Health Plan of Nevada, Inc.

www.uhcfeds.com

Customer Service 877-545-7378

HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

2018

A Health Maintenance Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This plan is accredited. See page 13.

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 15
- Summary of benefits: Page 78

Serving: Clark, Esmeralda and Nye Counties

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Enrollment codes for Clark, Esmeralda and Nye Counties:

NM1 Self Only
NM3 Self Plus One
NM2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Health Plan of Nevada, Inc. About Our Prescription Drug Benefit Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Health Plan of Nevada, Inc.'s prescription drug benefit coverage is, on average, expected to pay out as much as the standard Medicare prescription drug benefit coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go sixty-three (63) days or longer without prescription drug benefit coverage that is at least as good as Medicare's prescription drug benefit coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug benefit coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 (TTY 800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help
- Call 800-MEDICARE (800-633-4227), TTY 877-486-2048.

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Introduction

This brochure describes the benefits of Health Plan of Nevada, Inc. ("HPN"), a UnitedHealthcare company, under our contract (CS 1942) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 877-545-7378 or through our website: www.uhcfeds.com. The address for HPN's administrative offices is:

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

This brochure is the official statement of benefits. No statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on page 16. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means HPN.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health BenefitsProgram premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

  - Call the provider and ask for an explanation. There may be an error.

  - If the provider does not resolve the matter, call us at 877-545-7378 and explain the situation.

- If we do not resolve the issue:

CALL- THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise);
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intential misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include,falsifying a claim to obtain FEHB benefits, trying to obtaining services or coverage for yourself orfor someone who is not eligible for coverage, or enrolling in the Plan when you are no long eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received.You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The Health Plan of Nevada, Inc. complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, the Health Plan of Nevada, Inc. does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions, and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:

- "Exactly what will you be doing?"

- "About how long will it take?"

- "What will happen after surgery?"

- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use HPN preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

If an HAC (hospital acquired condition) occurs, the ACH (acute care hospital) may not balance bill the member for charges denied by HPN or SHL. The member will be held harmless for any difference in charges between what the ACH would have received if no HAC were present and what they were paid by the health plan.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined and explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your childreaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below). A Self Plus One enrollment covers you and your spouse, or one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2018 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2017 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five (5) years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined to a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee or an annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc. You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 877-545-7378 or visit our website at shophpn.com/exchange.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Health Plan of Nevada, Inc. holds the following accreditation: National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation, please visit the following website: www.ncqa.org. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

When we contract with a doctor or medical group to provide health care services, the contract specifies the amount the doctor or medical group will be paid for providing services - either on a fixed monthly basis or as a payment per service provided.

We have several types of payment arrangements with our doctors:

- Arrangement A: Your doctor may be part of a contracted medical group and may receive a salary. Some medical groups may pay their doctors a bonus.
- Arrangement B: Your doctor may receive a fixed amount of money each month, called a "capitation," to provide services to all Plan patients they see. Capitation may be considered to be an incentive plan.
- Arrangement C: Your doctor may be paid a pre-determined amount for each service he/she provides.

Your rights and responsibilities

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- HPN has operated as a mixed model HMO in Nevada for 29 years. HPN 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.
- We understand the importance of getting your questions answered. Whether you need an answer to a benefit question, have a concern about a claim or need help in selecting a provider, we are available Monday through Friday, 8 a.m. to 5 p.m. at 877-545-7378.
- At times, services required on your behalf by your provider may not be approved by HPN.The decision to deny coverage for services requested, courses of treatment or inpatient care is made by a physician. These denials are based upon medical necessity, benefit coverage and your individual needs. Written notification of the denial will be sent to you, your primary care provider and the provider who requested the service. You have the right to appeal these decisions.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Health Plan of Nevada at www.healthplanofnevada.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 877-545-7378, or write to Health Plan of Nevada, Inc., P.O. Box 15645, Las Vegas, NV 89114-5645. You may also visit our website at www.uhcfeds.com.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website Health Plan of Nevada at www.healthplanofnevada.com to obtain a Notice of our Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is: Clark, Esmeralda, and Nye counties

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2018

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

- The Plan will provide statins for the prevention of cardiovascular disease in adults at no cost to the enrollee.
- The Plan will expand the amount of medically supervised weight loss therapy required for the treatment of morbid obesity (bariatric surgery) to six consecutive months within the last 24 months of documented medically supervised weight loss.
- Your share of the non-Postal premium will increase for Self Only, increase for Self Plus One, and increase for Self and Family. See page 79.

Section 3. How you get care

Identification Cards

We will send you an Identification (ID) Card when you enroll. You should carry your ID Card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID Card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID Card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 877-545-7378 or write to us at Health Plan of Nevada, Inc., P.O. Box 15645, Las Vegas, NV 89114-5645. You may also request replacement cards through our website at www.healthplanofnevada.com and log into We're@YourService.

Where you get covered care

You obtain care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims.

- **Plan Providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

You should join our Plan because you prefer the benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

- **Plan Facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get Covered Care

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your health care. This plan has a provider directory, which we urge you to review before choosing your primary care provider.

