Accommodations:
- Semiprivate (or multibed unit) room, including bed, board and general nursing care.
- Private room including bed, board, and general nursing care, but only when treatment of the Member's condition requires a private room. The semiprivate room rate will be allowed toward the private room rate when a Member receives private room accommodations for any reason other than Medical Necessity.
Evidence of Coverage

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

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, Calendar Year Deductible and/or Coinsurance when such services are provided by a Plan Provider.
Covered Services include the following Preventive Healthcare Services in accordance with the recommended schedule outlined in the HPN Preventive Guidelines included in your member kit or you may access the most current version of these guidelines at any time by visiting HPN’s web site at www.myhpnonline.com.

- Evidence based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- Immunizations 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.

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

### 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.
- Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an Injury (not to include injuries caused by chewing) when the treatment starts within the first ten (10) days after the Injury and ends within sixty (60) days. Examples of Covered Services, in such instances, include:
  a) Root canal therapy, post and build up.
  b) Temporary crowns.
  c) Temporary partial bridges.
  d) Temporary and permanent fillings.
  e) Pulpotomy.
  f) Extraction’s of broken teeth.
  g) Incision and drainage.
  h) Tooth stabilization through splinting.

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

### 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.
Evidence of Coverage

- 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 or Urgently Needed Services

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

Benefits are limited to Eligible Medical Expenses for Non-Plan Provider Emergency Services as defined under “HPN Reimbursement Schedule”. You are responsible for any Non-Plan Provider Emergency Service charges that exceed payments made by HPN.

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

IMPORTANT NOTE: No benefits are payable for treatment received by a Member in a Hospital emergency room or other emergency facility for a condition other than an Emergency Service as defined in this EOC. Examples of conditions which require Medically Necessary treatment, but are not Emergency Services, include:

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

(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/TTY 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.
Evidence of Coverage

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 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:
Evidence of Coverage

- 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 are subject to the Utilization Management process through Behavioral Healthcare Options (BHO). Services must be offered in a treatment setting that is appropriate for the medically necessary level of care, as determined by staffing, ability to provide patient safety, treatment intensity, the diagnostic and therapeutic modalities available, the extent of supportive services and access to general medical care.

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

**Partial Hospitalization Programs (PHP):** A structured program that maintains hours of service for at least twenty (20) hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided.

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

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

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

### 6.20 Substance Abuse (Substance Use Disorder) Services

All benefits for Substance Abuse (Substance Use Disorder) Services are subject to the Utilization Management process through Behavioral Healthcare Options (BHO). Services must be offered in a treatment setting that is appropriate for the Medically Necessary level of care, as determined by staffing, ability to provide patient safety, treatment intensity, the diagnostic and therapeutic modalities available, the extent of supportive services and access to general medical care.
Evidence of Coverage

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

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

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

Partial Hospitalization Programs (PHP): A structured program that maintains hours of service for at least twenty (20) hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided.

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

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

NOTE: All non-routine, outpatient Mental Health, Severe Mental Illness or Substance Abuse (Substance Use Disorder) Services require Prior Authorization. Members must contact 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 (Substance Use Disorder ) 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.

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

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

6.21 Mastectomy Reconstructive Surgical Services

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

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

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

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

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

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 services 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 six (6) consecutive months with documented failure of weight loss. Significant clinical evidence that weight is affecting overall health and is a threat to life will also be required.

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

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

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;
Evidence of Coverage

3. For cardiovascular disease (cardiac/stroke) which is not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
4. For surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
5. Other diseases or disorders which are not life-threatening 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 both of following criteria:
     - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
     - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and has 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.

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6.28 Medical Supplies

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

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

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

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

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

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

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

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 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

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

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

HPN will cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Coverage for 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
Evidence of Coverage

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 an habilitative service. When the Member reaches his maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

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

6.33 Telemmedicine Services

Covered Services received through a Telemmedicine Provider do not require Prior Authorization unless the Covered Service would require Prior Authorization if provided in person. The Member does not have to establish a relationship with a Telemmedicine Provider to receive services.

HPN does not require the Provider delivering Telemmedicine Services to demonstrate the necessity to provide services through Telemmedicine or to receive additional certifications or licenses to provide Telemmedicine Services.

HPN will not refuse to provide coverage because of the distant site from which the contracted Telemmedicine Provider provides Covered Services or the originating site at which the Member receives Telemmedicine Covered Services. HPN will not require Covered Services to be provided through Telemmedicine as a condition of coverage.

6.34 Gender Dysphoria

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

For Adults andadolescents:

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

For Children:

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

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

2. **Cross-sex hormone therapy** is available as follows:
   - Oral and injectable therapy, administered by a provider, during an office visit or in an outpatient or inpatient setting.
   - Oral and injectable therapy dispensed from a pharmacy as prescribed by a provider.
   
   Puberty suppressing medication is not cross-sex hormone therapy.

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

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

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

**Breast Surgery:**

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

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

Genital Surgery:
The Member must provide documentation in the form of a written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Member. The assessment must document that the Member meets all of the following criteria:

1. Has persistent, well-documented Gender Dysphoria;
2. Has the Capacity to make a fully informed decision and to consent for treatment;
3. Must be 18 years or older;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled;
5. Complete at least 12 months of successful continuous full-time real-life experience in the desired gender; and
6. Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

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

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

7.8 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.

7.9 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
Evidence of Coverage

- 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.

7.10 The following infertility services and supplies are excluded, in addition to any other infertility services or supplies determined by HPN not to be Medically Necessary:
- Advanced reproductive techniques such as embryo transplants, in vitro fertilization, ZIFT procedures, assisted hatching, intracytoplasmic sperm injection, egg retrieval via laparoscope or needle aspiration, sperm preparation, specialized sperm retrieval techniques, sperm washing except prior to artificial insemination if required;
- Home pregnancy or ovulation tests;
- Monitoring of ovarian response to stimulants;
- CT or MRI of sella turcica unless elevated prolactin level;
- Evaluation for sterilization reversal;
- Removal of fibroids, uterine septae and polyps;
- Open or laparoscopic resection, fulguration, or removal of endometrial implants; and
- Surgical tube reconstruction.

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

7.12 Elective abortions.

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

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

7.15 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.

7.16 Venipuncture (drawing of blood for laboratory tests).

7.17 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.

7.18 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.

7.19 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. Mental Health Services and Substance Abuse (Substance Use Disorder) Services performed in connection with conditions not listed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or conditions listed as “Other Conditions” that may be of focus of clinical attention.

7.20 Outside of an initial assessment, Mental Health and Substance Abuse (Substance Use Disorder) Services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

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

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

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

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

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

7.26 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.

7.27 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.

