Health Plan of Nevada (HPN) Member Guide

Get to know your Health Maintenance Organization (HMO) or Point-of-Service (POS) plan, and find what programs and services are available to you.

Health Plan of Nevada
A UnitedHealthcare Company

Get to know your health plan benefits

Online member center

Our online member center brings your health insurance information together in one place. Use this convenient service to:

- Set up online invoicing and payment (individual plan members only).
- View, print or share your health plan ID card.
- Find out who is on record as your primary care provider (PCP).
- Track claim history and expenses.
- Check the status of a prior authorization or referral.
- Verify your pharmacy, dental or vision coverage.
- Review your plan documents.

To get started, visit **HealthPlanofNevada.com** and sign in. First-time users will need to create an account.

HPN & SHL app

Easily manage your health plan information on the go. Search for **HPN & SHL app** in your app store and download the app. Then sign in with your HealthSafe ID®. First-time users will need to create an account.

Use the HPN & SHL app to:

- Find out who is on record as your primary care provider (PCP).
- Talk with an advice nurse. Available 24/7.
- Video chat with a provider 24/7. No appointment needed.
- Search for a doctor, specialist, facility or lab.
- View, download and email your health plan ID card.
- Save your health plan ID card to your Apple Wallet.™
- See your copay, deductible, and out-of-pocket expenses, if applicable.
- Check the status of a claim, prior authorization or referral.
- Access your health records.[1]
- Update your contact information and address.
- Select communication preferences.
- Get turn-by-turn directions to contracted urgent care and hospital locations near you.

Your personal medical information is confidential and is only available to you and your provider.

[1]Only available to Southwest Medical patients who opt-in to receive electronic medical records.

Member Services

If you have a question about your health plan benefits, utilization management or need help selecting a provider, contact Member Services toll-free at **1-800-777-1840**, TTY **711**, Monday through Friday, 8 a.m. to 5 p.m. Exchange members call toll-free **1-877-752-8026**.

24/7 advice nurse

If you're unsure about your condition, our 24/7 advice nurse may be able to help. Our nurse is available to answer questions, provide self-care advice and help you decide whether to seek urgent care, emergency care, or schedule an appointment with your provider. This service is available at no additional cost to you. Just call toll-free **1-800-288-2264**, TTY **711**.

24/7 NowClinic® virtual visits

Secure video chat with a provider 24/7 from your computer or mobile device.[2] If needed, most prescriptions can be sent to your chosen pharmacy.

No appointment needed to get care for non life-threatening and non urgent medical conditions such as:

- Allergies
- Bladder infections
- Bronchitis
- Pink eye
- Sinus infections
- Viral illnesses

Consultations, follow-up care or visits with providers require an appointment for mental health, health education, case management and specialties.

If needed, a provider will reach out to you to schedule an appointment with a case manager or specialist. To make an appointment with a health educator or registered dietitian, call toll-free **1-800-720-7253**, TTY **711**. To schedule an appointment for mental health therapy, call toll-free **1-800-873-2246**, TTY **711**, and then press zero at the prompt. Restrictions apply. Visit **HealthPlanofNevada.com** to learn more.

Enroll and get care! Download the **NowClinic app** or go to **NowClinic.com** and sign up.

NowClinic is not intended to address emergency or life threatening medical conditions. Please call 911 or go to the emergency room under those circumstances.

NowClinic services may be covered by some health plans; copays and deductibles may apply. Members under the age of 18 must have a guardian contact NowClinic customer support for assistance in enrolling for their account. Customer support can be reached at **1-877-550-1515**.

[2]NowClinic is not intended to address emergency or life-threatening medical conditions. Please call 911 or go to the emergency room under those circumstances. NowClinic services may be covered by some health plans; copays and deductibles may apply. Members under the age of 18 must have a guardian contact NowClinic customer support for assistance in enrolling for their account. Customer support can be reached at **1-877-550-1515**.

$0 copays apply with most unscheduled NowClinic virtual visits. Scheduled NowClinic visits may require a copay. Virtual visits may be subject to calendar year deductibles and/or coinsurance according to the member's benefit plan. Copays may also apply for virtual visits with providers not on the NowClinic platform.

Urgent care

Get care for non life-threatening but urgent needs. Urgent care* visits are good for:

- Ear infections
- Colds and other respiratory problems including coughs and congestion
- Sprains and strains
- Most abdominal pain
- Vomiting and diarrhea
- Most cuts, burns, fevers and back pain

*For specialty urgent care locations visit your health plan's website.

Medical care that comes to you

Get on-demand care in the comfort of your home![4] Care that comes to you is available seven days a week[5] and providers can treat most things urgent care centers can for the same cost. Most prescriptions can be sent to your chosen pharmacy.

Some of the things at-home care is good for:

- Migraine headaches
- Cuts that need stitches and skin infections
- Urinary tract infections
- Flu and pneumonia
- Dehydration, IV placements and IV fluids
- Asthma attacks, COPD and respiratory infections

To check availability, call the 24/7 advice nurse toll-free at **1-800-288-2264**, TTY **711**. **If you have a life-threatening situation, call 911 or go to the nearest hospital emergency room**.

