www.uhcfeds.com

Customer Service 877-545-7378

Health Plan of Nevada

A UnitedHealthcare Company

2027

A Health Maintenance Organization (High Option)

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

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 15
- Summary of Benefits: Page 83

Serving: Clark, Esmeralda and Nye Counties

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

IMPORTANT: Postal Employees and Annuitants are no longer eligible for this plan (unless currently under Temporary Continuation of Coverage).

Enrollment codes for Clark, Esmeralda and Nye Counties:

NM1 High Option - Self Only
NM3 High Option - Self Plus One
NM2 High Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

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

The Office of Personnel Management (OPM) has determined that the Health Plan of Nevada, Inc.'s prescription drug benefit coverage meets the Centers for Medicare & Medicaid Services (CMS) requirements to be considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

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

Medicare's Low Income Benefits

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

Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB Plan. Refer to the Part D-IRMAA section of the Medicare website: https ://www. medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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

- Visit www. medicare.gov for personalized help.
- Call 800-MEDICARE (1-800-633-4227, TTY 877-486-2048).

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Introduction

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

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2027, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2027, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Plain Language

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

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

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except to your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

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

CALL- THE HEALTHCARE FRAUD HOTLINE

877-499-7295

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

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

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

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

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

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

- "Exactly what will you be doing?"
- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

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

Patient Safety Links

For more information on patient safety, please visit:

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

Preventable Healthcare Acquired Conditions ("Never Events")

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

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

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

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

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

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

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

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

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

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB Plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB Plan.

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined OPM.

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

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

- **When benefits and premiums start**

  The benefits in this brochure are effective January 1, except if you are an active employee and change your plan at open season. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2027 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. **However**, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2026 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

  If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

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

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

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot covert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

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

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

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

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

General features of our High Option

How we pay providers

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

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

We have several types of payment arrangements with our doctors:

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

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including copayments, to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

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

- HPN has operated as a mixed model HMO in Nevada for over 40 years. HPN has been awarded an accreditation status of Accredited from the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to measuring the quality of America's health care. Accreditation is for the Commercial HMO and Commercial POS product lines in Nevada.
- We understand the importance of getting your questions answered. Whether you need an answer to a benefit question, have a concern about a claim or need help in selecting a provider, we are available Monday through Friday, 8 a.m. to 5 p.m. at 877-545-7378.
- At times, services required on your behalf by your provider may not be approved by HPN. The decision to deny coverage for services requested, courses of treatment or inpatient care is made by a physician. These denials are based upon medical necessity, benefit coverage and your individual needs. Written notification of the denial will be sent to you, your primary care provider and the provider who requested the service. You have the right to appeal these decisions.

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

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

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

Your medical and claims records are confidential

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

Service Area

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

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

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

Section 2. Changes for 2027

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

Changes to High Option

- Your share of the premium rate will change for Self Only, Self Plus One and Self and Family. See Rate Information for Health Plan of Nevada, Inc., page 84.
- Excluded surgical procedures to alter physical traits to align with gender identity. See Section 5(b) Not Covered, page 42.
- Removed hormone therapy (chemical treatments) for gender transition in Section 5(f).
- Removed Continuation of Care Exception Policy for Sex-Trait Modification Treatment in Section 5(b).
- GLP-1 coverage for weight loss has been added at 50% coinsurance up to a maximum of $750.00 for a one-month supply. See Section 5(f), page 58.

Program-wide changes

- Well Care

Section 3. How You Get Care

Identification cards

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

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

Where you get covered care

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

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

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

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

This plan provides Case Management for complex conditions and can be reached 877-545-7378 for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website. This plan provides Care Coordinators for complex conditions and can be reached 877-545-7378 or www.healthplanofnevada.com for assistance.

What you must do to get covered care

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

- **Primary care**

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

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

- **Specialty care**

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

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

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

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

  If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause;

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or

  - reduce our service area and you enroll in another FEHB plan;

You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:

- We terminate our contract with your specialist for other than cause;
- We drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
- We reduce our service area and you enroll in another FEHB plan.

Contact us at 877-545-7378, or if we drop out of the Program, contact your new plan.

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

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

- **Hospital care**

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

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

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

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

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

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

You need prior Plan approval for certain services

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

It is best to contact your primary care provider before you seek any services.

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

- **Inpatient hospital admission**

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

- **Other services**

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

  - Transplants (including Plan paid transportation, lodging & meals)
  - All non-emergency hospital admissions
  - Admissions to skilled nursing facilities and inpatient hospice facilities
  - All non-emergency inpatient and outpatient surgeries
  - Non-preventive routine lab and x-ray services
  - Anti-cancer drug therapy, non-cancer related drug therapy or other medically necessary therapeutic drug services
  - Dialysis
  - Therapeutic radiology
  - Complex allergy diagnostic services (including RAST) and serum injections
  - Otologic evaluations
  - Other complex diagnostic imaging services, including CT scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; and complex neurological testing
  - Positron Emission Tomography (PET) scans

- Courses of treatment, including allergy testing or treatment, angioplasty, physiotherapy or manual manipulation
- Physical, occupational and speech therapy
- Hearing Aids
- Home Healthcare Services
- Prosthetic devices, orthotic devices and durable medical equipment
- Certain prescription drugs
- Pharmaceutical compounds that exceed $50
- Genetic disease testing
- Clinical trials or studies for the treatment of cancer or chronic fatigue syndrome
- Dental anesthesia for enrolled dependent children when determined to be medically necessary
- Non-emergency (ground or air) transport
- All elective inpatient and non-routine outpatient non-emergency mental health, severe mental illness, and substance related services, including intensive outpatient program treatment, electroconvulsive treatment, and psychological and neuropsychological testing.
- Infertility Services

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

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

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

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

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

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

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

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

What happens when you do not follow the precertification rules when using non-network facilities

A non-network facility admission would not be covered unless a medical emergency occurred (see Section 5(d) for what to do in case of emergency).