7.28 Bone anchored hearing aids are excluded except when both of the following applies:
   - The Member is not a candidate for an air-conduction hearing aid; and
   - The bone-anchored hearing aid is used according to FDA approved indications.

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

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

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

7.31 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.

7.32 Acupuncture or Hypnosis.

7.33 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.

7.34 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.

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

7.36 Nutritional supplements, vitamins, herbal medicines, appetite suppressants, and over-the-counter drugs, except as specifically covered herein. Drugs and medicines approved by the FDA for experimental, investigational or unproven use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan. Any drug...
7.37 Drugs and medicines approved by the FDA for experimental, investigational or unproven use or any drug that has been approved by the FDA for less than one (1) year unless Prior Authorized by HPN.

7.38 Care for conditions that federal, state or local law requires to be treated in a public facility.

7.39 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.

7.40 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.

7.41 Special formulas, food supplements other than as specifically covered in this EOC or special diets on an outpatient basis.

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

7.43 Milieu therapy, biofeedback treatment, behavior modification, sensitivity training, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcoticsynthesis, rolffing, vocational rehabilitation and wilderness programs.

7.44 Experimental, investigational or unproven treatment or devices as determined by HPN.

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

7.46 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.

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

7.48 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.

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

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

7.51 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.

7.52 Autologous blood donations.

7.53 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.

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

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

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

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

7.57 Services received in connection with Gender Dysphoria, which includes the following:
- Abdominoplasty;
- Blepharoplasty;
- Body contouring, such as lipoplasty;
- Breast enlargement, including augmentation mammoplasty and breast implants;
- Brow lift;
- Calf implants;
- Cheek, chin, and nose implants;
- Cryopreservation of fertilized embryos;
- Drugs for hair loss or growth;
- Face lift, forehead lift, or neck tightening;
- Facial bone remodeling for facial feminizations;
- Hair removal;
- Hair transplantation;
- Injection of fillers or neurotoxins;
- Lip augmentation;
- Lip reduction;
- Liposuction;
- Mastopexy;
- Pectoral implants for chest masculinization;
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;
- Rhinoplasty;
- Skin resurfacing;
- Sperm preservation in advance of hormone treatment or gender surgery;
- Surgical or hormone treatment on Members under eighteen (18) years of age;
- Surgical treatment not Prior Authorized by HPN;
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam’s Apple);
- Transportation, meals, lodging or other similar expenses;
- Voice lessons and voice therapy; and
- Voice modification surgery.

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.
- 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:
   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 trusted 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.
### Evidence of Coverage

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

In the event HPN decides to discontinue offering and renewing health benefit plans delivered or issued for delivery in this state, HPN will provide notice of its intention to all persons covered by the discontinued insurance at least 180 days before the nonrenewal of any health benefit plan by the HPN.

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.

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 1-877-545-7378.

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 it

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
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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:

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

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.
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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.

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
PO Box 14865
Las Vegas, NV 89114
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, investigational or unproven treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge as well as information regarding the Member’s right to request an External Review by the State of Nevada’s Office for Consumer Health Assistance (OCHA).

Limited extensions may be required if additional information is required in order for HPN to reach a resolution.

If the resolution to the 1st Level Formal Appeal is not acceptable to the Member and the Member wishes to pursue the matter further, the Member is entitled to file a 2nd Level Formal Appeal. The Member will be informed of this right at the time the Member is informed of the resolution of his 1st Level Formal Appeal.

### 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.
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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
- make a decision and communicate its decision to the Member within thirty (30) days following HPN’s receipt of the request for a 2nd Level Formal Appeal.

If the resolution of the 2nd Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

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

Address
Office for Consumer Health Assistance
555 East Washington Avenue #4800
Las Vegas NV 89101

Telephone Numbers and Website
(702) 486-3587
(888) 333-1597
Fax: (702)486-3586
www.dhhs_nv.gov

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

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 or if HPN fails to issue a written decision to the Member within thirty (30) days after the date the Appeal was filed, and the Member or Member’s Authorized Representative did not request or agree to a delay or, if HPN agrees to permit the Member to submit the adverse determination to OCHA without requiring the Member to exhaust all internal HPN Appeals Procedures. In such event, the Member shall be considered to have exhausted the applicable internal HPN Appeals Process.

Within five (5) days after OCHA receives a request for External Review, OCHA shall notify the Member, the Member’s Authorized Representative and HPN that such request has been received and filed. As soon as practical, OCHA shall assign an IRO to review the case.

Within five (5) days after receiving notification specifying the assigned IRO from OCHA, HPN shall provide to the selected IRO all documents and materials relating to the adverse determination, including, without limitation:

- Any medical records of the Member relating to the adverse determination;
- A copy of the provisions of the healthcare Plan upon which the adverse determination was based;
- Any documents used and the reason(s) given by HPN’s Managed Care Program for the adverse determination; and
- If applicable, a list that specifies each Provider who provided healthcare to the Member and the corresponding medical records from the Provider relating to the adverse determination.

Within five (5) days after the IRO receives the required documentation from HPN, they shall notify the Member or the Member’s Authorized Representative, if any additional information is required to conduct the review. If additional information is required, it must be provided to the IRO within five (5) days after receiving the request. The IRO will forward a copy of the additional information to HPN within one (1) business day after receipt.

The IRO shall approve, modify, or reverse the adverse determination within fifteen (15) days after it receives the information required to make such a determination. The IRO shall submit a copy of its determination, including the basis thereof, to the:
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, Investigational or Unproven Healthcare Service or Treatment.

A Standard or Expedited External Review of an adverse determination due to a requested or recommended healthcare service or treatment being deemed experimental, investigational or unproven, is available in limited circumstances as outlined in the following sections.

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 complete, 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;
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 experimental, investigational or unproven, and, if the treating provider certifies, in writing, that such service or treatment would be less effective if not promptly initiated.

An oral request for an Expedited External Review may be submitted directly to the OCHA upon the written submission of proof from the Member’s Provider to OCHA 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 unproven, or not Medically Necessary or appropriate.

External Review is only available for a Final Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service. An Adverse Benefit Determination is final if the Member has exhausted all complaint and Appeal Procedures set forth herein for the review of such Adverse Benefit Determination.

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.
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- 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 Behavior Interventionist” means a person who is registered as a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board, Inc., or its successor organization, and provides behavioral therapy under the supervision of: (1) A licensed psychologist; (2) A licensed behavior analyst; or (3) A licensed assistant behavior analyst.

13.7 “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.

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

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

13.10 “Calendar Year Out of Pocket Maximum” means the maximum amount of Out of Pocket expenses a Member is required to pay for Covered Services in a Calendar Year, as outlined in the Attachment A, Schedule of Benefits. Once the Calendar Year Out of Pocket Maximum is met, no further cost share is required for the remainder of the Calendar Year. For purposes of accumulating benefits paid toward any applicable benefit maximums under the Plan, the period of such accumulation will coincide with the time period of the Calendar Year applicable to the Group.