[4]Restrictions apply. Not available in all areas.
[5]Hours of availability may vary.

Emergency care

A true emergency medical condition is when symptoms are severe enough you could reasonably expect serious danger to your health, such as:

- Serious burns
- Major trauma
- Poisoning
- Serious breathing difficulties
- Heavy bleeding
- Severe chest pain
- Sudden paralysis

In an emergency, no matter if you are at home or out of town, call 911 or go to the nearest hospital emergency room.

Important! Your health plan is not contracted with certain freestanding and hospital emergency rooms. Call your health plan for more information. Some neighborhood hospitals may not have specialists on staff, so you could be transported to a hospital emergency room for complex conditions that require a specialist.

Health education and disease management programs

We offer classes and consults in-person, virtually and by phone on a wide variety of health topics to help you achieve your health goals. Work with a registered nurse, registered dietitian or licensed alcohol and drug counselor to receive the health education and support you need to live your healthiest life possible.

Weight management
Open to members age 18+ interested in weight-loss support.

Diabetes program
Open to members age 18+ with Type 1, Type 2 or gestational diabetes.

Prediabetes program
Open to members age 18+ diagnosed with prediabetes.

Asthma support
Open to members age 5+ diagnosed with asthma.

Kidney health
Open to members age 18+ diagnosed with stage 3 chronic kidney disease.

Tobacco cessation program
Open to members who want to quit tobacco/nicotine.

Our Health Education and Disease Management programs are available at no additional cost to eligible members. To join or opt-out of any of these programs, call toll-free **1-800-720-7253**, TTY **711**.

Pharmacy benefits

If your plan includes pharmacy benefits, you have prescription drug coverage from network pharmacies. Your copayment is based on levels called a prescription tier. The costs are lower on tier 1 and higher on tier 3, or tier 4 if applicable.

OptumRx, our online pharmacy benefit manager, has some great tools. When you register on OptumRx, you can view your medication history and copays, find a network pharmacy, see how much your medications will cost, and if there are any restrictions. View our prescription drug lists (PDL) at **HealthPlanofNevada.com** or sign in to **OptumRx.com** to use the drug lookup tool.

Generic vs. brand name drugs

All medicine - generic and brand name - must be approved by the U.S. Food and Drug Administration (FDA) before it can be sold to consumers. Generic drugs must meet the same standards as brand name drugs for purity, strength and quality. In fact, a generic must contain the exact active ingredients as a brand, must be absorbed into the body at the same rate and in the same manner, and must produce the same effects.

The difference between a generic and a brand name drug:

- A generic drug is not protected by a patent. Generic drugs become available after the patent expires for a brand name drug.
- A generic drug is called by its chemical name. A manufacturer assigns a brand name.
- Generic drugs typically cost less than brands.

Mail order pharmacy

Use our contracted mail order pharmacy to save time and money. Go to **HealthPlanofNevada.com** and download an order form. Then fill it out and mail it (along with your prescription and the applicable copayment) to **OptumRx, PO Box 2975, Mission, KS, 66201**.

Your provider should write your prescription for a 90-day supply with refills when appropriate (not a 30 day supply with three refills).

Need assistance? Fill out Section 1 of the OptumRx order form. Then ask your provider to fill out Section 2 and fax the form for you.

To refill a prescription, please call toll-free **1-800-788-4863**, TTY **711** or **OptumRx.com**.

Step therapy

You may be required to try step therapy. This means you must try certain drugs to treat your medical condition before we'll cover another drug for that condition. You may submit an exception request to waive step therapy requirements or quantity limit restrictions. Go to **HealthPlanofNevada.com** and view our PDL to see if your prescription drug requires step therapy. To download an exception request form, visit **HealthPlanofNevada.com** or call Member Services toll-free at **1-800-777-1840**, TTY **711**.

Quantity limits and refills

A pharmacy may refuse to fill or refill a prescription order if the professional judgment of the pharmacist is not to fill the prescription.

Benefits for prescriptions for mail order drugs submitted following Health Plan of Nevada's receipt of notice of a member's termination will be limited to the appropriate therapeutic supply from the date the notice of termination is received to the effective date of termination of the member.

If we determine you may be using prescription drugs in a harmful or abusive manner, or with harmful frequency, your selection of plan pharmacies may be limited. If this happens, we may require you to select a single plan pharmacy, which will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if you use the assigned single plan pharmacy.

If you do not make a selection within 31 days of the date you are notified, we will select a single plan pharmacy for you.

Save time and money with our 90-day supply benefit

Your health plan now covers a 90-day supply of medication through local Walgreens pharmacies. With a 90-day supply, you won't need to get a refill every month.

If you would like to participate:

- **Talk with your doctor.** Your doctor can write you a new prescription for a 90-day supply.
- **Talk to your Walgreens pharmacist.** Your pharmacist can call your doctor to get a new prescription for a 90-day supply.

What you need to know:

- 90-day supply is exclusively available at Walgreens pharmacies in Nevada. All other retail pharmacies can only fill one month at time.
- Pharmacy benefit coverage rules still apply. Only covered drugs will be available for a 90-day supply. Please check your pharmacy coverage rules for more details.
- Copays[6] are the same for 90 days at Walgreens and OptumRx Home Delivery (mail order).

