We want to be your partner in good health.

HEALTH PLAN OF NEVADA
MEMBER GUIDE
AT HEALTH PLAN OF NEVADA (HPN), WE STRIVE TO PROVIDE QUALITY HEALTH CARE COVERAGE THAT’S AFFORDABLE, CONVENIENT, AND EASILY ACCESSIBLE. The following pages will provide you with a description of your Health Maintenance Organization (HMO) or Point-of-Service (POS) plan, and give you information and resources on how best to use them.
GETTING TO KNOW YOUR PLAN

As Nevada’s oldest HMO, Health Plan of Nevada has provided Nevadans with health care coverage for more than 30 years.

The following pages present an overview of your benefits. The sections titled “Introducing Your Benefits,” “Measuring Quality,” and “How to Reach Us,” contain information applying to all members.

You will also find sections about our HMO and POS plans. These sections will help you understand how your plan type works. With either plan, we hope you are pleased with our benefits and services.

For specific details about your plan, refer to your Health Plan of Nevada Evidence of Coverage, Attachment A Benefit Schedule, applicable Endorsements and Riders, and Exclusions of Coverage. Copies of these documents are available online or upon request.

Plan documents govern in resolving any benefit questions or payments.

If you have questions or need additional information, please call Member Services at 1-800-777-1840; TTY 711.

If you need help with communication, such as the services of a language interpreter, please call Member Services.
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Introducing Your Benefits

Online Member Center

You can find information about your benefits through our online member center - 24/7/365.

Take advantage of these convenient service features:

- View, your plan documents
- Change your address
- View, email or print your virtual health plan ID card
- Request replacement health plan ID cards
- Verify your coverage for pharmacy, dental, or vision 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 the status of a prior authorization request
- Find out how much has been applied toward your deductible, if applicable

Simply visit us at myHPNonline.com. First-time visitors will need to register. Member medical information is confidential and is only available to you and your provider.

Member Services

If you have a question about your health plan benefits or need some help in selecting a provider, call Member Services. Member Services representatives are available to assist you Monday through Friday, 8 a.m. to 5 p.m. You may also call after hours and leave a message. Your call will be returned the next business day. Call us at 702-242-7300 or 1-800-777-1840; TTY: 711.

HPN/SHL Symptom Checker

Now you have a great tool to guide you on what type of care (if any) you may need. You may also find symptom relief for minor illnesses and injuries. Use the HPN/SHL Symptom Checker on your computer or mobile device (available in English and Spanish). You can select your symptoms and get information on ways which may help you feel better. It’s easy and available 24/7.

The HPN/SHL Symptom Checker app is available for iOS® and AndroidSM devices in the App StoreSM online store or Google PlayTM store. The app has additional features and you can take it with you wherever you go.

Simply visit myHPNonline.com. Or visit the App Store or Google Play store to download the app for free.

Telephone Advice Nurse Service

Health Plan of Nevada offers a 24-hour Telephone Advice Nurse service. This means, day or night, holiday or weekend, our Telephone Advice Nurse Service is available to provide you with advice or help you decide whether to seek urgent care, emergency care, or schedule an appointment with your provider. Just call 702-242-7330 or 1-800-288-2264; TTY: 711.
NowClinic® 24/7 Online Services

When you’re not feeling so great, but it’s not an emergency, it can be tough to find time to see a doctor. Health Plan of Nevada members have a convenient option which fits busy lifestyles.

Use NowClinic to connect with Southwest Medical and NowClinic providers via secure webcam, chat, phone, or mobile app anytime, 24/7/365. The wait is typically less than 10 minutes*, and you can connect wherever it’s convenient for you. You can even skip the short wait by asking the doctor to text you when he or she is ready.

NowClinic lets you talk just like you would in an exam room with providers who can diagnose, provide care recommendations, and prescribe**, if appropriate, for simple care needs such as flu, sinusitis, insomnia, and pink eye.

Most plans have the same copay as a walk-in clinic visit, so it’s both less expensive and easier than a typical trip to your family doctor.

To enroll, visit NowClinic.com or download the NowClinic mobile application for iOS® and Android™ devices from the App Store™ online store or Google Play™ store. Complete the short enrollment process and make sure to enter your name as it appears on your health plan ID card. Now a provider will be a click away when you need one.

*Recent stats support, but not guaranteed. No longer than 30 minutes.

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 providers do not replace your primary care physician. The services are not covered by Medicare and may not be covered by your private health plan or Medicaid, so check with them prior to using the services. If not covered, the consumer is responsible for paying the fees at the time of service. If covered, copays and deductibles may apply. NowClinic providers do not prescribe controlled substances and reserve the right to refuse to prescribe other drugs that are restricted by state law or may be harmful or non-therapeutic. Providers may also decline an individual as a patient if the medical problem presented is not appropriate for NowClinic care or for misuse of services. All trademarks are the property of their respective owners.