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 877-545-7378.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered services you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care provider, you pay a $10 copayment per office visit, and when admitted to the hospital, you pay a $300 copayment per admission.
Deductible	We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for costs associated for the treatment of temporomandibular joint pain dysfunction syndrome.
Differences between our Plan allowance and the bill	You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your out-of-pocket expenses (copayments and coinsurance) total $3,500 for Self Only, or $7,000 for a Self Plus One and Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $3,500 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.*** Example Scenario: Your plan has a $3,500 Self Only maximum out-of-pocket limit and a $7,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $3,500 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $7,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $3,500 for the calendar year before their qualified medical expenses will begin to be covered in full. However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services: • amounts charged for non-covered services • amounts exceeding applicable plan benefit maximums or eligible medical expenses payments • amounts charged for services requiring prior authorization if not obtained • amounts charged for services of non-plan providers, except in the case of emergency services or for other covered services provided by a non-plan provider that are prior authorized by HPN's Managed Care Program

Carryover

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

When Government facilities bill us

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

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan adopts and complies with the surprise billing laws of Nevada and NSA AB469.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.uhcfeds.com or contact the health plan at 877-545-7378.

The Federal Flexible Spending Account Program – *FSAFEDS*

- **Healthcare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you, your tax dependents, and your adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP Plans. This means that when you or your provider files claims with your FEHB or FEDVIP Plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

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Section 5. High Option Benefits Overview

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

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

Our High Option offers the following unique features.

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

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by providers and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In provider's office	$10 per office visit for Primary Care $25 per office visit for Specialist
• At home	$25 per visit
• In an urgent care center	$30 per visit
Primary care services • In a convenient care center • By a physician extender or assistant Note: Convenient care centers provide treatment for minor injuries and illnesses. Note: Physician extenders or assistants are health care providers who are not physicians but who perform medical activities typically performed by a physician; most commonly a nurse practitioner or physician assistant.	$5 per visit
• During a hospital stay • In a skilled nursing facility • Second surgical opinion • Initial examination of a newborn child	Nothing
Telehealth services	**High Option**
NowClinic Note: For non-life threatening and non-urgent medical conditions, connect virtually with a provider 24/7 by accessing NowClinic (a contracted telemedicine provider) from your computer or mobile device.	Nothing

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • EKG • Non-routine mammograms • Ultrasounds Note: See Section 3, *You need prior Plan approval for certain services.*	$10 per visit
• Complex diagnostic imaging services, such as nuclear medicine, CT scan, cardiac ultrasonography, MRI and arthrography • Complex vascular diagnostic and therapeutic services including Holter monitoring, treadmill stress testing, and impedance venous plethysmography • Complex neurological diagnostic services including EEG, EMG, and evoked potential • Complex pulmonary diagnostic services including pulmonary function testing and apnea monitoring • Otologic evaluation • Abdominal aortic aneurysm screening, one screening for men between the ages of 65 and 75 with a history of smoking Note: See Section 3, *You need prior Plan approval for certain services.*	$20 per test or procedure
• Genetic disease testing Note: We only cover genetic disease testing when we preauthorize the services. Ask us to authorize your genetic disease testing before you begin services. We will only cover genetic disease testing that we determine is medically necessary.	25% of EME (Eligible Medical Expense)
• Positron Emission Tomography (PET) scan	$200 per test
Preventive care, adult	**High Option**
Routine physical every 12 months **The following preventive services are covered at the time interval recommended at each of the links below.** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https ://www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
• Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at https ://www. hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder • When anti-obesity medication is prescribed see Section 5(f) or 5(f)(a), if applicable.	Nothing
• Routine mammogram	Nothing
• Routine use of adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visithttps ://www. cdc.gov/vaccines/imz-schedules/index.html Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments and coinsurance.	Nothing
• Routine exams limited to: - One routine eye exam every 12 months - One routine hearing exam every 12 months	Note: Coverage is provided for vision and hearing exams only when required to diagnose illness or injury. Office visit copay applies.
Not covered: • *Physical exams required for obtaining or continuing employment, licensing, or insurance; attending schools or camp; athletic exams; travel; or adoption purposes.* • *Exams or treatment ordered by a court, or in connection with legal proceedings.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy covered for 1 visit every week during the first month,1 visit every other week during months 2 through 6, 1 visit monthly during months 7 through 12 if weight-loss goals are met. • Obesity screening using BMI measurements • Dietary and nutritional assessment	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
• Intensive behavioral counseling focused on diet, exercise, and lifestyle changes to support sustained weight loss • Face-to-face counseling visits in a primary care setting with a qualified provider • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. • When anti-obesity medication is prescribed see Section 5(f) or 5(f)(a), if applicable. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity see Section 5(b). Note: Also see Section 5(h) [Carriers who offer nutritional and physical activity support for members can also state additional optional programs under Wellness and Other Special Features Section 5(h) and insert a cross reference to this Section 5(a)].	Nothing
Preventive care, children	**High Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org. For preventive immunizations see guidance below. • Routine use of children's immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) schedule and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www. cdc.gov/vaccines/imz-schedules/index.html • You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https ://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, and coinsurance.	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. • When anti-obesity medication is prescribed see Section 5(f) or 5(f)(a), if applicable.	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
• When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity see Section 5(b). Note: Also see Section 5(h) [Carriers who offer nutritional and physical activity support for members can also state additional optional programs under Wellness and Other Special Features Section 5(h) and insert a cross reference to this Section 5(a)].	Nothing
Routine exams limited to: • One routine eye exam every 12 months • One routine hearing exam every 12 months	Note: Coverage is provided for vision and hearing exams only when required to diagnose illness or injury. Office visit copay applies.
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes • Prenatal and Postpartum care • Delivery • Screening and counseling for prenatal and postpartum depression	Nothing for prenatal care or the first postpartum care visit; $10 per office visit for all postpartum care visits thereafter. $25 for inpatient professional delivery services.
Breastfeeding and lactation support, supplies and counseling for each birth.	Nothing
Note: • You do not need to pre-certify your vaginal delivery; see below for other circumstances, such as extended stays for you and your baby. • You have access to in-network home nurse visits and board certified lactation specialists during the prenatal and post-partum period. Your coverage includes any certified doula coverage (for both in-person and virtual). This coverage is only available in Nevada service areas. • You may remain in the hospital for up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	Nothing