The Out of Pocket Maximum does not include any amounts:
- resulting from the Member’s failure to comply with HPN’s Managed Care Program, including the inappropriate use of an emergency room facility for a condition which does not require Emergency Services;
- in excess of Eligible Medical Expenses;
- 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.

13.11 “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).


13.13 “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.)

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

13.15 “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
13.16 “Copayment” or “Cost-share” means the amount the Member pays when a Covered Service is received.

13.17 “Covered Drug” means a Brand Name or Generic Prescription Drug or diabetic supply or equipment which:
- can only be obtained with a prescription;
- has been approved by the Food and Drug Administration (“FDA”) for general marketing;
- is dispensed by a licensed pharmacist;
- is prescribed by a Plan Provider, except in the case of Emergency Services and Urgently Needed Services;
- is a Prescription Drug that does not have an over-the-counter Therapeutic Equivalent available; and
- is not specifically excluded herein.

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, excluding Copayments, that a Member must pay, either in the aggregate or for a particular service, before HPN will make any benefit payments for Covered Services. (See Attachment A Benefit Schedule.)

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 “Domestic Partner” is as defined in NRS 122A.030.

13.24 “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.

13.25 “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.

13.26 “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.

13.27 “Eligible Employee” means a natural person that meets the following criteria:
- Is employed full-time;
- Is in an active employment status;
- Works at least the minimum number of hours per week indicated by the Group in the Attachment A to the GEA (typically 30 hours);
- Meets the applicable waiting period indicated by the Group in the Attachment A to the GEA;
- Enrolls during an enrollment period;
- Lives or work in HPN’s Service Area; and
- Works for an employer that meets the Minimum Employer Contribution Percentage for the applicable coverage as set forth in the Attachment A to the GEA.

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.
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13.28 “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.

13.29 “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.

13.30 “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.


13.32 “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.

13.33 “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.

13.34 “Expedited Appeal” means if a Member appeals a decision regarding a denied request for Prior Authorization (Pre-Service Claim) for an Urgent Care Claim, the Member or Member’s Authorized Representative can request an Expedited Appeal, either orally or in writing. Decisions regarding an Expedited Appeal are generally made within seventy-two (72) hours from the Plan’s receipt of the request.

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

13.36 “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.

13.37 “Free Standing Diagnostic Center” means a licensed establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient diagnostic services.

13.38 “Gender Dysphoria” means there is a marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Gender Dysphoria is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one’s sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender.

13.39 “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.

13.40 “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.
13.41 “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.

13.42 “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.

13.43 “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.

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

13.45 “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.

13.46 “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.

13.47 “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.

13.48 “Hospice” means an establishment licensed by the state where it is located that furnishes a centrally administered program of palliative and supportive services. Such services are provided by a team of healthcare Providers and directed by a Physician. Services include physical, psychological, custodial and spiritual care for patients who are terminally ill and their families. For the purposes of this benefit only, “family” includes the immediate family, the person who primarily cared for the patient and other persons with significant personal ties to the patient, whether or not related by blood.

13.49 “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
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provided to the patient’s family after the patient dies.

13.50 “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:
- health resorts;
- nursing homes;
- Christian Science sanataria;
- 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.

13.51 “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.

13.52 “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.

13.53 “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.

13.54 “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.

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

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

13.57 “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.

13.58 “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.

13.59 “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.

13.60 “Manual Manipulation” means the diagnosis, treatment or maintenance by a Practitioner for the treatment of:
- musculoskeletal strain surrounding vertebra, spine, broken neck; or
- subluxation of vertebra.

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

13.61 “Medical Director” means a Physician named by HPN to review use of health services by Members.

13.62 “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:
Evidence of Coverage

- 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.

13.63 “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.

13.64 “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.

13.65 “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.

13.66 “Mental Health Professional” means any person qualified and licensed to provide assessments, diagnosis and therapy for mental health conditions or substance use disorders.

13.67 “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; or
- Personality disorder.

13.68 “Non-Plan Provider” means a Provider who does not have an independent contractor agreement with HPN.

13.69 “Occupational Illness or Injury” means any Illness or Injury arising out of or in the course of employment for pay or profit.

13.70 “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.

13.71 “Orthotic Devices” means an apparatus used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.
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13.72 “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.

13.73 “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.

13.74 “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.

13.75 “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.

13.76 “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.

13.77 “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.

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

13.79 “Prescription Drug” means a Federal legend drug or medicine that can only be obtained by a prescription order or that is restricted to prescription dispensing by state law. It also includes insulin and glucagon.

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

13.81 “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.

13.82 “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.

13.83 “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.

13.84 “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.

13.85 “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.

13.86 “Provider” means a:
- Hospital,
- Skilled Nursing Facility,
- Urgent Care Facility,
- 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.

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

13.88 “Residential Treatment Center” means a sub-acute facility or acute care facility which delivers twenty-four (24) hours/ seven (7) days a week assessment, diagnostic services and active behavioral health treatment to Members. The level of care and length of stay, in a facility with the appropriate licensure level, is authorized through the HPN Managed Care program.

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

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

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

13.92 “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.

13.93 “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.

13.94 “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.

13.95 “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.

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

13.97 “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.

13.98 “Small employer” or small group means as ascribed in 42 U.S.C. § 18024(b)(2).

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

13.100 “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.
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Note: Voluntary cancellation of healthcare coverage is not considered a Special Enrollment Event.

13.101 “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.

13.102 “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.

13.103 “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.

13.104 “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.

13.105 “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.

13.106 “Substance Use Disorder” as defined in the Diagnostic and Statistical Manual of Mental Disorder (DSM), fifth edition, is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. Substance Use Disorder treatment:
   • must be provided as a part of a treatment plan with clearly defined goals that are realistic and measurable. The plan must address significant impairment or deterioration in the Member’s occupational or scholastic function, social function, or ability to provide self-care.
   • must be provided by state licensed professionals who are practicing within the scope of this licensure.

13.107 “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.

13.108 “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.

13.109 “Therapeutic Supply” means the maximum quantity of supplies for which benefits are available for a single applicable Copayment or Coinsurance amount, if applicable, and may be less than but shall not exceed a thirty (30)-day supply.

13.110 “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.

13.111 “Transplant Benefit Period” means the period beginning with the date the Member receives a written Referral from HPN for care in a Transplant Facility and ending on the first of the following to occur:
   a. the date 365 days after the date of the transplant; or
   b. the date when the Member is no longer covered under this Plan, whichever is earlier.

13.112 “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.