Urgent Care

Consider visiting a facility which provides urgent care services when your medical condition requires prompt attention, such as:

- Ear infections
- Colds and other respiratory problems
- Sprains and strains
- Most abdominal pain
- Vomiting and diarrhea
- Most cuts
- Most burns
- Most fractures
- Most back pain

Emergency Care

A true emergency medical condition is when symptoms are severe enough you could reasonably expect serious danger to your health, such as the conditions listed below. In an emergency, no matter if you are at home or out of town, call 911 or go to the nearest hospital emergency room.

- Serious burns
- Major trauma
- Poisoning
- Serious breathing difficulties
- Heavy bleeding
- Severe chest pain
- Sudden paralysis
Health Education and Wellness

Whether you want to eat right, exercise more, stop smoking or relax, you have a wide range of resources to help you stay healthy. Our staff includes certified health education specialists, registered dietitians, and certified diabetes educators. A small fee may apply to cover class materials. Programs and classes include:

- Asthma - adult and child/caregiver
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)
- Diabetes management
- Heart health - cholesterol, blood pressure, triglycerides
- Smoking cessation
- Weight management - adult and children/adolescents

Online Health Education Resources

Our Health Education and Wellness (HEW) division has a long history of providing quality health education in a face-to-face setting. HEW has expanded its services to provide some of the same health education programs on the Internet. Log in to the online member center to access webisodes such as:

- Blood glucose meter use
- Foot care
- Insulin injection technique using an insulin pen or a syringe
- Three phases of a workout
- Waist circumference measurement
- Balancing food choices
- Sodium
- Tour of a buffet
- Bathing/burping a baby
- Using a car seat
- One minute stress workout
- Deep breathing exercise
- Stop smoking
- Preventive health care visit
- Walking

To register for a class or consultation, or for more information, call 702-877-5356 or 1-800-720-7253; TTY: 711.

Program for Chronic Conditions

Health Plan of Nevada offers members a Disease Management Program. This program is designed to help you reach your long term health goals by educating you on how best to manage your asthma or diabetes.

Program Highlights

As a member of the Disease Management Program, you will receive valuable information to assist you with managing your health. Some examples are:

- One-on-one coaching by a specially trained Registered Nurse (RN) Health Coach to teach you how best to manage your condition and improve your overall health and well being. Nurses call on your schedule.
- Assistance with medication questions or problems related to asthma or diabetes
- Information about how best to take your medicine, tips for exercising, keeping a healthy diet, how to quit smoking and triggers for asthma
- Logs to record key health care information like your weight and blood sugar levels, if you have diabetes and peak flow meter readings, if you have asthma

Who Can Join the Program?

Members with one or more of the health problems listed below can join the program.

- Adults and children with asthma
- Adults with diabetes

The Disease Management Program is free to all eligible members of Health Plan of Nevada. You may opt-out of the program any time after joining. To join the Disease Management Program, please call 702-242-7346 or 1-877-692-2059; TTY: 711. This program provides support and does not replace the treatment plans put into place by your provider. Always talk to your provider about any important health issues.
Prescription Drugs

If your employer offers a prescription drug plan, Health Plan of Nevada has prescription drug coverage and provides access to a large network of local and national pharmacies. In addition, you will benefit from a wide range of effective and affordable medications. These medications are listed on our Preferred Drug List (PDL), also known as a formulary. The PDL is a list of clinically proven generic and brand name medications used by our contracted providers. When you use a drug on a lower tier (Tier I or Tier II), your copayment is lower than if you use a Tier III drug (or if your plan offers, Tier IV).

You can view our PDL at myHPNonline.com or call the Member Services number on your health plan ID card.

Lower prescription drug costs – generic vs. brand name drugs

What is a generic drug?

A generic drug is sold or dispensed under a name which is not protected by a patent. Generic drugs become available after the patent expires for a brand name drug.

Do generic drugs work the same as brand name drugs?

Yes. The U.S. Food and Drug Administration (FDA) must approve all medicine before it can be sold to consumers. Generic drugs must meet exactly 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.

What’s the difference between a generic and a brand name drug?

Not much, except the name and price. A generic drug is called by its chemical name; a manufacturer assigns a brand name. Generic drugs typically cost less than “brands.” In most cases, your out-of-pocket costs will be lower as well when a generic is prescribed and obtained. Your health plan may place generics on multiple tiers, so to ensure you are saving the most money, check the PDL and use drugs on lower tiers.

Can using a mail order pharmacy benefit save time and money?