Benefit Description	You pay
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms **Note:** See additional Family Planning and Prescription drug coverage in Section 5(f) or 5(f)(a), if applicable. **Note**: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA- supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. Exception process: Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contactcontraception@opm.gov.	Nothing
Voluntary male sterilization	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling, except as indicated in Lab, X-ray, and other diagnostic tests*	*All charges*
Infertility services	**High Option**
Infertility is defined as: *A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of unprotected intercourse or artificial insemination for individuals under age 35. Evaluation and treatment for those individuals actively looking to achieve a conception may be justified based on medical history and diagnostic testing, and is warranted after six (6) months for individuals age 35 years or older.* Diagnosis and treatment of infertility such as: • Artificial insemination (AI) • Intravaginal Insemination (IVI)	50% of EME (Eligible Medical Expense)

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
• Intracervical Insemination (ICI) • Intrauterine Insemination (IUI) Coverage is provided for up to 6 cycles per member annually. Note: Prior Authorization is required.	50% of EME (Eligible Medical Expense)
Fertility drugs (See Section 5f)	Fertility drugs (See Section 5f)
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete, intra fallopian transfer (GIFT) and zygote intra fallopian transfer (ZIFT)* - *Cost of donor sperm* - *Cost of donor egg*	*All charges*
Iatrogenic infertility	**High Option**
Coverage is available for fertility preservation for medical reasons that cause irreversible infertility such as surgery, including surgical treatment of gender dysphoria, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. Covered benefits include the following procedures: • Collection of sperm • Cryo-preservation of sperm • Oocyte cryo-preservation • Embryo cryo-preservation • Ovarian stimulation, retrieval of eggs and fertilization *Not covered:* • *Embryo transfer* • *Long-term storage costs (greater than 1 year)* • *Elective fertility preservation* Benefits are further limited to one cycle of fertility preservation for iatrogenic infertility per covered person during the period of time he or she is enrolled for coverage under the policy. Fertility drugs: See Section 5(f). Note: Prior authorization is required.	50% of EME (Eligible Medical Expense)

Benefit Description	You pay
Iatrogenic infertility preservation	**High Option**
Fertility preservation for iatrogenic infertility The following tests or procedures are proven and medically necessary for diagnosing or treating infertility: • Antis-perm antibodies • Antral follicle count • Cryopreservation of sperm, semen, or embryos for individuals who are undergoing treatment with assisted reproductive technologies or are planning to undergo therapies that threaten their reproductive health, such as cancer chemotherapy • Cryopreservation of surgically derived sperm • Cryopreservation of mature oocytes (eggs) for woman who are undergoing treatment with assisted productive technologies or are planning to undergo therapies that threaten their reproductive health, such as cancer chemotherapy • Cryopreservation of supernumerary embryos or in the setting where the intent is to freeze all embryos for the purpose or an elective single embryo transfer Note: There is no period limit for storage and there is no dollar limit for iatrogenic infertility treatment.	50% of EME (Eligible Medical Expense)
Allergy care	**High Option**
• Testing and treatment • Allergy injections	$10 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on pages 40-44. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	$20 per office visit

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
Note: We only cover GHT when we pre-authorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* in Section 3.	$20 per office visit
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 30 sessions. Note: Cardiac rehabilitation services must be provided on a monitored basis.	$10 per office visit
• Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder Note: For members under the age of 18 or, if enrolled in high school, until such member reaches the age of 22. ABA for the treatment of autism is limited to 250 visits, not to exceed 1,500 total hours of therapy per member per calendar year.	$10 per office visit
Not covered: • *Sports medicine treatment intended to primarily improve athletic ability*	*All charges*
Physical and occupational therapies	**High Option**
Rehabilitation and Habilitative Services **S**ixty (60) days/visits per year for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a physician: • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Note: Prior authorization is required.	$10 per office visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Alternative treatments, such as acupuncture, hypnosis, biofeedback*	*All charges*

Benefit Description	You pay
Speech therapy	**High Option**
Rehabilitation and Habilitative Services from a speech therapist Sixty (60) days/visits per calendar year.	$10 per visit
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children*	$10 per office visit
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids and cochlear implants	$10 per office visit
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• Annual eye refraction Note: See *Preventive care, children* for eye exams for children.	$10 per office visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	50% of EME (Eligible Medical Expense)
Not covered: • *Eye examination required as a condition of employment or by a government body* • *Low vision aids* • *Orthoptics or vision training and exercises* • *Any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (except for surgical treatment).*	*All charges*

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

Benefit Description	You pay
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Speech generating devices • Traction equipment Note: Call us at 877-545-7378 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call. Note: Wheelchairs are limited to coverage of a single standard manual wheelchair as deemed medically necessary and appropriate. Note: Blood glucose monitors for diabetes are covered under Section 5 (f) prescription drug benefit. Note: Prior authorization is required.	Nothing
• Insulin pumps	$100 per device
• Insulin pump supplies	$10 per 30-day therapeutic supply
Not covered: • *Motorized wheelchairs* • *Custom wheelchairs* • *More than one piece of equipment serving essentially the same function except for replacements as authorized by the Plan. Coverage for alternate or spare equipment is not provided.*	*All charges*
Home health services	**High Option**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or a home health aide on an intermittent basis. • Services include oxygen therapy, intravenous therapy and medications. • Services include physical therapy, speech therapy, and occupational therapy by licensed therapists. • Medical and surgical supplies that are customarily furnished by the Home Health Care agency or program. • Prescribed drugs furnished and charged for by the Home Health Care agency or program. Prescribed drugs under this provision do not include self-injectable prescription drugs.	Nothing