13.113 “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
Evidence of Coverage

regain maximum function by waiting for a routine appeal decision. An Urgent Care Claim also means a Claim for Benefits that, in the opinion of a physician with knowledge of the Member’s medical conditions, would subject the Member to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for Prior Authorization of an Urgent Care service was denied, the Member could request an Expedited Appeal for the Urgent Care Claim.

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

13.115 “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.

13.116 “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.
**Attachment A Benefit Schedule**

The Calendar Year Out of Pocket Maximum is $7,150 per Member and $14,300 per family.

The Out Of Pocket Maximum does not include: 1) amounts charged for non-Covered Services, 2) amounts exceeding applicable Plan benefit maximums or EME payments; or, 3) penalties for not obtaining any required Prior Authorization or for the Member otherwise not complying with HPN’s Managed Care Program.

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

The Member is responsible for any/all amounts exceeding any stated maximum benefit amounts and/or any/all amounts exceeding the Plan’s payment to Non-Plan Providers under this Plan. Further, such amounts do not accumulate to the calculation of the Calendar Year Out of Pocket Maximum.

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Office Visits and Consultations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Convenient Care Facility</td>
<td>No</td>
<td>Member pays $15 per visit.</td>
</tr>
<tr>
<td>• Physician Extender or Assistant</td>
<td>No</td>
<td>Member pays $15 per visit.</td>
</tr>
<tr>
<td>• Physician</td>
<td>No</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td><strong>Specialist Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• With Referral</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>• Without Referral</td>
<td>No</td>
<td>Member pays $45 per visit.</td>
</tr>
<tr>
<td><strong>Preventive Healthcare Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For a complete list of Preventive Services, including all FDA approved contraceptives, go to <a href="http://doi.nv.gov/Healthcare-Reform/Indiv">http://doi.nv.gov/Healthcare-Reform/Indiv</a>iduals-Families/Preventive-Care/.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have a question about whether or not a service is “Preventive”, please contact the HPN Member Services Department (1-800-777-1840).

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*Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*
## Benefit Schedule

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-preventive Routine Lab and X-ray Services</strong>&lt;br&gt;The Copayment/Cost-share is in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician’s office or at an independent facility.</td>
<td>Yes</td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td>• Lab</td>
<td></td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td>• X-Ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Telemedicine Services (Available through select contracted Providers)</strong></td>
<td>No</td>
<td>Member pays $15 per visit.</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>No</td>
<td>Member pays $30 per visit.</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency Room Facility (includes Physician Services)</td>
<td>No</td>
<td>Member pays $300 per visit; waived if admitted.</td>
</tr>
<tr>
<td>• Hospital Admission - Emergency Stabilization (includes Physician Services)&lt;br&gt;Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</td>
<td>No</td>
<td>Member pays $500 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 (Elective and Emergency Post-Stabilization Admissions)</strong></td>
<td>Yes</td>
<td>Member pays $500 per admission.</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Facility Services</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 Hospital Facility</td>
<td>Yes</td>
<td>Member pays $0 per surgery.</td>
</tr>
<tr>
<td>• 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&lt;br&gt;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></td>
<td></td>
</tr>
<tr>
<td>• With Referral</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>• Without Referral</td>
<td>No</td>
<td>Member pays $45 per visit.</td>
</tr>
</tbody>
</table>

*Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.
<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastric Restrictive Surgery Services</strong>&lt;br&gt;HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Surgical Services</td>
<td>Yes</td>
<td>Member pays 50% of EME. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Physician's Office Visit</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td><strong>Organ and Tissue Transplant Surgical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $500 per admission.</td>
</tr>
<tr>
<td>• Physician Surgical Services - Inpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $0 per surgery.</td>
</tr>
<tr>
<td>• Transportation, Lodging and Meals&lt;br&gt;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>Yes</td>
<td>Member pays $0 per surgery. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Procurement&lt;br&gt;The maximum benefit per Member per Transplant Benefit Period for Procurement of the organ/tissue is $15,000 of EME.</td>
<td>Yes</td>
<td>Member pays $0. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Retransplantation Services&lt;br&gt;Benefits are limited to one (1) Medically Necessary Retransplantation per Member per type of transplant.</td>
<td>Yes</td>
<td>Member pays 50% of EME. Subject to maximum benefit.</td>
</tr>
<tr>
<td><strong>Post-Cataract Surgical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Frames and Lenses</td>
<td>Yes</td>
<td>Member pays $10 per pair of glasses. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Contact Lenses</td>
<td>Yes</td>
<td>Member pays $10 per set of contact lenses. Subject to maximum benefit.</td>
</tr>
<tr>
<td>Benefit is limited to one (1) pair of Medically Necessary glasses or set of contact lenses as applicable per Member per surgery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Healthcare Services</strong> (does not include Specialty Prescription Drugs)</td>
<td>Yes</td>
<td>Member pays $0 per visit.</td>
</tr>
<tr>
<td><strong>Hospice Care Services</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*
### Benefit Schedule

<table>
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<tr>
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<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient Hospice Facility</td>
<td>Yes</td>
<td>Member pays $500 per admission.</td>
</tr>
<tr>
<td>• Outpatient Hospice Services</td>
<td>Yes</td>
<td>Member pays $0 per visit.</td>
</tr>
</tbody>
</table>
| • Inpatient and Outpatient Respite Services  
  Benefits are limited to a combined maximum benefit of five (5) Inpatient days or five (5) Outpatient visits per Member per ninety (90) days of Home Hospice Care.  
  ◦ Inpatient  
  ◦ Outpatient  
  ◦ Bereavement Services  
  Benefits are limited to a maximum benefit of five (5) group therapy sessions. Treatment must be completed within six (6) months of the date of death of the Hospice patient. | Yes | Member pays $500 per admission.; Subject to maximum benefit. |
| Skilled Nursing Facility       | Yes                                           | Member pays $500 per admission; waived if admitted from an acute care facility. Subject to maximum benefit. |
| Residential Treatment Center   | Yes                                           | Member pays $500 per admission; waived if admitted from an acute care facility. Subject to maximum benefit. |
| Manual Manipulation            | Applies to Medical-Physician Services and Chiropractic office visit. 
  Subject to a maximum benefit of twenty (20) visits per Member per Calendar Year.  
  • With Referral  
  • Without Referral | Yes | Member pays $25 per visit. Subject to maximum benefit.  
  No | Member pays $45 per visit. Subject to maximum benefit. |
| Short-Term Habilitation Services (including but not limited to Physical, Speech and Occupational Therapy) | | |

<sup>(1)</sup>Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.
<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $500 per admission. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>Yes</td>
<td>Member pays $25 per visit. Subject to maximum benefit.</td>
</tr>
</tbody>
</table>

All Inpatient and Outpatient Short-Term Habilitation Services are subject to a combined maximum benefit of sixty (60) days/visits per Member per Calendar Year.