To find out what medications are included, call Member Services at the number on the back of your health plan ID card.

[6]Most members will save ½ a copay when they fill brand name and higher priced generic medications. Most lower priced generic medications will already pay at a rate less than a member's copay amount so savings may not be as substantial.

Get to know your HMO plan

With most Health Plan of Nevada HMO plans, there are no annual deductibles, claim forms, or annual maximum limits for many services. The HMO's one tier benefit design ensures that the copayments, that you are responsible for, are predictable and affordable.

Select or change your provider

For maximum coverage and the lowest out of pocket expenses, please be sure to choose your primary care provider (PCP) and specialists from the Health Plan of Nevada HMO provider directory. As your partner in health, your PCP will help coordinate the health care services you need.

- Every member of your family may choose a different PCP
- You may select a pediatrician as your child's PCP
- All female members ages 14 and older may choose an OB/GYN in addition to a PCP

The Health Plan of Nevada provider directory contains information to help you narrow your choices. You'll find the specialty, office address, telephone number, and board certification status of every contracted provider in our network. To view our provider directory online, go to **HealthPlanofNevada.com**. To get a copy, contact your employer's benefits department or Member Services toll-free at **1-800-777-1840**, TTY **711**.

To change your PCP, sign in to your online member center account, call Member Services or mail a change form to:

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

Benefit limitations

You need to get care from in-network (contracted) providers to receive benefit coverage, except for emergency services and urgent care. To receive benefit coverage, ask

your providers to use a network lab for any tests or diagnostic imaging services, such as X-rays, MRIs and CT scans. Referrals are needed in advance of receiving specialty care. Specialist visits without a referral from a PCP will not have benefit coverage or payment. Some exceptions apply. Experimental, investigational and some other services and procedures are excluded.

Detailed information on these exclusions is available upon request. Contact Member Services for additional information on referrals or exclusions.

Southwest Medical in Southern Nevada

Your plan includes access to Southwest Medical, one of Nevada's largest multi-specialty medical groups. Southwest Medical has health care centers across the Las Vegas Valley, including a **24-hour urgent care**. Find out more at **smalv.com**.

Routine appointments

If you are a Southern Nevada member and have selected a provider with Southwest Medical, please call their scheduling center at **702-877-5199**, TTY **711**, or go online to **smalv.com**. If you have a provider outside of Southwest Medical, call your provider's office directly. If you need to cancel an appointment, please be sure to call 24 hours in advance.

Specialty and hospital services

To receive the lowest out-of-pocket costs for specialty services, make sure your primary care provider (PCP) gives you a referral before you see a specialist. Depending on your plan, there may also be a cost share (such as a copayment or coinsurance) for X-rays or tests your PCP orders for you.

If you are scheduled for an elective or non-emergency hospitalization or surgical procedure, your PCP will request prior authorization from Health Plan of Nevada if needed. Be sure the hospital has the prior authorization. Without it, you may be responsible for all costs incurred. You are covered for unplanned emergency hospitalization, but special rules apply in those situations.

For more information, please contact Member Services or refer to your plan documents online.

Care away from home

If you become sick or injured while traveling outside our service area, please follow these simple steps:

- **For urgent care** — We cover urgently needed services if you are in the United States. When you are outside of our service area, it is not necessary to notify us in advance. However, please notify Member Services as soon as reasonably possible. For more information, call Member Services.
- **In case of emergency** — Call **911** or go to the nearest hospital emergency room. If possible, show your health plan ID card. Please contact Member Services within 48 hours, or as soon as reasonably possible to have your plan benefits reviewed for medically necessary services following or related to emergency care.

Benefits for follow-up care for an injury or illness are limited to care received before you can safely return to our service area. Follow-up care should be coordinated by your PCP. For additional information, please refer to your plan documents online.

Mental health services

Our behavioral health care team provides professional counseling, phone consultations, and online resources to help you find the right solutions to life's challenges and maintain a balanced and healthy life.

For confidential counseling services, including referrals to a psychologist, psychiatrist, or mental health provider, call toll-free **1-800-873-2246**, TTY **711**.

The helpline can be reached after hours by calling toll-free **1-800-873-2246** and selecting option one. You may find more information online at **bhoptions.com**. If you have benefits for behavioral healthcare plus, please consult your plan documents for information about additional services.

Get to know your POS plan

With a Health Plan of Nevada POS plan, you have a variety of benefits and covered services available within a 3-tier design: HMO, expanded plan provider and non-plan provider. Each tier is designed with different degrees of flexibility and cost sharing so every time you access care, you can choose the coverage you want based on your current needs.

When selecting your tier level, take into consideration copayments, provider access, deductibles, and coinsurance. To give you a better idea of the differences between the benefit tiers, we've summarized them for you.

Tier I HMO benefit option

This option gives you the most coverage for the least out of pocket cost.