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	**High Option**
Note: Home health aide services furnished to member only when receiving nursing services therapy. Note: Prior authorization is required.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Housekeeping or meal service*	*All charges*
Chiropractic	**High Option**
• Manual manipulation of the spine (except for reductions of fractures or dislocations) and extremities *Adjunctive procedures such as ultrasound and electrical muscle stimulation if they meet medical necessity requirements*	$25 per office visit
Not covered: • *Vibration therapy* • *Cold pack applications*	*All charges*
Alternative treatments	**High Option**
• Medical treatment in a Phase I, II, III or IV clinical trial or study for the treatment of cancer conducted in the state of Nevada • Medical treatment in a Phase II, III or IV clinical trial or study for the treatment of chronic fatigue syndrome conducted in the state of Nevada Note: Medical treatment must be provided by a contracted provider participating in an appropriately approved clinical trial (listed in https://clinicaltrials.gov/). Services must be provided by an HPN provider. In the event an HPN provider does not offer a clinical trial with the same protocol as the one the member's Plan provider recommended, the member may select a non-plan provider performing a clinical trial with that protocol within the state of Nevada. If there is no provider offering the clinical trial with the same protocol as the one the member's Plan provider recommended in Nevada, the member may select a clinical trial outside of Nevada but within the United States of America. Note: See the *Prescription Drug Benefits*, Section 5(f) for coverage of drugs and medications.	$25 per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture*	*All charges*

Alternative treatments - continued on next page

Benefit Description	You pay
Alternative treatments (cont.)	**High Option**
• *Any portion of the clinical trial or study that is customarily paid for by the government, biotechnical, pharmaceutical or medical industry* • *Services that are specifically excluded from coverage under this Plan regardless of whether such services are provided under the clinical trial or study* • *Expenses related to participation in the clinical trial or study including, but not limited to; travel, housing and other expenses* • *Expenses incurred by a person who accompanies a member during the clinical trial or study* • *Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the member* • *Extra care costs related to taking part in a clinical trial such as additional tests that are not part of the patient's routine care* • *Research costs related to conducting a clinical trial such as research physician and nurse time, analysis of results and clinical tests performed only for research purposes*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco Cessation program comprised of a 12-week evidence-based support group led by a Licensed Alcohol & Drug Counselor (LADC). The program includes 1:1 counseling in addition to group sessions and may include medication or nicotine replacement therapy. Member may continue attending support groups past 12 weeks. Call 702-877-5356 to register. Note: See *Prescription Drug Benefits,* Section 5(f) for coverage of tobacco cessation medication.	Nothing for counseling for up to two (2) quit attempts per year, including one (1) individual counseling session and at least six (6) group counseling sessions per quit attempt. Nothing for (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self-management: - Comprehensive diabetes management program include working with a registered nurse specializing in diabetes to receive personalized education and support to learn how to best self-manage their diabetes. Topics covered during weekly phone calls include healthy eating, medication management, blood sugar monitoring, and exercise. Adult type 1 diabetes support also provided by a Certified Diabetes Care and Education Specialist. Opportunity provided to members to attend a comprehensive diabetes class taught by a Registered Dietitian. To schedule an appointment call 702-242-7346.	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus (see *Reconstructive surgery*) • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices (see *Orthopedic and prosthetic devices* for device coverage information) • Treatment of burns Note: For female surgical family planning procedures see Family Planning Section 5(a). Note: For male surgical family planning procedures see Family Planning Section 5(a). Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.	$25 per surgery
• Surgically implanted contraceptives	Nothing
• Surgical treatment of severe obesity (bariatric surgery) Note:	50% of EME

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• Individuals must have a body mass index (BMI) of greater than 40 kg/m2, or greater than 35kg/m2 with significant co-morbidities such as cardiac disease, diabetes, hypertension, or diseases of the endocrine system, e.g., Cushing's syndrome, hypothyroidism, or disorders of the pituitary or adrenal glands. • Individuals must show documentation that medically supervised weight loss therapy for 6 consecutive months within the last 24 months has been ineffective. • Individuals must be age 18 or over and have a psychological/psychiatric evaluation by a licensed practitioner with a recommendation for gastric restrictive surgery. • Covered services rendered in the treatment of complications in connection with gastric restrictive surgery. • Contact the Plan at 877-545-7378 for additional eligibility criteria.	50% of EME
• Surgical Assistant Services	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot* (see *Section 5(a) Foot care*)	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birthmarks, webbed fingers, and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (See Section 5 (a) Prosthetic devices for coverage.) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$25 per surgery
Not covered: • *Cosmetic surgery – Any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury. (See Section 5(d) Accidental injury)* • *Surgery for Sex-Trait Modification to gender dysphoria*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Treatment of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth • Removal of teeth necessary in order to perform radiation therapy • Removal of stones from salivary ducts • Other surgical procedures that do not involve the teeth or their supporting structures	$25 per surgery
• Treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	50% of EME (Eligible Medical Expenses)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ and tissue transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *"You need prior Plan approval for certain services"* on page 18 for prior authorization procedures. Solid organ and tissue transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy only for patients with chronic pancreatitis) • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestines - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Kidney-pancreas • Liver • Lung: Single, bilateral or lobar • Pancreas	$25 per surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$25 per surgery
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency disease (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphyocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	$25 per surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Advanced non-Hodgkin's lymphoma with recurrence(relapsed) - Amyloidosis - Aggressive non-Hodgkin lymphomas - Breast cancer - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	$25 per surgery
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	$25 per surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
These **blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Beta Thalassemia Major - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphyocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MDDs) - Mylelodysplasia/Myelodysplastic syndromes - Ovarian cancer - Sickle cell anemia • Autologous transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma	$25 per surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian cancer - Mantle Cell (non-Hodgkin's lymphoma)	$25 per surgery
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.We cover donor testing for bone marrow/ stem cell transplants for up to 4 potential donors whether family or non family. National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplant in addition to the facilities that are directly contracted with the health plan for this service.	You pay 20% of EME
• Transportation, lodging and meals Note: Prior authorization is required.	All costs exceeding $200 per day; $10,000 per transplant period.
• Organ procurement	All costs exceeding $15,000 of EME
• Retransplantation services	All costs exceeding 50% of EME
Not covered: • *Donor screening tests and donor search expenses, except as indicated on this page* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Physician's office	$50 per surgery