**Short-Term Rehabilitation Services** (including but not limited to Physical, Speech and Occupational Therapy)

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient Hospital Facility</td>
<td>Yes</td>
<td>Member pays $500 per admission. Subject to maximum benefit.</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>Yes</td>
<td>Member pays $25 per visit. Subject to maximum benefit.</td>
</tr>
</tbody>
</table>

All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a combined maximum benefit of sixty (60) days/visits per Member per Calendar Year.

**Durable Medical Equipment**
Monthly rental or purchase at HPN’s option. Purchases are limited to a single purchase of a type of DME, including repair and replacement, once every three (3) years.

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Member pays $0. Subject to maximum benefit.</td>
</tr>
</tbody>
</table>

**Genetic Disease Testing Services**

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office Visit</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>• With Referral</td>
<td>No</td>
<td>Member pays $45 per visit.</td>
</tr>
<tr>
<td>• Without Referral</td>
<td>Yes</td>
<td>Member pays 25% of EME.</td>
</tr>
<tr>
<td>• Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Inpatient, Outpatient and independent Laboratory Services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Infertility Office Visit Evaluation**
Please refer to applicable surgical procedure Copayment/Cost-share and/or Coinsurance amount herein for any surgical infertility procedures performed.

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• With Referral</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>• Without Referral</td>
<td>No</td>
<td>Member pays $45 per visit.</td>
</tr>
</tbody>
</table>

**Medical Supplies**
(Obtained outside of a medical office visit)

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Member pays $0.</td>
</tr>
</tbody>
</table>

*Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.
### Covered Services and Limitations

<table>
<thead>
<tr>
<th>Other Diagnostic and Therapeutic Services</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Copayment/Cost-share amounts are in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office or at an independent facility.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services.</td>
<td>Yes</td>
<td>Member pays $25 per day.</td>
</tr>
<tr>
<td>- Dialysis</td>
<td>Yes</td>
<td>Member pays $25 per day.</td>
</tr>
<tr>
<td>- Therapeutic Radiology</td>
<td>Yes</td>
<td>Member pays $25 per day.</td>
</tr>
<tr>
<td>- Complex Allergy Diagnostic Services (including RAST) and Serum Injections</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>- Otologic Evaluations</td>
<td>Yes</td>
<td>Member pays $25 per visit.</td>
</tr>
<tr>
<td>- Other complex diagnostic imaging services including: CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; and complex neurological or psychiatric testing or therapeutic services.</td>
<td>Yes</td>
<td>Member pays $100 per test or procedure.</td>
</tr>
<tr>
<td>- Positron Emission Tomography (PET) scans</td>
<td>Yes</td>
<td>Member pays $100 per test or procedure.</td>
</tr>
</tbody>
</table>

### Prosthetic Devices

Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.

<table>
<thead>
<tr>
<th>Prosthetic Devices</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Member pays $750 per device. Subject to maximum benefit.</td>
<td></td>
</tr>
</tbody>
</table>

### Orthotic Devices

Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.

<table>
<thead>
<tr>
<th>Orthotic Devices</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Member pays $50 per device. Subject to maximum benefit.</td>
<td></td>
</tr>
</tbody>
</table>

### Self-Management and Treatment of Diabetes

<table>
<thead>
<tr>
<th>Self-Management and Treatment of Diabetes</th>
<th>Referral or Prior Auth. Required(^{(1)})</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Education and Training</td>
<td>No</td>
<td>Member pays $25 per visit.</td>
</tr>
</tbody>
</table>

*Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*
### Benefit Schedule

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Referral or Prior Auth. Required ( ^{(1)} )</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

**Special Food Products and Enteral Formulas**

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.

<table>
<thead>
<tr>
<th>Special Food Products and Enteral Formulas</th>
<th>Referral or Prior Auth. Required</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Member pays $0. Subject to maximum benefit.</td>
</tr>
</tbody>
</table>

**Temporomandibular Joint Treatment**

<table>
<thead>
<tr>
<th>Temporomandibular Joint Treatment</th>
<th>Referral or Prior Auth. Required</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Member pays 50% of EME.</td>
</tr>
</tbody>
</table>

**Mental Health and Severe Mental Illness Services**

- **Inpatient Hospital Facility**
  - Yes | Member pays $500 per admission. |

- **Outpatient Treatment**
  - Yes | Member pays $25 per visit. |

**Substance Abuse Services**

- **Inpatient Hospital Facility**
  - Yes | Member pays $500 per admission. |

- **Outpatient Treatment**
  - Yes | Member pays $25 per visit. |

**Hearing Aids**

Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.

<table>
<thead>
<tr>
<th>Hearing Aids</th>
<th>Referral or Prior Auth. Required</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Member pays $0. Subject to maximum benefit.</td>
</tr>
</tbody>
</table>

**Applied Behavioral Analysis (ABA) for the treatment of Autism for Members up to age 22**

Limited to one thousand five hundred (1,500) total hours of therapy per Member per Calendar Year.

<table>
<thead>
<tr>
<th>Applied Behavioral Analysis (ABA) for the treatment of Autism for Members up to age 22</th>
<th>Referral or Prior Auth. Required</th>
<th>Tier I HMO Benefit*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Member pays $25 per visit. Subject to maximum benefit.</td>
</tr>
</tbody>
</table>

The Member’s Tier I Copayment/Cost-share will not be more than 50% of the allowed cost of providing any single service or supplying an item to a Member, after the deductible, if applicable, has been met. A Member may not contribute any more than the individual CYD amount toward the family CYD amount. A Member may not contribute any more than the individual Calendar Year Out of Pocket Maximum toward the family Calendar Year Out of Pocket Maximum amount.

\( ^{(1)} \)Referral or Prior Auth. Required – Except as otherwise noted and, with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness and Substance 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.

*Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*
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;
- Medoidioplasty;
- 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>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office Consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Consultation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IMPORTANT NOTE: Copayment amounts paid by the Member do not accumulate to the calculation of the Calendar Year Copayment Maximum.
State of Nevada

4-Tier Outpatient Prescription Drug Rider to the HPN Group
Evidence of Coverage

<table>
<thead>
<tr>
<th>Prescription Drug Tier</th>
<th>Tier I HMO Plan Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier I</td>
<td>Member pays $7 Copayment per Designated Plan Pharmacy Therapeutic Supply.</td>
</tr>
<tr>
<td>Tier II</td>
<td>Member pays $40 Copayment per Designated Plan Pharmacy Therapeutic Supply.</td>
</tr>
<tr>
<td>Tier III</td>
<td>Member pays $75 Copayment per Designated Plan Pharmacy Therapeutic Supply.</td>
</tr>
<tr>
<td>Tier IV (Specialty Drugs)</td>
<td>Member pays 40% of EME per Designated Plan Pharmacy Therapeutic Supply.</td>
</tr>
</tbody>
</table>

**Plan Mail Order Prescription Drug Benefit**
Member pays 2.5 times the applicable Tier Cost-share per Plan Mail Order Pharmacy Therapeutic Supply.