- When you use the Tier I HMO benefit option, there are no annual deductibles, claim forms, or annual maximum limits for many services.
- Choose a primary care provider (PCP) from the Health Plan of Nevada HMO provider directory.
- Always get a referral or a prior authorization from your PCP before visiting a specialist, or scheduling elective surgery or hospitalization. Specialist visits without a referral from a PCP will not have benefit coverage or payment. Some exceptions apply. You should contact Member Services or your PCP for additional information on referrals to a specialist.

Tier II expanded plan provider benefit option

This option gives you access to a larger network of contracted providers, specialists, and health care facilities.

- When you use Tier II benefits, you share more of the cost than you would with the Tier I HMO benefit option. This may include copayments or coinsurance for office visits, coinsurance for other covered services and a deductible.
- Some services may require you to submit claim forms or to receive prior authorization before payment may be provided. Services without a referral may not have benefit coverage. Some exceptions apply. You should contact Member Services or your PCP for additional information on referrals to a specialist.
- Benefits for certain covered services may only be available under the Tier I HMO benefit option.
- If your POS plan includes a national provider network, you will have access under your Tier II benefit to the nationwide UnitedHealthcare Choice Plus Network.

Tier III non-plan provider benefit option

This option allows you to visit any licensed health care provider or hospital. However, you are responsible for paying all costs for care at the time of service, filing claim forms for reimbursement, meeting a deductible, and sharing higher coinsurance.

- Tier III non-plan providers do not accept the Health Plan of Nevada reimbursement schedule as payment in full for covered services. This means you will be responsible for any fees that exceed our reimbursement schedule, as well as for services not covered by your health plan.
- Some services may require you to submit claim forms or to receive prior authorization before treatment may be provided.
- Benefits for certain covered services may only be available under the Tier I HMO benefit option.

Select or change your provider

As a POS member, you can select your PCP or specialists from three different benefit option tiers.

- If your PCP or specialist is contracted with Health Plan of Nevada as a Tier I benefit provider, you will pay the least out-of-pocket costs. These providers are listed in the Health Plan of Nevada HMO provider directory. Remember to get a referral from your PCP to see a specialist in order for Tier I benefits to be payable. Specialist visits without a referral from a PCP will not have benefit coverage or payment. Some exceptions apply. You should contact Member Services or your PCP for additional information on referrals to a specialist.
- If your PCP or specialist is contracted with Health Plan of Nevada as a Tier II benefit provider, you will share in more of the cost and enjoy a larger network of providers to choose from. These providers are listed in the Sierra Health and Life PPO provider directory.
- If your PCP or specialist is not contracted with Health Plan of Nevada, your benefits will be paid under the Tier III benefit option, which includes the highest cost share. You may select any licensed health care provider when utilizing your Tier III benefits.

It's important to refer to your plan documents for specific information related to your coverage.

You may change your PCP at any time by calling Member Services.

Southwest Medical in Southern Nevada

Your plan includes access to Southwest Medical, one of Nevada's largest multi-specialty medical groups. Southwest Medical has health care centers across the Las Vegas Valley, including a **24-hour urgent care**. Find out more at **smalv.com**.

Routine appointments

If you are a Southern Nevada member and have selected a provider with Southwest Medical, please call their scheduling center at **702-877-5199**, TTY **711**, or go online to **smalv.com**. If you have a provider outside of Southwest Medical, call your provider's office directly. If you need to cancel an appointment, please be sure to call 24 hours in advance.

For ongoing treatment of a chronic condition, consider using your Tier I benefit. However, you may select Tier II or Tier III benefits in order to see a provider without first getting a referral or authorization from your PCP. Some members use this option for providers they see only a few times a year, such as an allergist or a dermatologist.

Specialty and hospital services

To use your Tier I HMO benefit option, you will need a referral from your PCP to see a specialist. When using Tier II expanded plan provider or Tier III non-plan provider benefit options, you may visit a specialist without first obtaining a referral from your PCP. However, there will be a higher copayment and additional coinsurance costs. For more details, please contact Member Services or refer to your plan documents online.

To use your Tier I HMO benefit option for an elective or non-emergency hospitalization or surgery, your PCP needs to obtain prior authorization from Health Plan of Nevada. You are covered for emergency hospitalization, but special rules apply in those situations. If you seek non-emergency hospitalization or surgery services without prior authorization from Health Plan of Nevada, your benefits will be reduced and paid under Tier II or Tier III options, as appropriate. We will only pay for nonauthorized hospital services at the Tier I benefit level when they are provided for emergency conditions.

For more information, please contact Member Services or refer to your plan documents online.

Care away from home

If you become sick or injured while traveling outside Health Plan of Nevada's service area, please follow these simple steps:

- **For urgent care** — We cover urgently needed services if you are in the United States. When you are outside of our service area, it is not necessary to notify us in advance. However, please notify Member Services as soon as reasonably possible. For more information, call Member Services.
- **In case of emergency** — Call **911** or go to the nearest hospital emergency room. If possible, show your health plan ID card. Please contact Member Services within 48 hours, or as soon as reasonably possible to have your plan benefits reviewed for medically necessary services following or related to emergency care.

Urgent care and emergency services are paid under your HMO Tier I benefit level within or outside the service area.