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$300 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medications • Clinical pathology and laboratory services and supplies and X-rays • Dressing, splints, casts, and sterile tray services • Medical supplies including oxygen and its administration • Blood or blood plasma, if not donated or replaced • Intravenous injections and solutions • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing See section 5(b) *Surgical and anesthesia services.*
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes and schools, including room and board at therapeutic boarding schools* • *Personal comfort items, such as telephone, television, barber services, guest meals, and beds* • *Private nursing care, except when medically necessary*	*All charges*

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

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**High Option**
Note: Inpatient and Outpatient respite services are limited to a combined maximum benefit of 5 Inpatient days or 5 Outpatient visits per member per 90 days of Hospice Care.	$10 per visit
• Bereavement services Note: Bereavement services provided to the member's family after death are limited to five (5) group therapy sessions per event. Treatment must be completed within six (6) months of the date of death.	$20 per visit
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
End of life care	**High Option**
No Benefits	*All charges*
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate	$50 per trip
• Emergency air ambulance	$250 per trip
• Non-emergency (ground or air) transport	Nothing

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

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

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office	$10 per office visit for Primary Care $25 per office visit for Specialist
• Emergency care at an urgent care facility	$30 per visit
• Emergency care in a hospital emergency room Note: We waive the ER copay if you are admitted to the hospital.	$150 per visit
Not covered: Elective care or non-emergency care	*All charges*

Benefit Description	You pay
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office	$10 per office visit for Primary Care $25 per office visit for Specialist
• Emergency care at a non-Plan urgent care facility	$30 per visit
• Emergency care in a hospital emergency room Note: We waive the ER copay if you are admitted to the hospital.	$150 per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**High Option**
• Professional ambulance service when medically appropriate Note: See *Section 5(c)* for non-emergency service. Non-emergency (ground or air) transport requires prior authorization.	$50 per trip
• Emergency air ambulance Note: Ambulance services will be reviewed on a retrospective basis to determine medical necessity. The member will be fully liable for the cost of ambulance services that are not medically necessary.	$250 per trip

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9, about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- To be eligible to receive these benefits, you must obtain a treatment plan and follow the network authorization process.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3, *How you get care*, to be sure which services require precertification.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy Note: Prior authorization is required for intensive outpatient program treatment, electroconvulsive therapy treatment, and psychological and neuropsychological testing.	$10 per visit
Not covered:	*All charges*

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
• *Mental health services and substance-related and addictive disorder services performed in connection with conditions not listed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or conditions listed as "Other Conditions" that may be of focus of clinical attention.* • *Outside of an initial assessment, mental health and substance-related and addictive disorder services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.* • *Outside of an initial assessment, treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, personality disorders (with the exception of dialectical behavior therapy for borderline personality disorders) and paraphilic disorder.* • *Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction, and learning.* • *Tuition for services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.* • *Outside of an initial assessment, unspecified disorders for which the provider is not obligated to provide the clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.* • *Hypnosis.* • *Milieu therapy, biofeedback treatment, behavior modifications, sensitivity training, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolffing, vocational rehabilitation and wilderness programs.*	*All charges*
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and/or substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$10 per test
Not covered: • *Mental health services and substance-related and addictive disorder services performed in connection with conditions not listed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or conditions listed as "Other Conditions" that may be of focus of clinical attention.* • *Neuropsychological testing when not required for the diagnosis of a mental illness, substance use disorder, or developmental disability.*	*All charges*

Diagnostics - continued on next page

Benefit Description	You pay
Diagnostics (cont.)	**High Option**
• *Tuition for services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.*	*All charges*
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$300 per admission
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization or facility-based intensive outpatient treatment	$50 per visit

Section 5(f). Prescription Drug Benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal or state laws prevent the pharmacy from accepting unused drugs.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, about coordinating benefits with other coverage, including with Medicare.
- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services).
- **We do not exclude coverage for entire classes of pharmaceuticals**, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

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

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

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

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

- **These are the dispensing limitations.** A dispensing limitation is the quantity of a medication for which benefits are available for a single applicable copayment, or in the case of maintenance drugs, two copayments for a 90-day therapeutic supply of maintenance medication obtained through our mail order program. Dispensing limitations may include but are not limited to:
  - A period of time that a specific medication is recommended by the manufacturer and/or the FDA to be an appropriate course of treatment when prescribed for a particular condition, or
  - A predetermined period of time established by the Plan, or
  - The FDA-approved dosage of a medication when prescribed for a particular condition.

- Dispensing limitations may be less than but shall not exceed a 30-day supply for drugs obtained at a Plan pharmacy. Maintenance drugs are available for up to a 90-day supply, provided the medication is on the Plan maintenance drug list. Prescriptions that exceed the dispensing limitation established by the Plan will not be covered.