Please refer to the HPN Prescription Drug List (PDL) for the listing of Covered Drugs and for any Covered Drugs requiring Prior Authorization and/or Step Therapy as outlined in the HPN EOC.

This Prescription Drug Benefit Rider is issued in consideration of: (a) Group’s election of coverage under this Rider, (b) your eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Prescription Drug Benefit Rider is a supplement to your Evidence of Coverage (EOC) and Attachment A Benefit Schedule issued by Health Plan of Nevada, Inc., and amends your coverage to include benefits for Covered Drugs. This coverage is subject to the applicable terms, conditions, limitations and exclusions contained in your HPN EOC and herein.

**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.

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.

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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 Tier IV benefit. If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, HPN may direct you to a Designated Plan Pharmacy with whom HPN has an arrangement to provide those Covered Drugs.

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 lowest Cost-share option for Covered Drugs.
(b). Tier II is the low Cost-share option for Covered Drugs.
(c). Tier III is the midrange Cost-share option for Covered Drugs.
(d). Tier IV is the Cost-share option for Specialty Covered Drugs.
(e). Mandatory Generic benefit provision applies when:
   - a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. After satisfying any applicable CYD, the Member will pay the applicable tier Cost-share 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. The difference in the amount between such Brand Name and Generic Covered Drug paid by the Member does not accumulate to any otherwise applicable plan Calendar Year Prescription Drug Deductible, overall plan CYD or annual Out of Pocket Maximum.
(f). When a Drug is dispensed through the Mail Order Plan Pharmacy, the applicable CYD and Mail Order Plan Pharmacy Cost-share 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, Tier III or Tier IV Cost-share 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, III or IV 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, Tier III or Tier IV Cost-share.

(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 Benefits are available for refills of Covered Drugs, including prescription eye drops, only when dispensed as ordered by a duly licensed health care provider. Refills are provided once a given amount of the Covered Drug is used through the course of therapy; amounts vary by the type of Covered Drug. Refill dates of Covered Drugs can be aligned so that drugs that are refilled at the same frequency can be refilled concurrently.

2.3 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.

2.4 Benefits for prescriptions for Mail Order Drugs submitted following HPN’s receipt of notice of Member’s termination will be limited to the appropriate Therapeutic Supply from the date such notice of termination is received to the Effective Date of termination of the Member.

2.5 Benefits are not payable if the Member is directed to a Designated Plan Pharmacy and chooses not to obtain the Covered Drug from that Designated Plan Pharmacy.

2.6 If HPN determines that the Member may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, the Member’s selection of Plan Pharmacies may be limited. If this happens, HPN may require the Member to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if the Member uses the assigned single Plan Pharmacy. If a selection is not made by the Member within thirty-one (31) days of the date of notification, then HPN will select a single Plan Pharmacy for the Member.

2.7 Certain Specialty Prescription Drugs may be dispensed by the Designated Pharmacy in fifteen (15) day supplies up to ninety (90) days and at a pro-rated Copayment or Coinsurance. The Member will receive a fifteen (15) day supply of the Specialty Prescription Drug Product to determine if the Member will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Member each time prior to dispensing the fifteen (15) day supply to confirm if the Member is tolerating the Specialty
**PRESCRIPTION DRUG RIDER**

Prescription Drug Product. The list of these certain Specialty Prescription Drugs is available through review of the HPN Prescription Drug List (PDL).

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

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/or 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 Biosimilar Prescription Drugs.

3.30 Publicly available software applications and/or monitors that may be available with or without a prescription order or refill.

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

3.32 Drugs and medicine 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.

3.33 Unit dose packaging of Prescription Drugs.

**SECTION 4. Glossary**

4.1 *“Biosimilar Prescription Drug”* means a biological Prescription Drug approved based on showing that it is highly similar to a Reference Product, and has no clinically meaningful differences in terms of safety and effectiveness from the Reference Product.

4.2 *“Brand Name Drug”* is a Prescription Drug which is marketed under or protected by:

- a registered trademark;
PRESCRIPTION DRUG RIDER

- or a registered trade name;
- or a registered patent.

4.3 **“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.

4.4 **“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 3.31 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.

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

4.6 **“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.

4.7 **“Dispensing Period”** as established by HPN means 1) a predetermined period of time; or 2) a period of time up to a predetermined age attained by the Member that a specific Covered Drug is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition.

4.8 **“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.

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

4.10 **“Mail Order Plan Pharmacy”** is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide Covered Drugs to Members by mail.

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

4.12 **“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.

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

4.14 **“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.

4.15 **“Reference Product”** means a biological Prescription Drug.

4.16 **“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.
4.17 **“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.

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

4.19 **“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.

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.

Questions about HPN’s PDL should be directed to the Member Services Department at 1-800-777-1840 or the PDL and the Pharmacy Reimbursement Claim Form is available at [http://www.uhcnevada.com/](http://www.uhcnevada.com/) which leads to HPN’s portal [www.myhpnonline.com](http://www.myhpnonline.com).

- **Coupons:** HPN may not permit certain coupons or offers from pharmaceutical manufacturers to apply to the Member’s annual CYD and/or Out of Pocket Maximum or to reduce the Member’s Copayments and/or Coinsurance. Costs defrayed for the Member as a result of pharmaceutical coupons are not Eligible Expenses. Questions regarding which coupons or offers are available can be addressed at [https://www.myuhc.com/](https://www.myuhc.com/).
Vision Care Services Rider
to the HPN Evidence of Coverage

Option 6: 12/12/24/10-10-100

The Vision Care Services Rider is issued in consideration of: (a) the Group’s election of coverage under this Rider, (b) the Member’s eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Rider is a supplement to the Health Plan of Nevada (“HPN”) Evidence of Coverage (“EOC”) and Attachment A Benefit Schedule and amends your coverage to include benefits for Vision Care Services.

SECTION 1. Vision Care Services

Subject to definitions, terms and conditions in the EOC, a Member is entitled to receive the vision care services set forth in this Rider. The Member shall be entitled to vision care services only if a Plan Provider prescribes Lenses and Frames and the prescription was ordered while the Member was enrolled in HPN.