- **Primary Care**

Your primary care provider can be a family practitioner, pediatrician, or internist who practices as a primary care provider. Women may also select an Obstetrician/ Gynecologist. Your primary care provider will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care providers or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty Care**

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral. However, women may see their Obstetrician/ Gynecologist without a referral.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will work with the Plan and your specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. Your primary care provider will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we: you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.
  - terminate our contract with your specialist for other than cause;
  - drop out of the FEHB Program and you enroll in another FEHB Program plan; or
  - reduce HPN's service area and you enroll in another FEHB plan;

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital Care**

Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 877-545-7378. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your Plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

- **You need prior Plan approval for certain services**

  Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

  Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

  Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

  - Transplants
  - All non-emergency hospital admissions
  - Admissions to skilled nursing facilities and inpatient hospice facilities
  - All non-emergency inpatient and outpatient surgeries
  - Specialists visits or consultations
  - Many diagnostic procedures
  - Courses of treatment, including allergy testing or treatment, angioplasty, physiotherapy or manual manipulation
  - Physical, occupational and speech therapy
  - Hearing Aids
  - Home Healthcare Services
  - Prosthetic devices, orthotic devices and durable medical equipment
  - Certain prescription drugs
  - Pharmaceutical compounds
  - Genetic disease testing
  - Clinical trials or studies for the treatment of cancer or chronic fatigue syndrome
  - Dental anesthesia for enrolled dependent children when determined to be medically necessary
  - Non-emergency (ground or air) transport
  - It is best to contact your primary care provider before you seek any services. Failure to follow the requirements of the prior authorization process will result in higher out-of-pocket costs to you.

  Contact Customer Service at 877-545-7378 for additional details.

- **How to request precertification for an admission or get prior authorization for Other services**

  First, your physician, your hospital, you, or your representative, must call us at 877-545-7378 before admission or services requiring prior authorizations are rendered.

  Next, provide the following information:

  - enrollee's name and Plan identification number;
  - patient's name, birth date, indentification number and phone number;
  - reason for hospitalization, proposed treatment, or surgery;
  - name and phone number of admitting physician;
  - name of hospital or facility; and
  - number of days requested for hospital stay.

- **Non-Urgent Care Claims**

  For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

  If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent Care Claims**

  If you have an urgent care claim (i.e., when waiting for the regular time limit for medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information, or (2) the end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 877-545-7378. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 877-545-7378. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

• **If your treatment needs to be extended**	If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.
• **What happens when you do not follow the precertification rules when using non-network facilities**	A non-network facility admission would not be covered.
Circumstances beyond our control	Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.
• **If you disagree with our pre-service claim decision**	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
• **To reconsider a non-urgent care claim**	Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to: 1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or 2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. 3. Write to you and maintain our denial.
• **To reconsider an urgent care claim**	In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.
• **To file an appeal with OPM**	After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered services you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician, you pay a $10 copayment per office visit, and when admitted to the hospital, you pay a $300 copayment per admission.
Deductible	We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for costs associated with emergency air ambulance and/or for the treatment of temporomandibular joint pain dysfunction syndrome.
Differences between our Plan allowance and the bill	Eligible Medical Expenses (EME) means charges up to the Plan reimbursement schedule amount, incurred by you while covered under this Plan for covered services. Plan providers have agreed to accept the Plan's reimbursement schedule amount as payment in full for covered services, plus your payment of any applicable copayment or coinsurance. Non-plan providers have not. If you use the services of non-Plan providers, you will receive no benefit payments or reimbursement for charges for the service, except in the case of emergency services, urgently needed services, or other covered services provided by non-Plan providers that are prior authorized by the Plan. In no event will the Plan pay for more than the applicable Plan reimbursement schedule amount for such services.
Your catastrophic protection out-of-pocket maximum	After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $3,500 for Self Only, or $7,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $3,500 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.*** Example Scenario: Your plan has a $3,500 Self Only maximum out-of-pocket limit and a $7,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $3,500 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $7,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $3,500 for the calendar year before their qualified medical expenses will begin to be covered in full. However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services: • amounts charged for non-covered services • amounts exceeding applicable plan benefit maximums or eligible medical expenses payments • penalties for not obtaining any required prior authorization or for the member otherwise not complying with HPN's managed care program

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to the plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High Option Benefits

See page 16 for how our benefits changed this year. Page 79 is a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High Option Benefits Overview

This Plan offers a High Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available under this option in which you are enrolled.

The High Option Section 5 is divided into subsections. Please read the *important things you should keep in mind* at the beginning of the subsections. Also read the *general exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our High Option benefit, contact us at 877-545-7378 or on our website at www.uhcfeds.com.

Our High Option offers the following unique features.

High Option

- The formulary consists of a four (4) tier design. This allows the formulary to be managed by level of clinical necessity and cost rather than by the designations of brand or generic.
  - Tier 1 represents the lowest copayment tier and includes the most inexpensive drugs.
  - Tier 4 is filled with costly medications when compared to available alternatives or medications that have relatively low clinical utility. While specialty drugs are usually substantially more expensive than non-specialty drugs, Tier 4 is not a specialty-only tier.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office	$10 per office visit for Primary Care $25 per office visit for Specialist
• House calls by physician	$25 per visit
• During a hospital stay • In a skilled nursing facility • Second surgical opinion	Nothing
Telehealth Services	**High Option**
Now Clinic/Telemedicine Convenient Care Physicians Extender Assistant	$5 per visit
Lab, X-ray and other diagnostic tests	**High Option**
• Laboratory Services Routine tests, such as: • EKG • X-rays	$10 per visit
• Complex diagnostic imaging services, such as nuclear medicine, CT scan, cardiac ultrasonography, MRI and arthrography • Complex vascular diagnostic and therapeutic services including Holter monitoring, treadmill stress testing, and impedance venous plethysmography • Complex neurological diagnostic services including EEG, EMG, and evoked potential • Complex pulmonary diagnostic services including pulmonary function testing and apnea monitoring • Otologic evaluation • Abdominal aortic aneurysm screening, one screening for men between the ages of 65 and 75 with a history of smoking	$20 per test or procedure

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**High Option**
• Genetic disease testing when medically necessary and prior authorized by the Plan	25% of EME
• Positron Emission Tomography (PET) scan	$200 per test
Preventive care, adult	**High Option**
Routine physical every 12 months which includes: Routine screenings, such as: • Total Blood Cholesterol • Chlamydial infection • Colorectal Cancer Screening, including - Fecal occult blood test • Osteoporosis screening • Sigmoidoscopy screening - every five years starting at age 50 • Colonoscopy screening - every ten years starting at age 50 Well woman care; based on current recommendations such as: • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screening • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing
Routine mammogram – covered for women.	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive list of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicetaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/	

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
For additional information: healthfinder.gov/myhealthfinder/default.aspx	
Not covered: • *Physical exams required for obtaining or continuing employment, licensing, or insurance; attending schools or camp; athletic exams; travel; sports; or adoption purposes.* • *Exams or treatment ordered by a court, or in connection with legal proceedings.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**High Option**
Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx	
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women after 24 weeks • Delivery • Postnatal care	Nothing for prenatal care or the first postpartum care visit; $10 per office visit for all postpartum care visits thereafter. $25 for inpatient professional delivery services.
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 30 for other circumstances, such as extended stays for you and your baby.	