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

- **Mandatory Generic benefit provision** applies when a brand name covered drug is dispensed and a generic covered drug equivalent is available. You will pay the applicable tier cost-share plus the difference between the Eligible Medical Expenses ("EME") of the generic covered drug and the EME of the brand name covered drug to the designated Plan pharmacy for each therapeutic supply. The difference in the amount between such brand name and generic covered drug paid by the member does not accumulate to the annual out of pocket maximum.
- **Why use Tier 1 drugs?** Tier 1 drugs are lower-priced drugs that are the therapeutic equivalent to more expensive Tier 2, 3, or 4 drugs. Tier 1 drugs must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. FDA sets quality standards for Tier 1 drugs to ensure that these drugs meet the same standards of quality and strength as Tier 2, Tier 3, and Tier 4 drugs.
- **Specialty Pharmacy Program.** Our Specialty Pharmacy Program is designed to address the rare, complex and life threatening diseases. We want to make these medications accessible and cost effective for our members. That's why we offer the Specialty Pharmacy Program. This program supports the health care provider/patient relationship and provides focused support to help better manage rare and complex conditions. **Members who have been prescribed specialty medications must obtain these medications from one of the designated specialty pharmacies.** You will continue to pay the applicable Tier copay for your specialty medications. Prescriptions for most specialty medications must be filled for a maximum of a 30-day supply. If you're out of refills, the specialty pharmacy will contact your doctor to get a new prescription. Members can contact customer service at 877-545-7378 for more information. Your specialty pharmacy will be able to help you transfer your active prescriptions from your current pharmacy.
  - Certain specialty prescription drugs may be dispensed by the designated pharmacy in fifteen (15) day supplies up to ninety (90) days and at a pro-rated copayment. You will receive a fifteen (15) day supply to determine if you will tolerate the specialty prescription drug product prior to purchasing a full supply. The designated pharmacy will contact the member each time prior to dispensing the fifteen (15) day supply to confirm if you are tolerating the specialty prescription drug product. The list of these certain specialty prescription drug products are available through review of the HPN Prescription Drug List (PDL) online at www. HealthPlanofNevada.com or by calling 877-545-7378.
- **When you do have to file a claim.** You normally won't have to submit claims to us. If you do need to file a claim, please send us all of the documents for your claim (including itemized billings and receipts) as soon as possible. You must submit claims by December 31 of the year after you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time. Send completed claims to Health Plan of Nevada, Inc., Attn: Correspondence/CRR, P.O. Box 14865, Las Vegas, NV 89114-5645.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a provider and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Insulin • Drugs for sexual dysfunction • Oral contraceptive drugs • Growth hormone therapy • Self-injectable drugs	Tier 1 = $7 per therapeutic supply; mail order = $14 Tier 2 = $35 per therapeutic supply; mail order = $70 Tier 3 = $55 per therapeutic supply; mail order = $110 Tier 4 = $100 per therapeutic supply; mail order = $200 Note: You pay two applicable copayments for a 90-day therapeutic supply of maintenance medication obtained through our mail order program.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Pediatric and prenatal vitamins, except those listed under preventive care medications • Medications prescribed to treat obesity Note: Preferred sexual dysfunction drugs are limited to 15 pills/tablets per therapeutic supply and require prior authorization by the Plan. Contact the Plan for details. Note: We only cover Growth Hormone Therapy (GHT) when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 18. Note: A "self-injectable" is to be administered subcutaneously or intramuscularly and does not require administration by a licensed practitioner. Note: Supplies, such as sharps containers, needles, syringes, and tubing necessary to administer an injectable specialty drug available at no cost. Not covered: • Drugs and supplies for cosmetic purposes • Drugs to enhance athletic performance • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Non-prescription medications unless specifically indicated elsewhere	Tier 1 = $7 per therapeutic supply; mail order = $14 Tier 2 = $35 per therapeutic supply; mail order = $70 Tier 3 = $55 per therapeutic supply; mail order = $110 Tier 4 = $100 per therapeutic supply; mail order = $200 Note: You pay two applicable copayments for a 90-day therapeutic supply of maintenance medication obtained through our mail order program. Note: GLP-1's for obesity will be covered subject to a 50% coinsurance per prescription up to a maximum member payment of $750 per therapeutic supply; mail order 50% coinsurance per prescription up to a maximum member payment of $1,875 per prescription.
• Diabetic supplies, including: - disposable needles and syringes for the administration of covered medications - urine checking reagents - blood glucose measuring strips (Contour Next)	$35 per 30-day therapeutic supply
• Diabetic supplies, including: - blood glucose measuring strips (OneTouch) - lancet strips	$7 per 30-day therapeutic supply
• Diabetic equipment, including: - blood glucose monitors (OneTouch) - lancet device	$7 per unit
Tobacco cessation drugs (e.g., nicotine patches)	Nothing. Limited to 2 quit attempts per year.
Drugs for infertility Drugs associated with any IVF procedures will be covered up to 3 cycles of medical annually.	Tier 1 = $7

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Drugs associated with artificial insemination (IUI, IVI, ICI) procedures will be covered with no limitations. Covered products include: • Clomiphene	Tier 1 = $7
• Endometrin • Follistim • Ganirelix made by Merck/Organon	Tier 2 = $35
• Chorionic Gonadotropin • Pregnyl • Progesterone • Novarel	Tier 3 = $55
• Ganirelix made by Ferring • Ovidrel • Cetrorelix • Crinone • Gonal-F • Menopur • Fyremadel Note: FDA dosing limits are applied to coverage to align with covered cycles. Note: Prior authorization is required.	Tier 4 = $100
Contraceptive drugs and devices as listed in the Health Resources and Services Administration sitehttps ://www. hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any non-covered drugs including contraceptives would require prior authorization. Members or their providers, on the member's behalf, can fill out and submit the Prior Authorization Request Form available at healthplanofnevada.com. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy.	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a). If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contactcontraception@opm.gov.	Nothing
Compounds, when medically necessary and prior authorized by the Plan	Tier 3 = $55 per therapeutic supply; mail order = $110
Special food products/enteral formulas • Special food product means a food product specially formulated to have less than one gram of protein per serving intended to be consumed under the direction of a physician. The term does not include food that is naturally low in protein.	Nothing
Preventive Medications The following are covered: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations. Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a). Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections.	Nothing
Not covered: • *Anorexic agents* • *Drugs and medicine approved by the FDA for experimental or investigational use except when prescribed for the treatment of cancer or chronic fatigue syndrome, or any drug that has been approved by the FDA for less than one (1) year unless prior authorized by HPN.* • *Vitamin C nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *General vitamins, except the following which require a prescription order or refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins* • *Medical Marijuana* • *Prescription drugs as a replacement for a previously dispensed prescription drug that was lost, stolen, broken, or destroyed.*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• *Drugs or supplies available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless HPN has designated the over-the-counter medication as eligible for coverage as if it were a prescription drug and it is obtained with a prescription order or refill from a physician. Prescription drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain prescription drugs that HPN has determined are therapeutically equivalent to an over-the-counter drug.* • *Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of illness or injury except for prescription drug products that are enteral formulas prescribed for the treatment of inherited metabolic diseases as defined by state law.* • *Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available prescription drug.* • *A prescription drug that contains an active ingredient(s) which is (are) a modified version of and/or therapeutically equivalent to a covered drug may be excluded as determined by the Plan.* • *Covered drugs that are not FDA approved for a specific diagnosis.* • *Unit dose packaging of prescription drugs.*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