<table>
<thead>
<tr>
<th>Covered Services and Limitations</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision Examination</strong></td>
<td>$10 copay for each examination by a Plan Provider. Subject to limitation.</td>
</tr>
<tr>
<td>One (1) vision examination by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be provided each twelve (12) consecutive calendar month period.</td>
<td></td>
</tr>
<tr>
<td><strong>Lenses (Plastic)</strong></td>
<td>$10 copay for one pair of Lenses (Plastic). Subject to limitation.</td>
</tr>
<tr>
<td>One (1) pair of Lenses will be provided during any twelve (12) consecutive calendar month period, when a prescription change is determined Medically Necessary by a Plan Provider. Lenses are limited to single vision, bifocal, trifocal, lenticular and other complex Lenses.</td>
<td></td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$100 maximum allowance for Frames. Subject to limitation.</td>
</tr>
<tr>
<td>Expenses incurred in connection with Frames, from an approved frame selection will be considered covered vision expenses once during each twenty-four (24) consecutive calendar month period. Charges for Frames in excess of the maximum allowance shall be the responsibility of the Subscriber. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.</td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td>$250 maximum allowance for medically necessary Contact Lenses. Subject to limitation.</td>
</tr>
<tr>
<td>Expenses incurred in connection with the purchase of one (1) pair of Contact Lenses prescribed by a Plan Provider may be considered covered vision expense on the condition that the Subscriber elects to receive an allowance for the purchase of such Contact Lenses in lieu of all other vision benefit once during any twelve (12) consecutive month period (with the exception of the annual vision examination which shall continue to be available). Charges for Contact Lenses in excess of the Maximum allowance shall be the responsibility of the Subscriber. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.</td>
<td></td>
</tr>
<tr>
<td>$115 maximum allowance for conventional or disposable Contact Lenses. Subject to limitation.</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 2. Exclusions

This section tells you what services and supplies are not covered under the Evidence of Coverage. The following services and resulting complications are excluded from coverage hereunder.

2.1 Any services and supplies not provided for in the EOC, not Medically Necessary as defined by the EOC or not required in accordance with the accepted standards of vision practice of the community.

2.2 Services provided by non-participating vision care providers.

2.3 Charges for services by a vision Plan Provider to his or her Dependents.

2.4 Charges for care or services and supplies provided before the Effective Date or after the termination date of the Evidence of Coverage.

2.5 Services or materials that are experimental or investigational.

2.6 Services or materials provided under Workers’ Compensation or Employer’s Liability laws.

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

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

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

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

2.11 Two pairs of eyeglasses in lieu of bifocals.

2.12 Visual therapy.

2.13 Replacement of lost or stolen eyewear.

SECTION 3. Limitations

3.1 The following options are excluded from coverage hereunder; however, if the Member wishes to pay the full cost of any option, it will be made available by the Plan Provider. The Plan Provider will maintain a schedule listing the full cost of these options:

- oversize Lenses;
- cost of Frames in excess of Frames allowance;
- tinted of photochromic Lenses;
- coated Lenses;
- cosmetic Contact Lenses
- no-line bifocal Lenses;
- plastic multi-focal Lenses;
- two pairs of Lenses and Frames in lieu of bifocal Lenses and Frames; or
- all prescription sunglasses.


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.
This section tells you meanings of some of the more important words in the Evidence of Coverage. Please read it carefully. It will help you to understand the rest of the Evidence of Coverage.

5.1 “Blended Lenses” means bifocals which do not have a visible dividing line.

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

5.3 “Coated Lenses” means a substance which is added to a finished lens on one or both surfaces.

5.4 “Contact Lenses” means ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Plan Provider to be fitted directly to the patient’s eyes.

5.5 “Course of Treatment” means an interdependent series of Medically Necessary Covered Services prescribed by a Vision Provider to correct a specific optical condition.

5.6 “Eligible Vision Expenses” (EVE) means the maximum allowable amount the Company will pay for a particular Covered Service as determined by the Company in accordance with the HPN Reimbursement Schedule. Vision Plan Providers have agreed to accept the HPN Reimbursement Schedule as payment in full for Covered Services, less any applicable Copayment. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.

5.7 “Frames” mean standard eyeglass Frames adequate to hold two Lenses.

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

5.9 “Lenses” mean ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Vision Plan Provider to be fitted into frames.

5.10 “Medically Necessary” means any vision care services or supplies required to preserve the Member’s visual health and which, as determined by the Company’s Managed Care Program and or Medical Director, are:

- consistent with the symptoms or diagnosis and treatment of the Member’s vision deficiency;
- appropriate with regard to standards of good vision practice; and
- not solely for the convenience of the Member or Provider; and
- the most appropriate supply or level of service which can be provided to the Member.

Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by a Provider. The Company may consult with professional consultants, or other appropriate sources for recommendations regarding the services or supplies the Member receives are Medically Necessary.

5.11 “Non-Plan Vision Provider” means a Vision Provider who does not have an independent contractor agreement with HPN.

5.12 “Occupational Illness or Injury” means any Illness or Injury arising out of or in the course of employment for pay or profit.

5.13 “Orthoptics” means the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

5.14 “Oversize Lenses” means larger than standard lens blank, to accommodate prescriptions.

5.15 “Photochromic Lenses” means lenses which change color with intensity of sunlight.

5.16 “Plano Lenses” means lenses which have no refractive power.

5.17 “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
Vision Care Service Rider

agreement to pay for a service.

5.18 “Professional Service” means examination, material selection, fitting of glasses, related adjustments, etc.

5.19 “Tinted Lenses” means lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc).

5.20 “Vision Plan Provider” means a Provider who has an independent contractor agreement with HPN to provide certain Covered Services to Members. A Vision Plan Provider’s agreement with HPN may terminate, and a Member will be required to select another Vision Plan Provider.
Advance Directives

DURABLE POWER OF ATTORNEY
DECLARATION OF LIVING WILL

NOTE: This document is not intended as a substitute for legal advice. You should seek qualified legal guidance to assist you in completing and executing an Advance Directive in accordance with the law.

Introduction

There may come a time when you will be seriously injured or become gravely ill and unable to make healthcare decisions for yourself. You may wish to choose in advance what kinds of treatments are administered and whether or not life support systems should be maintained or withdrawn.

Most states allow a competent adult to execute a document which allows him or her to accept or refuse treatment in the event that he or she has a terminal condition and is not able to make decisions for himself or herself. Many states do not specify the particular form that a directive must follow to be effective, but you should check the laws in your own state to be sure. However, we have included information for you on where you can get forms which may be available.

Glossary

**Advance Directive** - an instruction, such as a Declaration/Living Will or Durable Power of Attorney for Healthcare Decisions, to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

**Attorney In Fact** - a person authorized by another to act in his place either for some particular purpose, as to do a particular act, or for the transaction of business in general which is not of a legal nature.