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• You may remain in the hospital for up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	
Not covered: • *Routine sonograms to determine fetal age, size, or sex* • *Amniocentesis, except when medically necessary under the guidelines of the American College of Obstetrics and Gynecology* • *Services and supplies rendered in connection with member acting as or utilizing the services of a surrogate mother*	*All charges*
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization [See Surgical procedures *Section 5(b)]* • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms **Note:** We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Voluntary abortions* • *Genetic testing and counseling, except as indicated in Lab, X-ray, and other diagnostic tests*	*All charges*

Benefit Description	You pay
Infertility services	**High Option**

Diagnosis and treatment of infertility such as:
 	
Diagnostic and therapeutic infertility services determined to be medically necessary and prior authorized by the Plan.
• Laboratory studies
• Diagnostic procedures
• Artificial insemination services, up to six (6) cycles per member per lifetime
  • Intracervical insemination (ICI)
  • Intrauterine insemination (IUI)
• Fertility drugs
 	
Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.
	$25 per office visit

Not covered:
• *Assisted reproductive technology (ART) procedures, such as:*
  - *In vitro fertilization (IVF)*
  - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)*
• *Services and supplies related to excluded ART procedures*
• *Cost of donor sperm*
• *Cost of donor egg*
• *Low tubal transfers*
	All charges

Allergy care	**High Option**
• Testing and treatment • Allergy injections	$10 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy **Note:** High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on pages 40-44. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) **Note:** Growth hormone is covered under the prescription drug benefit.	$20 per office visit

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 19.	$20 per office visit
• Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder Note: For members under the age of 18 or, if enrolled in high school, until such member reaches the age of 22. ABA for the treatment of autism is limited to 250 visits, not to exceed 1,500 total hours of therapy per member per calendar year.	$10 per office visit
Not covered: • *Sports medicine treatment intended to primarily improve athletic ability*	*All charges*
Physical and occupational therapies	**High Option**
Rehabilitation and Habilitative Services of each of the following: • Qualified physical therapists • Occupational therapists **Note:** We only cover therapy when a provider orders the care. **Note:** Maximum benefit of sixty (60) days/visits per member per calendar year. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 30 sessions. Note: Cardiac rehabilitation services must be provided on a monitored basis.	$10 per office visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Alternative treatments*	*All charges*
Speech therapy	**High Option**
Rehabilitation and Habilitative Services of a speech therapist **Note:** Maximum benefit of sixty (60) days/visits per member per calendar year.	$10 per office visit

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist **Note:** For routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive *care, children*	$10 per office visit
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants **Note:** For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	$10 per office visit
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• Annual eye refraction Note: See *Preventive care, children* for eye exams for children.	$10 per office visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	50% of EME
Not covered: • *Eye examination required as a condition of employment or by a government body* • *Low vision aids* • *Orthoptics or vision training and exercises* • *Medical or surgical treatment of the eyes* • *Any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Braces which include only rigid and semi-rigid devices used for supporting a weak or deformed body member or restricting or eliminating motion of a diseased or injured part of the body • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Terminal devices, such as hand or hook • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Implanted hearing-related devices, such as bone achored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy • Foot orthotics when part of a lower body brace • Lumbosacral supports • Adjustments of an initial Prosthetic or Orthotic device required by wear or by change in patient's condition when ordered by a Plan provider Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) Services provided by a hospital or other facility, and ambulance services.	50% of EME, not to exceed $200 per device
External hearing aids Note: Benefit coverage is limited to a single purchase of a type of hearing aid, including repair and replacement once every three (3) years.	$100 or 50% of EME, whichever is less.
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cops* • *Arch supports* • *Special shoe accessories or corrective shoes unless they are an integral part of a lower body brace* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* Prosthetic replacements provided less than three years after the last one we covered	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs - limited to coverage of single standard manual wheelchair as deemed medically necessary and appropriate • Crutches • Walkers • Traction equipment **Note:** Call us at 877-545-7378 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing
• Insulin pumps	$100 per device
Not covered: • *Motorized wheelchairs* • *Custom wheelchairs* • *More than one piece of equipment serving essentially the same function except for replacements as authorized by the Plan. Coverage for alternate or spare equipment is not provided.*	*All charges*
Home health services	**High Option**
Covered services and supplies provided by a Home Health Care agency include: • Professional services of a registered nurse, licensed practical nurse, licensed vocational nurse or a health aide on an intermittent basis. • Physical therapy, speech therapy and occupational therapy by licensed therapists. • Medical and surgical supplies that are customarily furnished by the Home Health Care agency or program. • Prescribed drugs furnished and charged for by the Home Health Care agency or program. Prescribed drugs under this provision do not include self-injectable prescription drugs. • Health aid services furnished to member only when receiving nursing services therapy.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Housekeeping or meal service*	*All charges*