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

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. • Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an injury (not to include chewing) when the treatment starts within the first 10 days after the injury and ends within 60 days, such as: - Root canal therapy, post and build-up; - Temporary crowns; - Temporary partial bridges; - Temporary and permanent fillings; - Pulpotomy; - Extractions of broken teeth; - Incision and drainage; - Tooth stabilization through splinting.	$25 per visit
• Dental anesthesia for enrolled dependent children Note: Dental anesthesia is covered only when determined to be medically necessary by a Plan provider and prior authorized by the Plan.	Nothing
Dental benefits	**High Option**
We have no other dental benefits.	*All charges*

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claim process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24-Hour Telephone Advice Nurse Service	It doesn't matter if it's day or night, a holiday or weekend, our free Telephone Advice Nurse Service is open twenty-four (24) hours a day, seven (7) days a week to provide helpful advice on simple medical concerns. Depending on your situation, our Telephone Advice Nurse may help you decide whether to seek urgent care or wait until the next day to see your primary care provider. When you have health questions or concerns, call our Telephone Advice Nurse Service at 800-288-2264.
Services for deaf and hearing impaired	We have a TTY:/TDD number for use by hearing-impaired members. The TTY:/TDD number is 711.
Preventive Health **Disease Management**	We offer numerous preventive health management programs to assist members with early detection and prevention of serious illnesses. These programs may include member notifications for childhood immunizations, annual reminders for breast and cervical cancer screenings, educational classes or consults for heart health, smoking cessation, and weight management for adults and children. For information and registration, call 800-720-7253. We also provide programs to assist those members with chronic conditions to better manage their health. We offer disease management programs for asthma and diabetes.
Well Care	Our Well Care approach is designed to support the whole person -- honoring individual autonomy, embracing precision medicine, and promoting a truly patient-centered experience. We believe that achieving mental and physical wellness goes beyond treating symptoms. It begins with empowering members to take proactive steps towards long-term health. With Well Care, members have access to a range of personalized health and lifestyle interventions that help prevent costly conditions. This includes opportunities to engage with providers who deliver care-aligned with each members personal values, ensuring support that feels both meaningful and individualized.

	• Functional medicine • Lifestyle-based care options • Weight loss • Therapy: including intensive behavioral therapy, supervised exercise therapy and cognitive behavioral therapy.
Online Member Center	Day, night and even on holidays, you may access information about your benefits through the Health Plan of Nevada Online Member Center. Take advantage of these convenient service features: • Change your address • Request new ID cards • Verify your coverage for pharmacy services • Check your copayment amounts for medical services • Review the status of a claim • Find out who is on record as your primary care provider (PCP) • Check status of a prior authorization request Simply visit us at www.myhpnonline.com. First time visitors will need to register for a user ID and password.

Non-FEHB Benefits Available to Plan Members

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

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

If you are enrolled in this Plan through FEHB, have Medicare Part A coverage *and* purchased Part B coverage, you may also enroll in a Medicare Advantage program. For 2026, there are a variety of Medicare Advantage plans available to you. These Medicare Advantage plans include Part A and Part B Medicare covered benefits, as well as benefits not covered by Original Medicare in a managed care environment.

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

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies we are prohibited from covering under the Federal Law.
- Chemical or surgical modification of an individual's sex trait through medical interventions (to include "gender transition" services)
- Any benefits or services required solely for your employment are not covered by this Plan.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

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

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

Medical and hospital benefits

In most cases, providers and facilities file HIPAA compliant electronic claims for you. In cases where a paper claim must be used, the provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 877-545-7378, or at our website at www.uhcfeds.com.

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

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

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

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

Prescription drugs

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

Other supplies or services

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

Deadline for filing your claim

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

Post-service claims procedures	We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this Brochure.
Records	Keep a separate record of the medical expenses of each covered family member.
Authorized Representative	You may designate an Authorized Representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your Authorized Representative without your express consent. For the purpose of this section, we are also referring to your Authorized Representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provide, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.
Overseas claims	For emergency covered services received by providers and hospitals.
When we need more information	Please reply promptly when we ask for additional information.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

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

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Health Plan of Nevada, Inc., P.O. Box 15645, Las Vegas, NV 89114-5645; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms. e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email address, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information

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

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

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

You must write to OPM within:

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

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

Send OPM the following information:

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

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

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

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

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

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

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

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

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

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not to be job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

Clinical trials

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

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

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

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 877-545-7378. You may also contact us by fax at (702) 270-6281 or see our website at www.uhcfeds.com.

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

- Medical services and supplies provided by physicians and other healthcare professionals.