**Life-sustaining Treatment** - a medical procedure or intervention that uses mechanical or other artificial means to sustain, restore or supplant a vital function. It only artificially postpones the moment of death of a patient in a Terminal Condition whose death is imminent or will result within a relatively short time without the application of the procedure. The term does not include the administration of medication or the performance of a medical procedure considered to be necessary to provide comfort or care, or to alleviate pain.

**Terminal Condition** - an incurable and irreversible condition caused by injury, disease or illaess that would result in death without the application of life-sustaining procedures, according to reasonable medical judgement. The application of life-sustaining procedures serves only to postpone the moment of the patient’s death.

Types of Advance Directives

A Declaration/Living Will is one type of Advance Directive. A Declaration/Living Will directs your attending physician to withdraw treatment that only prolongs a Terminal Condition. To be valid under law, a Declaration/Living Will must be signed by you as the declarant and must also be signed by two witnesses who 1) are not related to you by blood or marriage, 2) are not mentioned in your will and 3) would have no claim on your estate.

In addition the Declaration/Living Will may not be witnesses by your physician or by anyone working for your physician. If you are in a healthcare facility at the time you sign the Declaration/Living Will, you may not use as a witness any other patient, or employee of the facility if they are involved in providing direct patient care to you or are directly involved in the financial affairs of the facility. The signatures of the witnesses do not have to be notarized to make the Declaration/Living Will a valid legal document.

A Durable Power of Attorney for Healthcare Decisions may also be executed. This document allows you to appoint someone to make a variety of healthcare decisions for you should you become unable to do so. Requirements under the law are very specific for properly executing this document, and you should seek qualified legal guidance to assist you in completing and executing an Advance directive in accordance with the law.
**Advance Directive**

**Advance Directives as Part of your Permanent Medical Record**

Once you have executed an Advance Directive of any kind, please notify your physician and provide a copy of it to him or her so that it may be made a part of your permanent medical record.

Upon learning of the existence of an Advance Directive, a physician must make reference to the fact that you have an Advance Directive in your permanent medical record.

**Frequently Asked Questions**

**How long is an Advance Directive valid?**

Generally, any Advance Directive is effective until it is revoked. You may want to consider initialing and dating your Advance Directive periodically to show that it still expresses your wishes. You may revoke your Advance Directive at any time and in any manner, without regard to your mental or physical condition. A revocation is effective when your attending physician or other healthcare provider receives notice of the revocation from you or from a witness to the revocation. Pursuant to the law, to the extent that a Durable Power of Attorney for Healthcare or Declaration/Living Will conflicts with a directive or treatment decision executed under the law, the instrument executed later in time controls.

**What will happen if I become terminally ill and I am unable to make healthcare decisions by myself, yet I haven’t executed an Advance Directive?**

In preparation for this possibility, you should, at the very least, make your wishes known to those you love. Laws in your state may give a "surrogate decision maker" the authority to consent to the withholding or withdrawal of life-sustaining treatment for you. (This consent must be in writing and attested by two witnesses.)

A "surrogate decision maker" is, in order of authority:

- your spouse;
- your adult child or, if you have more than one child, a majority of the adult children who are reasonably available to consult;
- your parents;
- your adult sibling or, if you have more than one adult sibling, a majority of the adult siblings who are reasonably available to consult;
- or your nearest other adult relative by blood or adoption who is reasonably available to consult.

If a class of "surrogate decision makers" entitled to consent is not reasonably available to consult and competent to decide, or declines to decide, the next class is authorized to make the decision. An equal division in a class does not authorize the next class to decide.

**What if my doctor objects to the withholding or withdrawal of life-sustaining treatment?**

Healthcare providers have varying beliefs regarding the implementation of an individual’s Advance Directive. An attending physician or other provider of healthcare who is unwilling to honor your Advance Directive must take all reasonable steps as promptly as possible to transfer your care to another physician or healthcare provider.

**How will my execution of an Advance Directive affect my health and life insurance policies?**

The making of an Advance Directive does not affect the sale, purchase or issuance of a life insurance or annuity policy, nor does it affect the terms of an existing policy. It also cannot be prohibited or required as a condition of being insured for, or receiving, healthcare.

**What are our policies on the administration of life-sustaining treatment?**

As a company we are committed to the preservation of life and the alleviation of suffering. If, however, you wish to have life-sustaining treatment withheld or withdrawn in the event you become terminally ill, we will make every effort to see that your wishes are honored. If you have already executed an Advance Directive, please give a copy to your doctor(s) to be placed in your medical record.
Where can I obtain a Declaration/Living Will or Durable Power of Attorney for Healthcare Decisions form?

Forms are available from a variety of sources, including some physicians, attorneys, and healthcare facilities.

Once you have completed an Advance Directive, discuss your decisions with your family, next of kin, or other responsible parties, and give your attorney and each one of your doctors a copy to be placed in all of your medical records. It is also advisable to keep a copy with you at all times.

Conclusion

It is difficult for people to make good decisions when they are under pressure or emotional strain, particularly in areas where there are no clear-cut answers about life-sustaining treatment. These issues require a great deal of discussion and careful thought. The information provided here has been presented in the hope that you will discuss it with your doctor and others and come to a decision that is right for you or someone you love.
We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** UHC_Civil_Rights@uhc.com

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

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

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card or plan documents.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


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

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card or plan documents.

**English:**

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

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card or plan documents.
Español (Spanish)
Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan o los documentos de su plan.

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

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

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

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

አማርኛ (Amharic)
በምትፈልጉት እርዳታና መረጃ ያላለዎት። ከአማርኛ ወጪ ማግኘት በመብት እለዎት፣ የአማርኛ ለመጠየቅ፣ በጤናካርድዎ ከሚረጋገጡ በተዘረዘረውን ይዘት ወለዎት፣ ከአማርኛ ከምልክት፣ ከአማርኛ ለምሳሌ፣ ከአማርኛ በአማርኛ ወለዎት።

ภาษาไทย (Thai)
คุณมีสิทธิ์ขอความช่วยเหลือหรือขอข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายใด ๆ เมื่อต้องการติดต่อของแผนสุขภาพหรือเอกสารแผนสุขภาพของคุณที่อยู่บนบัตรแผนสุขภาพหรือเอกสารแผนสุขภาพของคุณ

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

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

Русский (Russian)
Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты или документах о вашем плане.
Vous avez le droit d’obtenir gratuitement de l’aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d’affilié du régime de soins de santé ou dans la documentation relative à votre régime.

فارسی (Persian)
یپرا دیکن افستی در گانو مورا صورت به خونشان زبان به را اطلاعات و پیشنهداهنا تادیهست برخورد در حق نوا از شما طرحان به مربوط اسناد ای سلامت طرح پیشنام کارتر در موجود گانورا تلفنهش ممکنه با، ویشوهه متزخم درخواست دیدار ممکن.

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

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

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