Benefit Description	You pay
Chiropractic	**High Option**
• Chiropractic services for the manual manipulation of the spine (except for reductions of fractures or dislocations)	$25 per office visit
Alternative treatments	**High Option**
• Medical treatment in a Phase I, II, III or IV clinical trial or study for the treatment of cancer conducted in the state of Nevada • Medical treatment in a Phase II, III or IV clinical trial or study for the treatment of chronic fatigue syndrome conducted in the state of Nevada • Pain relief Note: See the Prescription drug benefits *(Section 5 (f))* for coverage of drugs and medicines.	$25 per office visit
Not covered: • *Any portion of the clinical trial or study that is customarily paid for by the government, biotechnical, pharmaceutical or medical industry* • *Services that are specifically excluded from coverage under this Plan regardless of whether such services are provided under the clinical trial or study* • *Services that are customarily provided by the sponsors of the clinical trial or study* • *Expenses related to participation in the clinical trial or study including, but not limited to; travel, housing and other expenses* • *Expenses incurred by a person who accompanies a 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* • *Any cost for the management of research relating to the clinical trial or study*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco cessation programs, including individual, group, telephone counseling, and over the counter (OTC) and prescription drugs approved by the Federal Drug Administration (FDA) to treat tobacco dependence. • Counseling for up to two (2) attempts to quit per year, including one (1) individual counseling session and at least six (6) group counseling sessions per quit attempt. Note: See Prescription drug benefits *Section 5(f)* for coverage of tobacco cessation medication.	Nothing
• Diabetes self-management • Education: Three-part class for treatment of diabetes. Covered services include medically necessary training and education for:	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
- the care and management of diabetes, after initial diagnosis of diabetes, to include counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes - a subsequent diagnosis that indicates a significant change in the symptoms or condition which requires modification of the self-management program - the development of new techniques and treatment for diabetes	Nothing
• Diabetes supplies, including: - syringes - needles - blood glucose measuring strips - urine checking reagents • Disposable needles and syringes for the administration of covered medications	$5 per 30-day therapeutic supply
• Insulin pump supplies	$10 per 30-day therapeutic supply
• Diabetes equipment, including: - blood glucose monitor - lancet device Note: See Durable medical equipment [*Section 5(a)]* for coverage of insulin pumps. See Prescription drug benefits [*Section 5(f)]* for coverage of diabetes medication.	$20 per unit

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SURGICAL PROCEDURES**. Please refer to the prior authorization information in Section 3, *How you get care,* to be sure which services require prior authorization and identify which surgeries require prior authorization.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus (see Reconstructive surgery [*Section 5(b)])* • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery [*Section 5(b)])* • Insertion of internal prosthetic devices. See Orthopedic and prosthetic devices [*Section 5(a)]* for device coverage information • Treatment of burns • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.	$25 in a physician's office Inpatient: $25 per surgery Outpatient: $25 per surgery
• Surgically implanted contraceptives	Nothing
• Surgical treatment of morbid obesity (bariatric surgery) - Individuals must have a body mass index (BMI) of greater than 40 kg/m2, or greater than 35kg/m2 with significant co-morbidities such as cardiac disease, diabetes, hypertension, or diseases of the endocrine system, e.g., Cushing's syndrome, hypothyroidism, or disorders of the pituitary or adrenal glands	50% of EME

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
- Individuals must show documentation that medically supervised weight loss therapy for 6 consecutive months within the last 24 months has been ineffective - Individuals must be age 18 or over and have a psychological/ psychiatric evaluation by a licensed practitioner with a recommendation for gastric restrictive surgery - Covered services rendered in the treatment of complications in connection with gastric restrictive surgery - Contact the Plan at 877-545-7378 for additional eligibility criteria - The Plan will expand the amount of medically supervised weight loss therapy required for the treatment of morbid obesity (bariatric surgery) to six consecutive months within the last 24 months of documented medically supervised weight loss. Note: See *You need prior Plan approval for certain services* on page 19.	50% of EME
• Surgical Assistant Services	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot* [see Foot care, *Section 5 (a)]*	*All charges*
Reconstructive surgery	**High Option**
Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: cleft lip, cleft palate, birthmarks, webbed fingers, and webbed toes. All stages of breast reconstruction surgery following a mastectomy, such as: • Surgery to produce a symmetrical appearance on the other breast; • Treatment of any physical complications, such as lymphedemas; • Breast prostheses and surgical bras and replacements [see Prosthetic devices *Section 5(a)]* • Surgical treatment for gender reassignment is limited to the following: - For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy - For male to female surgery: penectomy, orchiectomy	$25 per surgery
Not covered:	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Gender reassignment surgical procedures other than those listed above*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Treatment of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth • Removal of teeth necessary in order to perform radiation therapy • Removal of stones from salivary ducts • Other surgical procedures that do not involve the teeth or their supporting structures	$25 per surgery
• Treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	50% of EME
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Single, double or lobar lung • Intestinal transplants - Isolated Small intestines - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney	$25 per surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Kidney-Pancreas • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy only for patients with chronic pancreatitis). These **tandem blood or marrow stem cell transplants** for covered transplants are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Autologous tandem transplants for • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer) **Blood or marrow stem cell transplants** The Plan extends coverage for the diagnoses as indicated below. - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced neuroblastoma - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Pineoblastoma - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: - Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia	$25 per surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia - Autologous transplants for - Allogeneic transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia - Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma	$25 per surgery
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.	$25 per surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Chronic inflammatory demyelination polyneuropathy (CIPD) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathies - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic Syndromes - Multiple myeloma Autologous transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Aggressive non-Hodgkin lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) as required and can be limited to procedures performed in clinical trials • Breast Cancer • Childhood rhabdomyosarcoma • Colon cancer • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian cancer lymphoma) • Multiple myeloma • Myelodysplasia/Myelodysplastic Syndromes • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas	$25 per surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Sickle Cell Anemia - Chronic lymphocytic leukemia - Chronic myelogenous leukemia	$25 per surgery
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	
We cover Blood or Marrow stem cell transplant donor testing services for up to four potential donors.	You pay 50% of EME
• Transportation, lodging and meals Note: Prior authorization is required.	All costs exceeding $200 per day; $10,000 per transplant period.
• Organ procurement	All costs exceeding $15,000 of EME
• Retransplantation services	All costs exceeding 50% of EME
Not covered: • *Donor screening tests and donor search expenses, except as indicated on this page* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in: • Hospital - Inpatient • Hospital - Outpatient • Skilled Nursing Facility • Ambulatory surgical center • Physician's office	$50 per surgery