Benefits for follow-up care for an injury or illness are limited to care received before you can safely return to Health Plan of Nevada's service area. Follow-up care should be coordinated by your PCP. For additional information, please refer to your plan documents online.

Mental health services

Our behavioral health care team provides professional counseling, phone consultations, and online resources to help you find the right solutions to life's challenges and maintain a balanced and healthy life. With your POS plan, you can access confidential counseling services with psychologists, psychiatrists or mental health providers under your Tier I HMO benefit option or Tier II expanded plan provider benefit option. To receive services under your Tier I HMO benefit option, request a referral by calling toll-free **1-800-873-2246**, TTY **711**.

To receive services under your Tier II expanded plan provider benefit option, call Utilization Management for prior authorization toll-free at **1-800-873-2246**, TTY **711**.

Once you receive prior authorization, you can select a provider from our HPN network.

For routine information and assistance, please call toll-free **1-800-873-2246**, TTY **711**, Monday through Friday, 8 a.m. to 5 p.m.

The helpline can be reached after hours by calling toll-free **1-800-873-2246** and selecting option one. You may find more information online at **bhoptions.com**. If you have benefits for behavioral healthcare plus, please consult your plan documents for information about additional services.

Measuring quality

We're committed to improving the quality of health care and services for our members. The goals of our quality program are to measure, monitor and analyze the outcomes of health care and services received by health plan members. Then we plan and carry out focused quality initiatives for health plan members and providers in order to improve those outcomes.

Each year we develop a quality improvement work plan, which is monitored by the health plan's Quality Improvement Committee and evaluated annually by the health plan's board of directors. If you have any comments or questions about our quality program and ongoing quality initiatives, please contact our Member Services department at the number on your health plan ID card.

Appropriate, timely and necessary patient care

If you are admitted to a hospital, rehabilitation center or other inpatient facility, we will monitor your care by performing initial and ongoing reviews. This is to make sure the care you receive is appropriate, provided in the right setting, and medically necessary. Our case managers will provide these reviews either at the hospital or by telephone with one of the facility's nurses or your attending physician.

Hospital discharge planning

If you are hospitalized, our case manager will begin working with you and your provider within the first 24 hours of admission. We will arrange for any ongoing care, services, and equipment you may need after leaving the hospital. Depending on your situation, these plans could include transfer to another facility, such as a rehabilitation hospital. Or, you may be discharged home to continue treatment on an outpatient basis. Be sure to contact your primary care provider, so he/she can coordinate your follow-up care.

Your PCP will help coordinate your care if you should ever need to be admitted to a hospital on a non-emergency basis. To ensure you get appropriate, quality care in a timely manner and pay the lowest out-of-pocket costs possible, we've contracted with most area hospitals. Please refer to your plan documents for details about any copayments and/or coinsurance that may be related to hospital visits, physician services, and anesthesia. For a complete list of hospitals, please refer to your provider directory.

Evaluating care you received

If you are admitted to a non-contracted facility or receive care or services outside of our service area, we may perform a retrospective review (after care was received) to evaluate the appropriateness of the medical care, services, treatments, and procedures you received. As part of this process, we will review your medical records, admitting diagnosis, and presenting symptoms.

New medical technology

For safety reasons, we formally evaluate new and emerging medical discoveries before including them in our member benefit package. Conducted by a highly skilled technical staff, including physicians, our review process evaluates new technology against medical standards and clinical research to assess effectiveness and safety:

- New medical procedures, drugs, and devices
- New applications of existing technologies

If you, your provider, or another interested party would like to submit a request for the review of new medical technology, please contact Member Services at the number on your health plan ID card.

Prior authorization

Your provider may prescribe a health care service, treatment, equipment or medication, which requires review and approval. This process is called prior authorization, and the goal is to ensure you receive the most appropriate, medically necessary care.

All requests requiring a medical or clinical decision are reviewed by a licensed physician or under the supervision of one. Furthermore, only a physician may deny a request. To learn more, please consult your plan documents.

You or your provider may file an appeal if coverage is denied. To appeal a decision, mail a written request within 180 days from the date of the denial to:

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

You will receive a response regarding the outcome of your appeal within 30 days. In urgent situations, you will receive a response within 72 hours. If prior authorization is denied or not obtained, you may be responsible for the entire cost of health care service, treatment, equipment or medication.

No incentives for prior authorization denials

We prohibit the compensation of physicians, other health care professionals, or staff to be based upon or used as incentive for the denial of benefits. All decisions regarding your benefits are given special consideration based on your medical needs and appropriateness of the care and service.

Health Plan of Nevada employees who perform utilization review duties do not receive any incentives, financial, or otherwise, to encourage their denial of benefits. This means we provide no incentive for anyone on our team to restrict benefits from our members. For more information, please call Member Services at the number on your health plan ID card.

Appeals (internal and external review)

If you receive a decision that adversely affects your coverage, benefits or relationship with the plan, Health Plan of Nevada provides internal review to help ensure member satisfaction in the decision-making process. Additionally, external independent review is provided by a panel of impartial medical professionals for eligible denials which have already undergone internal review.