Yes. Consider using our contracted mail order Pharmacy, OptumRx, for your medication needs. Health Plan of Nevada members can use one of the easy methods below to get started:

Send your prescription by mail. If you prefer to send your prescription by mail, go to myHPNonline.com and download an order form. Your provider should write your prescription for a 90-day supply with refills when appropriate (not a 30-day supply with three refills). Complete the order form, then mail it with your prescription to the address provided.

Ask your provider to do it. Fill out section one of the OptumRx fax order form, then ask your provider to fill out section two and fax the form for you. The form is available on myHPNonline.com. Your provider should write your prescription for a 90-day supply with refills when appropriate (not a 30-day supply with three refills).

For additional assistance with your order or all other related questions, please call the Member Services number on the back of your health plan ID card.
What’s Prior Authorization?
If your doctor wants to prescribe you a drug that the plan has specific requirements for use or is not on the PDL, you may need prior authorization. Prior authorization is the process of notification and approval for a prescription drug which has certain restrictions or is not on the PDL. This process is usually requested by your doctor and is necessary to provide you with the most appropriate and cost-effective health care possible. If prior authorization is not received before you pick up your prescription drug, you may be responsible for the cost of the drug. Please refer to your Evidence of Coverage or Agreement of Coverage and your plan documents for more details on how prior authorization works.

What’s Step Therapy?
Step therapy is a program designed for people who have certain conditions—arthritis, high blood pressure, and high cholesterol, for example—conditions which require them to take medications regularly.

In some cases, your health plan requires you to first try certain drugs to treat your medical condition before it will cover another drug for that condition.

For example, if drug A and drug B both treat your medical condition, we may not cover drug B unless you try drug A first. If drug A doesn’t work for you, then the plan will cover drug B. You and your doctor will work together to choose the best prescription drug options for you.

You can find out which prescription drugs require step therapy by viewing Health Plan of Nevada’s Preferred Drug List (PDL) at myHPNonline.com.

Are There Limits on Dosage and Refills?
A pharmacy may refuse to fill or refill a prescription order when in the professional judgment of the pharmacist the prescription should not be filled. Benefits for prescriptions for mail order drugs submitted following 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 Health Plan of Nevada determines 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 thirty-one (31) days of the date you are notified, then we will select a single plan pharmacy for you.

What’s an Exception Request?
An exception request allows you, your provider, or someone on your behalf to ask that the plan waive step therapy requirements or quantity limit restrictions. The exception request form is available at myHPNonline.com or Member Services at 1-800-777-1840; TTY: 711.
**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 Quality Improvement department at 702-242-7735; TTY: 711.

**Appropriate, Timely and Necessary Patient Care**

If you are admitted into a hospital, rehabilitation center or other inpatient facility, Health Plan of Nevada 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 PCP, 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 which 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 the Health Plan of Nevada 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, Health Plan of Nevada formally evaluates 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 providers, or other interested parties 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.

**No Incentives for Prior Authorization Denials**

Who makes the decisions concerning your care? You and your provider. Health Plan of Nevada prohibits 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.
Internal and External Review for Denial of Benefits

If a benefit is denied, Health Plan of Nevada provides internal review to help ensure member satisfaction in the medical 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.

Expedited appeals are available when decisions are needed quickly. For additional information, please refer to your plan documents online or call Member Services.

Your Right to an Appeal

How do you appeal a decision which may adversely affect your coverage, benefits, or relationship with Health Plan of Nevada?

An appeal is a request for Health Plan of Nevada to review a decision regarding the denial of coverage for health care benefits or services. Members have 180 days from the date of the denial to file an appeal. You or your provider may submit a request or initiate an appeal for the informal review of a decision by calling Member Services or mailing a written request to:

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

Prior Authorization

Prior authorization is the process of notification and approval for certain types of health care services, treatment, or equipment by Health Plan of Nevada. This step is necessary to ensure benefit payment. Please consult your plan documents for detailed information about the health care services, treatments, and equipment requiring prior authorization.

Except in cases of medical emergency, referrals for out-of-area care require prior authorization before benefits may be paid. You, a family member, your provider, or a representative from a licensed facility may contact Member Services for information regarding the status of a prior authorization.

All prior authorization 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. Our medical director reviews each request on a case-by-case basis, taking any special circumstances into consideration.

If your request is denied or you have any questions regarding a prior authorization, you may call Member Services. To initiate an appeal of a prior authorization decision, call Member Services or write to:

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

If You Have a Complaint

We’ll definitely want to know. We strive to meet your expectations in every way. If you are ever dissatisfied with services or care, or with the operations or administration of your health plan, please 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

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, please obtain your medical records and all bills from the provider. Please make a copy for your personal records. Be sure your member ID number is on all documents, and then mail the originals directly to Health Plan of Nevada.