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9*, Coordinating benefits with Medicare and other coverage*, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRIOR AUTHORIZATION FOR ELECTIVE HOSPITAL STAYS.** Please refer to Section 3, *How you get care,* to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room or special duty nursing when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medicines • Clinical pathology and laboratory services and supplies and X-rays • Dressing, splints, casts, and sterile tray services • Medical supplies including oxygen and its administration • Blood or blood plasma, if not donated or replaced • Intravenous injections and solutions • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	$300 per admission See section 5(b) Surgical and anesthesia services.
Not covered: • *Custodial care* • *Non-covered facilities* • *Private nursing care, except when medically necessary*	*All charges*

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Clinical pathology and laboratory services and supplies and X-rays • Dressing, splints, casts, and sterile tray services • Medical supplies including oxygen and its administration • Blood or blood plasma, if donated or replaced • Pre-surgical testing • Intravenous injections and solutions Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$50 per visit
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Skilled nursing facility (SNF): • Bed, board, and general nursing care • Prescribed drugs and medicines • Clinical pathology and laboratory services and supplies and X-rays • Dressing, splints, casts, and sterile tray services • Oxygen and its administration • Blood or blood plasma, if not donated or replaced • Pre-surgical testing • Intravenous injections and solutions Note: Maximum benefit of 100 days per member per calendar year.	$300 per admission
Not covered: • *Custodial care*	*All charges*
Hospice care	**High Option**
Supportive and palliative care for terminally ill members are covered in the home or in a hospice facility. Covered services include: • Inpatient hospice services • Inpatient respite services **Note:** Inpatient and Outpatient respite services are limited to a combined maximum benefit of 5 Inpatient days or 5 Outpatient visits per member per 90 days of Hospice Care.	$300 per admission
• Outpatient hospice	Nothing
• Outpatient respite services Note: Inpatient and Outpatient respite services are limited to a combined maximum benefit of 5 Inpatient days or 5 Outpatient visits per member per 90 days of Hospice Care.	$10 per visit
• Bereavement services	$20 per visit

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**High Option**
Note: Bereavement services are limited to five (5) group therapy sessions per event. Treatment must be completed within six (6) months of the date of death.	$20 per visit
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
End of Life Care	**High Option**
• No Benefits	All Charges
Ambulance	**High Option**
• Covered services include ground ambulance transportation to the nearest appropriate facility	$50 per trip
• Emergency air ambulance	$250 per trip
• Non-emergency (ground or air) transport **Note:** Non-emergency transport requires prior authorization.	Nothing
Note: 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. **Note:** Non-emergency medically necessary benefits are payable only upon prior authorization from the Plan.	

Section 5(d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage.*

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or the sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care provider. In extreme emergencies, if you are unable to contact your physician, contact **911** or go to the nearest hospital emergency room. Be sure to tell the emergency personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 24 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan receives timely notification.

You may also receive care at the Plan's Urgent Care Centers (see Provider Directory). Benefits are available from non-Plan providers in an emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside our service area: You are covered for any medically necessary health services that are immediately required because of injury or unforeseen illness. If you need to be hospitalized, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be provided in a Plan hospital, you will be transferred when medically appropriate with any charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at an Urgent Care Facility	$30 per visit
• Emergency care in a hospital emergency room	$150 per visit; waived if admitted

Benefit Description	You pay
Emergency outside our service area	**High Option**
• Emergency care at a non-plan Urgent Care Facility	$30 per visit
• Emergency care in a hospital emergency room	$150 per visit; waived if admitted
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the Service Area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**High Option**
• Covered services include ambulance services to the nearest appropriate hospital Note: See *Section 5(c)* for non-emergency ambulance services.	$50 per trip
• Emergency air ambulance	$250 per trip
• Non-emergency (ground or air) transport **Note:** Non-emergency transport requires prior authorization.	Nothing
Note: 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. **Note:** Non-emergency medically necessary benefits are payable only upon prior authorization from the Plan.	

Section 5(e). Mental health and substance misuse disorder benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

To be eligible to receive these benefits, you must obtain a treatment plan and follow the network authorization process.

Note: **Members must contact Behavioral Healthcare Options (BHO) at 702-364-1484 or 800-873-2246 for assistance in scheduling their first appointment. See Section 3 for services that require prior authorization.**

Benefit Description	You pay
Professional Services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance misuse disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$10 per visit

Benefit Description	You pay
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and/or substance misuse disorder practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$10 per test
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$300 per admission
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization or facility-based intensive outpatient treatment	$50 per visit
Not Covered	**High Option**

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications as described in the chart beginning on page 53.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this Brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage.*

There are important features you should be aware of which include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill your prescription at a plan pharmacy, or by mail order for certain maintenance medications. Medications available through mail order are limited to those determined by the Plan to be maintenance medications. The list of maintenance medications is maintained by the Plan at its sole discretion.
- **We use a formulary.** We use a formulary (also referred to as "Preferred Drug List") to serve as a guide for providers in the selection of cost-effective drug therapy and to help maximize the value of our members' prescription drug coverage. Our formulary is a list of FDA approved Tier 1, Tier 2, Tier 3, and Tier 4 medications developed and maintained by the Plan. The formulary is reviewed by physicians and pharmacists on a regular basis and may change throughout the year at the Plan's sole discretion. Patient needs, scientific data, drug effectiveness, availability of drug alternatives currently on the formulary, and cost are considerations in selecting medications for inclusion on the formulary. If your physician believes a Tier 2 product is necessary or if there is no Tier 1 available, your physician may prescribe a Tier 2 drug from the formulary. Inclusion of drugs on the formulary does not guarantee that your provider will prescribe that medication.