You can request an expedited appeal if you believe waiting for a claim decision may put your health at risk, such as if you urgently require medication or are currently in the hospital.

If you have a complaint

If you're dissatisfied with services or care, or with the operations or administration of your health plan, we want to know. Call Member Services or write a letter to Health Plan of Nevada. Either way, you will receive a written response to your complaint.

How to submit a claim

Your health care provider will submit a claim to Health Plan of Nevada after you receive treatment, services, medications or medical goods. We will review the claim and decide if your health plan covers the service and how much you or your provider should get reimbursed.

Out of area hospitals and providers usually bill Health Plan of Nevada directly for services other than your copayment. If you are required to pay up front, obtain your medical records and all bills from the provider. Be sure your member ID number is on all documents. Then mail the originals to:

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

Why would a claim be denied

Health Plan of Nevada may deny a claim for many reasons, including:

- The treatment or service isn't deemed medically necessary or appropriate.
- Your health plan doesn't cover the treatment, service, medication or goods.
- The health care provider isn't in your plan's network.
- Your health plan requires preauthorization or a referral from your primary care provider.
- The treatment is considered experimental.
- Your coverage has ended.
- A data entry error prevented the claim from being processed correctly.
- The claim wasn't filed on time.

If your claim is denied, you and your provider will receive a letter by mail explaining why the claim was denied or Explanation of Benefits (EOB) by email.

How to submit an appeal

You have 180 days to file an appeal if coverage is denied. To appeal a decision, mail a letter with all the facts and details to support your claim to:

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

Internal review

Health Plan of Nevada strives to ensure member satisfaction in the medical decision-making process. If a benefit is denied, you may request a fair and complete internal review to reconsider your claim.

External review

Once the internal review is complete, eligible denials will go through an external review provided by a panel of impartial, third-party medical professionals.

Your privacy rights

We're careful to protect your privacy by developing operational policies and procedures for the way we work with other companies. We share protected health information (PHI) only with the individuals or entities as necessary to coordinate your health care or administer your health benefits. When you enroll in one of our plans, we may use your PHI for future, known or routine purposes, such as treatment or conducting quality assessments. And, of course, we share PHI in accordance with state and federal law.

We use security precautions to protect PHI or data about you containing personal facts and health information which is personally identifiable, either implicitly or explicitly. We also require our contracted providers to take similar steps to protect your PHI. We do not share your PHI unrelated to plan information, unless we have your authorization. We use medical data to promote and improve the quality of care you receive. When conducting research and measuring quality, we use summary information whenever possible, not PHI. When we do use PHI, steps are taken to help protect it from inappropriate disclosure. We do not allow PHI to be used for research by organizations without your consent.

You have the right to access your medical records and can do so by contacting your provider of care. When you request specific medical records to be shared with others, we may require you to sign an authorization form. We may also ask you for special consent for non-routine use of your personal data. When we ask you for authorization to release your PHI, you have the right to refuse. In addition to authorizing us to release your PHI, this extra step helps you to understand why your PHI will be shared. When a member lacks the ability to authorize a release, we obtain authorization from persons recognized by state or federal laws to give such authorization. To obtain a complete copy of the privacy policy, visit **HealthPlanofNevada.com** or contact Member Services.

If your coverage is through an employer sponsored group health plan, we may share summary health information, and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

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

Member rights and responsibilities

Health Plan of Nevada is committed to ensuring that members are treated in a manner that respects their rights and promotes effective healthcare. We have also identified its expectations of members' responsibilities in this joint effort. Our statement regarding Members' Rights and Responsibilities includes the following:

Members' rights

1. To be treated with respect and dignity and every effort made to protect your privacy.
2. To select a primary care provider from HPN's extensive provider list including the right to refuse care from specific practitioners.
3. To be provided the opportunity to voice complaints or appeals about the plan and/or the care provided.
4. To receive information about the plan, its services, its providers, and members' rights and responsibilities.
5. To participate with your practitioner in the decision making process regarding your health care.
6. To make recommendations regarding the organization's members' rights and responsibilities policies.
7. To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
8. To have direct access to women's health services for routine and preventive care.
9. To have direct access to medically necessary specialist care in conjunction with an approved treatment plan developed with the primary care physician. Required authorizations should be for an adequate number of direct access visits.
10. To have access to emergency health care services in cases where a "prudent layperson" acting reasonably, would have believed that an emergency existed.
11. To formulate advance directives.
12. To have access to your medical records in accordance with applicable state and federal laws.

Members' responsibilities

1. To know how HPN's managed care program operates.
2. To provide, to the extent possible, information that HPN and its providers need in order to provide the best care possible.
3. To take responsibility for maximizing health habits and to follow the health care plan that you, your physician and HPN have agreed upon.
4. To consult your primary care physician and HPN before seeking non-emergency care in the service area. We urge you to consult your physician and HPN when receiving urgently needed care while temporarily outside the HPN service area.
5. To obtain a written referral from your physician before going to a specialist, unless you are utilizing Point of Service benefits.
6. To obtain prior authorization from HPN and your physician for any routine or elective surgery, hospitalization, or diagnostic procedures.
7. To be on time for appointments and provide timely notification when canceling any appointment you cannot keep.
8. To pay all applicable copayments at the time of service.
9. To avoid knowingly spreading disease.
10. To recognize the risks and limitations of medical care and the health care professional.
11. To be aware of the health care provider's obligation to be reasonably efficient and equitable in providing care to other patients in the community.
12. To show respect for other patients, health care providers, and plan representatives.
13. To abide by administrative requirements of HPN, health care providers, and government health benefit programs.
14. To report wrongdoing and fraud to appropriate resources or legal authorities.