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

Your Privacy Rights

Health Plan of Nevada is 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.

Health Plan of Nevada uses 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. Health Plan of Nevada does 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 myHPNonline.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.
Getting 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. Your copayments are predictable and affordable as a result of the HMO’s one tier benefit design. Your benefits are easy to understand and access.

Selecting or Changing 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 myHPNonline.com. To get a copy, contact your employer’s benefits department or Member Services at 702-242-7300 or 1-800-777-1840; TTY: 711.

To change your PCP, please call Member Services or mail a change form to:

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

Southwest Medical Associates in Southern Nevada

As a Health Plan of Nevada member, you have access to Southwest Medical Associates, one of Nevada’s largest multi-specialty medical groups. Southwest Medical has more than 250 primary care and specialty care providers, and an outpatient surgery center. With convenient locations throughout the Las Vegas Valley and Pahrump, Southwest Medical is ready to provide the care you need.

Some Southwest Medical health care centers include urgent cares and most provide laboratory and radiology services on site for your convenience.

Southwest Medical’s online patient center can help you manage your health care. My SMA Health Online® features 24-hour Internet access to appointment scheduling, medical records, prescription renewals, E-visits, and more.

For additional information, please visit smalv.com or call 702-877-5199; TTY: 711.

Routine Appointments

To make an appointment, call your provider’s office. 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. 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 Health Plan of Nevada’s service area, please follow these simple steps:

For Urgent Care — Health Plan of Nevada covers urgently needed services if you are in the United States. When you are outside of our service area, it is not necessary to notify Health Plan of Nevada 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 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.

Behavioral Health Services

Behavioral Healthcare Options (BHO) provides professional counseling, telephone 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 BHO at 702-364-1484 or 1-800-873-2246; TTY: 711.

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

Getting 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 three-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 below.
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.

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.
• 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.

Selecting or Changing 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.
• 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 Associates in Southern Nevada

As a Health Plan of Nevada member, you have access to Southwest Medical Associates, one of Nevada’s largest multi-specialty medical groups. Southwest Medical has more than 200 primary care and specialty care providers and an outpatient surgery center. With convenient locations throughout the Las Vegas Valley and Pahrump, Southwest Medical is ready to provide the care you need.

Some Southwest Medical health care centers include urgent cares and most provide laboratory and radiology services on site for your convenience.

Southwest Medical’s online patient center can help you manage your health care. Health Online™ features 24-hour Internet access to appointment scheduling, medical records, prescription renewals, E-visits, and more.

For additional information, please visit smalv.com or call 702-877-5199; TTY: 711.

Routine Appointments

To make an appointment, call your provider’s office. 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: 1-800-326-6888, 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. Health Plan of Nevada will only pay for non-authorized 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 — Health Plan of Nevada covers urgently needed services if you are in the United States. When you are outside of our service area, it is not necessary to notify Health Plan of Nevada 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.

**Behavioral Health Services**

Behavioral Healthcare Options (BHO) provides professional counseling, telephone 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 BHO at **1-800-873-2246; TTY: 711**.

To receive services under your Tier II Expanded Plan Provider benefit option, call BHO Utilization Management for prior authorization at **702-364-1484 or 1-800-873-2246; TTY: 711**.

Once you receive prior authorization, you can select a provider from BHO’s network.

For routine information and assistance, please call BHO during regular business hours, Monday through Friday at **702-364-1484 or 1-800-873-2246; TTY: 711**.

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

**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. Health Plan of Nevada has also identified its expectations of members’ responsibilities in this joint effort. Health Plan of Nevada’s statement regarding Members’ Rights and Responsibilities includes the following:

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 primary care provider in the decision making process regarding your healthcare.

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 healthcare 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.

**Member’s 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 healthcare 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 healthcare professional.
11. To be aware of the healthcare 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, healthcare providers, and plan representatives.

13. To abide by administrative requirements of HPN, healthcare 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 our 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.

How to Reach Us

24-Hour Telephone Advice Nurse Service
702-242-7330 or 1-800-288-2264; TTY: 711.

Member Services
702-242-7300 or 1-800-777-1840; TTY: 711.
Office hours are 8 a.m. to 5 p.m. Monday through Friday, local time

Online Member Center
myHPNonline.com

Health Education and Wellness Division
702-877-5356 or 1-800-720-7253; TTY: 711.

Behavioral Healthcare Options
Routine calls and after-hours helpline
702-364-1484 or 1-800-873-2246; TTY: 711.

Claims Administration - Mailing Address
P.O. Box 15645
Las Vegas, NV 89114-5645
HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

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