Your copayment is lower when formulary drugs are prescribed for you. However, your benefit also includes coverage for non-formulary drugs. Non-formulary drugs are available for the higher non-formulary copayment. Prior authorization may be required for preferred generic, preferred brand-name, non-preferred generic, and non-preferred brand-name drugs.

To obtain a copy of our Preferred Drug List, contact our Customer Service Department at 877-545-7378 or visit our website at www.uhcfeds.com.

"Compound" means to form or create a medically necessary customized composite drug product by combining two or more different ingredients according to a physician's specifications to meet an individual patient's needs.

"Maintenance Drug" is a preferred covered drug prescribed to treat certain chronic or life-threatening long-term conditions as determined by the Plan, such as diabetes, arthritis, heart disease, and high blood pressure.

"Therapeutic Supply" is the quantity of a covered drug for which benefits are available for a single applicable copayment and may be less than but shall not exceed a 30-day supply.

- **These are the dispensing limitations.** A dispensing limitation is the quantity of a medication for which benefits are available for a single applicable copayment, or in the case of maintenance drugs, two copayments for a 90-day therapeutic supply of maintenance medication obtained through our mail order program. Dispensing limitations may include but are not limited to:
  Dispensing limitations may be less than but shall not exceed a 30-day supply for drugs obtained at a Plan pharmacy. Maintenance drugs are available for up to a 90-day supply, provided the medication is on the Plan maintenance drug list. Prescriptions that exceed the dispensing limitation established by the Plan will not be covered.

- A period of time that a specific medication is recommended by the manufacturer and/or the FDA to be an appropriate course of treatment when prescribed for a particular condition, or
- A predetermined period of time established by the Plan, or
- The FDA-approved dosage of a medication when prescribed for a particular condition.

Plan members called to active military duty or in time of national emergency who need to obtain prescription medication should contact our Customer Service Department at 877-545-7378.

- **A Tier 1 equivalent will be dispensed if it is available**, unless your physician specifically requires a Tier 2 drug. If you receive a Tier 2 drug when a Federally-approved Tier 1 drug is available, you have to pay the difference in cost between the Tier 2 drug and the Tier 1 in addition to the Tier 1 drug copayment.
- **Why use Tier 1 drugs?** Tier 1 drugs are lower-priced drugs that are the therapeutic equivalent to more expensive Tier 2, 3, or 4 drugs. Tier 1 drugs must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. Food and Drug Administration sets quality standards for Tier 1 drugs to ensure that these drugs meet the same standards of quality and strength as Tier 2, Tier 3, and Tier 4 drugs.
- **When you do have to file a claim.** You normally won't have to submit claims to us. If you do need to file a claim, please send us all of the documents for your claim (including itemized billings and receipts) as soon as possible. You must submit claims by December 31 of the year after you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time. Send completed claims to Health Plan of Nevada, Inc., Attn: Correspondence/CRR, P.O. Box 14865, Las Vegas, NV 89114-5645.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Insulin (See Educational classes and programs [*Section 5(a)]* for coverage of diabetes supplies) • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medicines. • Drugs for sexual dysfunction. Sexual dysfunction drugs are limited to 6 pills/tablets per therapeutic supply and require prior authorization by the Plan. Contact the Plan for details. • Oral contraceptive drugs • Tobacco cessation drugs (e.g., nicotine patches) • Growth hormone • Orphan drugs • Self-injectable drugs • Pediatric and prenatal vitamins • Vitamin D for adults 65 and older. Note: A "self-injectable" is to be administered subcutaneously or intramuscularly and does not require administration by a licensed practitioner.	Tier 1 = $7 per therapeutic supply; Tier 1 (mail order) = $14 Tier 2 = $35 per therapeutic supply; Tier 2 (mail order) = $70 Tier 3 = $55 per therapeutic supply; Tier 3 (mail order) = $110 Tier 4 = $100 per therapeutic supply; Tier 4 (mail order) = $200 Note: You pay two applicable copayments for a 90-day therapeutic supply of maintenance medication obtained through our mail order program. No Charge for cessation drugs. Limited to 2 quit attempts per year.
Women's contraceptive drugs and devices	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
The "morning after pill" is considered a preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy. The "morning after pill" should be addressed under the pharmacy benefit as an over-the-counter (OTC) emergency contraceptive drug.	Nothing
• Compounds, when medically necessary and prior authorized by the Plan	$55
Special food products/enteral formulas • 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.	Nothing
Preventive care medications	**High Option**
Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 6 months-1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tables, solution (not toothpaste, rinses) for children age 0-6 • The Plan will provide statins for the prevention of cardiovascular disease in adults at no cost to the enrollee. **Note:** To receive this benefit a prescription from a doctor must be presented to the pharmacy.	*Nothing*
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Nonprescription medicines (except insulin)* • *Anorexic agents* • *Injectable and oral drugs to treat fertility* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Drugs and medicines approved by the FDA for experimental or investigational use except when prescribed for the treatment of cancer or chronic fatigue syndrome.*	*All Charges*

Preventive care medications - continued on next page

Benefit Description	You pay
Preventive care medications (cont.)	**High Option**
• *Vitamin C nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Vitamin supplements are not covered except as stated above.* • *Medical Marijuana* **Note:** Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the cessation benefit. (See page 36)	*All Charges*

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with Medicare and other coverage*.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. • Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an injury (not to include chewing) when the treatment starts within the first 10 days after the injury and ends within 60 days, such as: - Root canal therapy, post and build-up; - Temporary crowns; - Temporary partial bridges; - Temporary and permanent fillings; - Pulpotomy; - Extractions of broken teeth; - Incision and drainage; - Tooth stabilization through splinting.	$25 in a physician's office $25 per surgery
• Dental anesthesia for enrolled dependent children when determined to be medically necessary by a Plan provider and prior authorized by the Plan.	Nothing

Dental benefits

We have no other dental benefits.