15. To know your medications. Keep a list and bring it with you to your appointment with your primary care provider.
16. To address medication refill needs at the time of your office appointment. When you obtain your last refill, notify the office that you will need refills at that time. Do not wait until you are out of your medication.
17. To report all side effects of medications to your primary care provider. Notify your primary care provider if you stop taking your medications for any reason.
18. To ask questions during your appointment time regarding physical complaints, medications, any side effects, etc.
19. To understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

Contact us

24/7 advice nurse
1-800-288-2264, TTY **711**

Online member center
Visit **HealthPlanofNevada.com** and sign in

HPN & SHL app
Search for **HPN & SHL** in your app store and download the app.

Member Services
1-800-777-1840, TTY **711**

Exchange members call toll-free
1-877-752-8026

Office hours are Monday through Friday, 8 a.m. to 5 p.m.

Health Education and Wellness
1-800-720-7253, TTY **711**

Behavioral health care services
Routine calls and after hours helpline
1-800-873-2246, TTY **711**

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

Many of your benefits are included in this Member Guide. There are also some exclusions you should be aware of. For specific details about your plan, refer to your HPN Evidence of Coverage, Attachment A Benefit Schedule, applicable endorsements and riders. Copies of these documents are available online or upon request by calling Member Services toll-free at **1-800-777-1840**, TTY **711**.

Health Plan of Nevada and Sierra Health and Life comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card or plan documents.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

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

If you need help filing a complaint, call the toll-free number on your member ID card or plan documents.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone: 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at:
https://healthplanofnevada.com/content/dam/hpnv-public-sites/documents/NVStandard15Taglines.pdf or https://sierrahealthandlife.com/content/dam/hpnv-public-sites/documents/NVStandard15Taglines.pdf.

ATTENTION: If you speak **English**, language help and communications in other formats, like large print, are available and free to you. Call the toll-free number on your health plan ID card.

ATENCIÓN: Si habla **español** (**Spanish**), tiene acceso gratuito a asistencia lingüística y a materiales en otros formatos, como impresión en tamaño grande. Llame al número gratuito que figura en su tarjeta de identificación del plan de salud.

ATENSYON: Kung nagsasalita ka ng **Tagalog**, ang tulong sa wika at komunikasyon sa iba pang mga format, tulad ng malalaking print, ay available at libre para sa iyo. Tawagan ang toll-free na numero na nasa iyong ID card sa planong pangkalusugan

تنبيه: إذا كنت تتحدث اللغة العربية)Arabic(، فإن المساعدة اللغوية والتواصل بتنسيقات أخرى، مثل الطباعة بحروف كبيرة، متاحة لك مجانًا. يُرجى االتصال بالرقم المجاني المدّون على بطاقة هوية خطتك الصحية.

মনোযোগ দিন: আপনি যদি **বাংলায় (Bengali),** কথা বলেন, তাহলে ভাষা সহায়তা এবং বড় প্রিন্টের মতো অন্যান্য ফর্ম্যাটে যোগাযোগ আপনার জন্য বিনামূল্যে উপলভ্য। আপনার হেলথ প্ল্যানের আইডি কার্ডে দেওয়া টোল-ফ্রি নম্বরে কল করুন

ARONGORONG: Ngare' ukassal falawasch, eyoor alillis me' **arongorong** (**Carolinian**), llon akaaw met, gnare' min tuttumogh na iisch, emween ubwe ya'ya' sin ubwe abwos. Ffaingii dibwaddi numuro ye eno won yoomw health plan ID card.

ATENSION: Yanggen fumimino' **Chamorro** hao, guaha dibåtde para hagu na ayudun lengguahi yan kumunikasion ni difirentes na fotmat, yan danglulo na tinigi'. Agang i dibåtde na numero gi aidentifikasion planun hinemlo kard mu

注意：如果您說**中文(Chinese)**，您可以免費獲得語言協助和其他格式（例如大字版）的通訊。撥打您的健康計劃ID 卡上的免付費電話號碼。

توجه: اگر به فارسی)Farsi(، صحبت میکنید، خدمات کمکی زبان و مطالب در قالبهای دیگر، مانند پرینت درشت، بصورت رایگان برای شما فراهم است. با شماره تلفن رایگان درجشده روی کارت شناسایی بیمه سالمت خود تماس بگیرید

ATTENTION: si vous parlez **français** (**French**), une assistance linguistique et des communications dans d'autres formats, tels que du texte en gros caractères, sont gratuitement mis à votre disposition. Appelez le numéro de téléphone gratuit figurant sur votre carte de régime d'assurance santé