Section 5(h). Wellness and Other Special features

Feature	Description
Feature	**High Option**
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contractbenefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claim process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Telephone Advice Nurse Service	It doesn't matter if it's day or night, a holiday or weekend, our free Telephone Advice Nurse Service is open to provide helpful advice on simple medical concerns. Depending on your situation, our Telephone Advice Nurse may help you decide whether to seek urgent care or wait until the next day to see your primary care provider. When you have health questions or concerns, call our Telephone Advice Nurse Service at 800-288-2264.
Services for deaf and hearing impaired	We have a TTY:/TDD number for use by hearing-impaired members. The TTY:/TDD number is 711 or 800-349-3538.
Preventive Health **Disease Management**	We offer numerous preventive health management programs to assist members with early detection and prevention of serious illnesses. These programs may include member notifications for childhood immunizations, annual reminders for breast and cervical cancer screenings, educational classes or consults for heart health, smoking cessation, and weight management for adults and children. For information and registration, call 800-720-7253. We also provide programs to assist those members with chronic conditions to better manage their health. We offer disease management programs for asthma, congestive heart failure, diabetes, and chronic obstructive pulmonary disease.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
We're@YourService	Our online Member Center is available 24 hours a day. Day, night and even on holidays, you may access information about your benefits through the Health Plan of Nevada online member center. Take advantage of these convenient service features: • Change your address • Request new ID cards • Verify your coverage for pharmacy services • Check your copayment amounts for medical services • Review the status of a claim • Find out who is on record as your primary care provider (PCP) • Check status of a prior authorization request Simply visit us at www.myhpnonline.com. First time visitors will need to register for a user ID and password.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums, if applicable. These programs and materials are the responsibility of HPN, and all appeals must follow their guidelines. For additional information, contact HPN's Member Services or Customer Service Department at 877-545-7378 or visit their website at www.myhpnonline.com or www.uhcfeds.com.

HPN's Supplemental Dental Program provides discounted dental care services from dentists who have agreed to participate in the program to FEHB members enrolled in HPN. The non-refundable annual premium is due at the beginning of each plan year, and **you are required to re-enroll into the dental plan every year during the open enrollment period**. You may obtain information regarding HPN's discount dental program by contacting us at 877-545-7378, or by obtaining an enrollment packet during Open Season.

If you are enrolled in this Plan through FEHB, have Medicare Part A coverage *and* purchased Part B coverage, you may also enroll in a Medicare Advantage program. For 2017, there are a variety of Medicare Advantage plans available to you. These Medicare Advantage plans include Part A and Part B Medicare covered benefits, as well as benefits not covered by Original Medicare in a managed care environment. HPN, offers a Health Maintenance Organization (HMO) plan called Senior Dimensions. Like your FEHB Plan, you generally must obtain your routine services from Plan doctors and providers, except for out-of-area urgent and emergent care and renal dialysis. Sierra Health and Life Insurance Company, Inc. (SHL), a UnitedHealthcare Company, offers a Regional Preferred Provider Organization (RPPO) plan called Sierra Spectrum. The Sierra Spectrum plan offers the freedom to see providers that are in *and* out of the plan's provider network. Cost-sharing is generally higher than that provided in an HMO plan, but less than Original Medicare. SHL also offers Medicare Supplement plans to offset some of the out-of-pocket medical service costs for those who prefer their medical services coverage through the Original Medicare plan. Senior Dimensions and Sierra Spectrum are Medicare Advantage plans that offer Medicare Part D prescription drug coverage as part of their comprehensive health care plans.

Individuals who have Original Medicare can purchase their Medicare Part D coverage from Ovations Enterprise Services, an affiliate of UnitedHealth Group. Plans include AARP MedicareRx Preferred and AARP MedicareRx Enhanced, which are both Medicare Part D prescription drug plans (PDP). These PDPs utilize formularies with both generic and brand name medications that can be prescribed for minimal cost-sharing. The pharmacy network is extensive and members may also conveniently purchase drugs by mail (from a plan mail order vendor).

HPN and SHL offers many choices for coverage in 2017. Since so much choice can be confusing, we suggest you contact (800-274-6648 (TTY:/TDD: 711) for assistance in determining what plan(s) might be best for your needs. Representatives will be happy to discuss the differences and advantages relative to your needs and/or send you materials with details about Senior Dimensions and Sierra Spectrum so that you can make informed decisions at your convenience.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Experimental or investigational procedures, treatments, drugs or devices except clinical trials for studies for the treatment of cancer or chronic fatigue syndrome conducted in the state of Nevada (see specifics on page 36)
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs related to taking part in a clinical trial such as additional tests that are not part of the patient's routine care.
- Research costs related to conducting a clinical trial such as research physician and nurse time, analysis of results and clinical tests performed only for research purposes.
- Room and board at therapeutic boarding schools.
- Services rendered or billed by schools.
- Personal comfort items, such as telephone, television, barber services, guest meals and beds.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 877-545-7378, or at our website at www.uhcfeds.com.

When you must file a claim – such as for services you received outside the Plan's Service Area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number, and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:
Health Plan of Nevada, Inc.
Attn: Claims
P.O. Box 15645
Las Vegas, NV 89114-5645

Prescription drugs

To submit claims for prescription drugs, contact the plan at 877-545-7378. We will assist you in completing a Direct Member Reimbursement form and help you process your claim.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this Brochure.

Authorized Representative

You may designate an Authorized Representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your Authorized Representative without your express consent. For the purpose of this section, we are also referring to your Authorized Representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provide, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.uhcfeds.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact HPN's Member Services or Customer Service Department by writing to Health Plan of Nevada, Inc., P.O. Box 15645, Las Vegas, NV 89114-5645 or calling 877-545-7378.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: Health Plan of Nevada, Inc., P.O. Box 15645, Las Vegas, NV 89114-5645; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms.

e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email address, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within thirty (30) days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this Brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your Authorized Representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to file a law suit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 877-545-7378. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.healthplanofnevada.com

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337, TTY 877-889-5680, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs - costs related to taking part in a clinical trial such as additional test that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age

- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.
- For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Association online at www.socialsecurity.gov, or call them at 800-772-1213 (TTY: 800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213 (TTY: 800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 877-545-7378. You may also contact us by fax at (702) 270-6281 or see our website at www.uhcfeds.com.

We waive some costs if the Original Medicare Plan is your primary payor - We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.
  - Primary Care Physician copay
  - Specialist copay
  - Inpatient Hospital copay

Please review the following table. It illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

-

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$0	$0
Out of Pocket Maximum	$3,500 self only/$7,000 family	$3,500 self only/$7,000 family
Primary Care Physician	$10	$0
Specialist	$15	$0
Inpatient Hospital	$300	$0
Outpatient Hospital	Nothing	$0
Rx	Tier 1 -$7 Tier 2 -$35 Tier 3 - $55 Tier 4 – $100	Tier 1 - $7 Tier 2 - $35 Tier 3 - $55 Tier 4 - $100
Rx – Mail Order (90 day supply)	2x retail copay	2x retail copay

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. If you are a FEHB annuitant and enrolled in our Medicare Advantage plan, we waive the copayments for your FEHB coverage. If you are an active FEHB employee and enrolled in our Medicare Advantage plan, we do not waive cost sharing for your FEHB coverage.

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments or coinsurance. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded, conducted under an investigational new drug application reviewed by the Food and Drug Adminstration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 22.

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, or
6. blood pressure checks.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 22.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this Brochure.

Custodial care

Care that is designed essentially to assist individuals in meeting activities of daily living. These include personal care services (help in walking and getting in or out of bed; assistance in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision over medication which can usually be self-administered) that do not require the continuing attention of trained medical or paramedical personnel. Custodial care that lasts 90 days or more is sometimes knows as long-term care.

Deductible

This plan does not have a deductible.

Eligible Medical Expense (EME)	Charges up to the Plan reimbursement schedule amount, incurred by you while covered under this Plan for covered services. Plan providers have agreed to accept the Plan's reimbursement schedule amount as payment in full for covered services, plus your payment of any applicable copayment. Non-plan providers have not. If you use the services of non-plan providers, you will receive no benefit payments or reimbursement for charges for the service, except in the case of emergency services, urgently needed services, or other covered services provided by a non-plan provider that are prior authorized by the Plan. In no event will the Plan pay more than the applicable Plan reimbursement schedule amount for such services.
Experimental or investigational service	This plan regularly evaluates for possible coverage new medical technologies and new applications of existing technologies. New technologies may include medical procedures, drugs and devices. The evaluation process includes a review of information on the proposed service from appropriate government regulatory bodies as well as from published scientific evidence.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	Medical necessity (also "Medically Necessary") means a service is needed to improve a specific health condition or to preserve your health. Medical necessity is present when the Plan determines that the care requested is: consistent with the diagnosis and treatment of your illness or injury; the most appropriate level of service which can be safely provided to you; and not provided solely for your convenience or that of your provider or hospital. When applied to inpatient services, Medically Necessary further means that your condition requires treatment in a hospital rather than any other setting. Services and accommodations are not automatically considered to be Medically Necessary because a physician prescribes them.
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.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Telemedicine

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.

Us/We

Us and We refers to Health Plan of Nevada, Inc. or HPN.

Urgent Care Claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 877-545-7378. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

You

You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no govenment contribution.

Important information about four federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money.

Annuitants are not eligible to enroll.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,600 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** - Reimburses you for eligible oout-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter (OTC) drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA)** - Designed for employees enrolled in or covered by a High Deductibe Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).

- **Dependent Care FSA (DCFSA)** - Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS, 877-372-3337 (TTY, 1-866-353-8058), Monday through Friday, 9 a.m. until 9 p.m. Eastern Time.

The Federal Employees Dental and Vision Insurance Program - *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitation for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia but it may be limited. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses, and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 877-888-3337, (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. Long term care can be received in your home, in a nursing home, in an assisted living facility or in adult day care. You must apply, answer health questions (called underwriting), and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Your qualified relatives can apply even if you do not. Certain medial conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 800-LTC-FEDS, 800-582-3337, (TTY 800-843-3557) or visit www.ltcfeds.com.

The Federal Employees' Group Life Insurance Program - *FEGLI*

Peace of Mind for You and Your Family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the High Option of the Health Plan of Nevada, Inc. - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this Brochure. On this page, we summarize specific expenses we cover. For more detail, review contents herein.
- If you want to enroll or change your enrollment in this Plan, be sure to list the correct Enrollment Code from the cover of the Plan requested on your Enrollment Form.
- We only cover services provided or arranged by Plan physicians, except when specifically prior authorized by HPN or for urgent and emergency services.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 Primary Care; $25 Specialist	27
Services provided by a hospital:		
• Inpatient	$300 per admission	45
• Outpatient	$50 per visit	46
Emergency benefits:		
• In Area	$30 per visit $150 per visit, waived if admitted	48
• Out of Area	$30 per visit $150 per visit, waived if admitted	49
Mental health and substance misuse disorder treatment:	Regular cost-sharing	50
Prescription drugs:	Tier 1 = $7, Mail order = $14; Tier 2 = $35, Mail order = $70; Tier 3 = $55, Mail order = $110; Tier 4 = $100, Mail order = $200	52
Dental care:	No benefit	56
Vision care:	$10 per visit for one refraction annually and 50% of EME for costs associated with vision supplies	33
Special features:	Flexible benefits option, Telephone Advice Nurse Service, Services for the deaf and hearing impaired, Preventive Health/ Disease Management, We're@YourService	57
Protection against catastrophic costs (out of pocket maximum):	Nothing after $3,500/Self Only or $7,000/Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection.	22

2018 Rate Information

For 2018 FEHB plan premium information, please see:

https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribal employer's Human Resources department.