HINWEIS: Wenn Sie **Deutsch** (**German**), sprechen, stehen Ihnen Sprachdienste und Mitteilungen in anderen Formaten, wie z. B. in Großdruck, kostenlos zur Verfügung. Rufen Sie die kostenfreie Nummer auf Ihrer Versichertenkarte an.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)**, બોલો છો, તો ભાષા સહાય અને સંદેશાવ્યવહાર અન્ય ફોર્મેટમાં, જેમ કે મોટી પ્રિન્ટમાં, તમારા માટે નિઃશુલ્ક અને ઉપલબ્ધ છે. તમારા હેલ્થ પ્લાન ID કાર્ડ પરના ટોલ-ફ્રી નંબર પર કૉલ કરો

ATANSYON: Si w pale **Kreyòl Ayisyen** (**Haitian Creole**), genyen èd pou lang ou a disponib gratis pou ou ansanm ak kominikasyon nan lòt fòma, pa egzanp gwo lèt. Rele nan nimewo gratis ki sou kat ID plan sante w la

ध्यान दें: यदि आप **हिन्दी (Hindi)**, बोलते हैं, तो भाषा संबंधी मदद और अन्य प्रारूपों, जैसे बड़े प्रिंट, में संचार, आपके लिए उपलब्ध और निःशुल्क हैं। अपने स्वास्थ्य योजना ID कार्ड पर दिए गए टोल-फ्री नंबर पर कॉल करें

ATTENZIONE: se parla **italiano** (**Italian**), può usufruire gratuitamente di assistenza linguistica e comunicazioni in altri formati, come la stampa a caratteri grandi. Chiami il numero verde riportato sulla scheda identificativa del piano sanitario.

注意： 日本語**(Japanese)**,を話される場合は、言語サポートや大きな活字などの他の形式でのコミュニケーションを無料でご利用いただけます。保険プランIDカードに記載されているフリーダイヤル番号までお電話ください。

참고: 한국어를 **(Korean)** 구사하신다면 언어 지원 및 의사소통을 큰 인쇄물과 같은 형식으로도 무료로 이용하실 수 있습니다. 의료보험 ID 카드에 있는 무료 전화번호로 전화하십시오.

BAA'ÁKONÍNÍZIN: Diné (Navajo), bizaad bee yáníłti'go, saad bee áka'aná'awo' dóó bee ahił dahane'í nááná łahgo át'éego bee hada'dilyaaígíí, díí nitsaa bee ak'eda'ashchíní táá jiik'eh ná dahóló. Nits'íís át'éhí bee ha'dít'éhí ninaaltsoos nitł'izíID bąąh t'áá jiikeh námboo bee hane'í bee hodíilnih.

WICHDICH: Wann du **Deitsch** (**Pennsylvania Dutch**), schwetzscht, kenne mer dich Schprooch-Hilf griege, wann du's brauchscht, un Information in differnti Wege, so wie gross Schreiwes (large print). All sell zellt dich nix koschde. Call der Toll-Free-Number uff dei Health-Plan-ID Card.

UWAGA: jeśli mówisz po **polsku** (**Polish**), oferujemy bezpłatną pomoc językową i materiały w innych formatach, w tym napisane dużym drukiem. Zadzwoń pod bezpłatny numer podany na Twojej karcie ubezpieczenia zdrowotnego.

ATENÇÃO: se você fala **português** (**Portuguese**), a ajuda com o idioma e as comunicações em outros formatos, como letras grandes, por exemplo, estão disponíveis e são gratuitas. Você pode ligar para o número gratuito no seu cartão de identificação do plano de saúde.

ВНИМАНИЕ: Если Вы говорите по-**русски**)**Russian**), Вы можете бесплатно воспользоваться помощью переводчика и информационными материалами в альтернативных форматах, например, крупным шрифтом. Позвоните по бесплатному номеру, указанному на Вашей идентификационной карте плана медицинского страхования.

MO LE SILAFIA: Pe afai e te tautala i le faa-**Samoa** (**Samoan**), o le fesoasoani tau gagana ma feso'ota'iga i isi auala, e pei o lomiga e lapopo'a mata'itusi, o loo avanoa mo oe aunoa ma se totogi. Valaau le numera e lē totogia o loo i lau ID card o le peleni o le soifua mālōlōina.

توجہ فرمائیں: اگر آپ اردو)Urdu(, بولتے ہیں تو بڑے پرنٹ جیسی دوسری شکلوں میں لسانی امداد اور مواصلت آپ کے لیے مفت میں دستیاب ہوتی ہیں۔ اپنے ہیلتھ پالن کے آئی ڈی کارڈ پر موجود ٹول فری نمبر پر کال کریں

LƯU Ý: Nếu quý vị nói tiếng **Việt**)**Vietnamese**), quý vị sẽ được hỗ trợ ngôn ngữ miễn phí và các định dạng thông tin miễn phí khác như bản in khổ lớn. Hãy gọi số điện thoại miễn cước trên thẻ ID chương trình bảo hiểm y tế của quý vị.

Health plan coverage provided by Health Plan of Nevada.

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