Please review the following examples which illustrate your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description:Catastrophic Protection Out of Pocket Maximum
You pay without Medicare: $3,500 self only/$7,000
You pay with Medicare Part B: $3,500 self only/$7,000

Benefit Description:Part B Premium Reimbursement Offered
You pay without Medicare: N/A
You pay with Medicare Part B: N/A

Benefit Description: Primary Care Provider
You pay without Medicare: $10
You pay with Medicare Part B: $0

Benefit Description: Specialist
You pay without Medicare: $15
You pay with Medicare Part B: $0

Benefit Description: Inpatient Hospital
You pay without Medicare: $300
You pay with Medicare Part B: $0

Benefit Description: Outpatient Hospital
You pay without Medicare: Nothing
You pay with Medicare Part B: $0

Benefit Description: Incentives offered
You pay without Medicare: N/A
You pay with Medicare Part B: N/A

You can find more information about how our plan coordinates benefits with Medicare at www.uhcfeds.com.

Tell us about your Medicare coverage

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

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

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

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

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

Clinical trials cost categories

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

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

Coinsurance

See Section 4, page 22.

Compound

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

Convenient care facility

Means a facility that provides services for Medically Necessary, non-urgent or non-emergent injuries or illnesses. Examples of such conditions include:

1. diagnostic laboratory services;
2. general health screenings;
3. minor wound treatment and repair;
4. minor illnesses (cold/flu);
5. treatment of burns and sprains, or

6. blood pressure checks.

Copayment	See Section 4, page 22.
Cost-sharing	See Section 4, page 22.
Covered services	Care we provide benefits for, as described in this Brochure.
Custodial care	Care that is designed essentially to assist individuals in meeting activities of daily living. These include personal care services (help in walking and getting in or out of bed; assistance in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision over medication which can usually be self-administered) that do not require the continuing attention of trained medical or paramedical personnel. Custodial care that lasts 90 days or more is sometimes knows as long-term care.
Deductible	This Plan does not have a deductible.
Eligible Medical Expense (EME)	Charges up to the Plan reimbursement schedule amount, incurred by you while covered under this Plan for covered services. Plan providers have agreed to accept the Plan's reimbursement schedule amount as payment in full for covered services, plus your payment of any applicable copayment. Non-plan providers have not. If you use the services of non-plan providers, you will receive no benefit payments or reimbursement for charges for the service, except in the case of emergency services, urgently needed services, or other covered services provided by a non-plan provider that are prior authorized by the Plan. In no event will the Plan pay more than the applicable Plan reimbursement schedule amount for such services.
Experimental or investigational service	This plan regularly evaluates for possible coverage new medical technologies and new applications of existing technologies. New technologies may include medical procedures, drugs and devices. The evaluation process includes a review of information on the proposed service from appropriate government regulatory bodies as well as from published scientific evidence.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Infertility	Infertility is defined as: A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of unprotected intercourse or artificial insemination for individuals under age 35. Evaluation and treatment for those individuals actively looking to achieve a conception may be justified based on medical history and diagnostic testing, and is warranted after six (6) months for individuals age 35 years or older.
Infertility (iatrogenic)	Iatrogenic infertility is defined as a form of infertility that occurs as an unintended consequence of medical treatment or surgery. Unlike infertility caused by natural conditions or genetic factors, iatrogenic infertility results directly from interventions meant to treat or manage other health issues. Examples include cancer treatments, surgical procedures, medications or other medical interventions.
Maintenance Drug	A preferred covered drug prescribed to treat certain chronic or life-threatening long-term conditions as determined by the Plan, such as diabetes, arthritis, heart disease, and high blood pressure.

Medical necessity	Medical necessity (also "Medically Necessary") means a service is needed to improve a specific health condition or to preserve your health. Medical necessity is present when the Plan determines that the care requested is: consistent with the diagnosis and treatment of your illness or injury; the most appropriate level of service which can be safely provided to you; and not provided solely for your convenience or that of your provider or hospital. When applied to inpatient services, Medically Necessary further means that your condition requires treatment in a hospital rather than any other setting. Services and accommodations are not automatically considered to be Medically Necessary because a physician prescribes them.
Observation care	The Emergency Health Care Services copayment/benefit level will apply if the member has been placed in an observational bed for the purpose of monitoring the member's condition, rather than being admitted as an inpatient in the hospital. If the member is admitted to the hospital for observational care then the member will be subject to an inpatient copayment and the emergency room copayment is waived. If the member is not admitted, then the emergency room copayment would apply to the visit.
Physician extender/ Physician assistant	Means a health care provider who is not a physician (MD/DO) but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.
Plan Allowance	Means the "Eligible Medical Expenses" or the maximum amount HPN will pay for a particular Covered Service as determined by HPN in accordance with HPN's Reimbursement Schedule. You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.

Telemedicine	Certain Covered Services for diagnosis and treatment of low acuity medical conditions delivered to HPN Members through the use of interactive audio, video, or other telecommunications or electronic technology by a contracted HPN Telemedicine Provider listed as such in the HPN Provider Directory at a site other than the site at which the patient is located. Telemedicine is available in all states where HPN contracted Telemedicine Providers offer telemedicine services. Telemedicine does not include the use of standard telephone calls, facsimile transactions or e-mail messaging and is only available through designated providers listed as Telemedicine Providers in the HPN Provider Directory.
Therapeutic Supply	The quantity of a covered drug for which benefits are available for a single applicable copayment and may be less than but shall not exceed a 30-day supply.
Us/We	Us and We refers to Health Plan of Nevada, Inc. or HPN.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 877-545-7378. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
You	You refers to the enrollee and each covered family member.

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

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Notes

Summary of Benefits for the High Option of the Health Plan of Nevada, Inc. - 2027

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. uhcfeds.com/health-benefits/hpofnevada.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct Enrollment Code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except when specifically prior authorized by HPN or for urgent and emergency services.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $10 Primary Care; $25 Specialist	27
Services provided by a hospital: Outpatient	$50 per visit	46
Services provided by a hospital: Inpatient	$300 per admission	45
Emergency benefits: Out of Area	$30 per visit at a non-plan urgent care facility $150 per visit in a hospital emergency room, waived if admitted	49
Emergency benefits: In Area	$30 per visit at urgent care facility $150 per visit in a hospital emergency room, waived if admitted	48
Mental health and substance use disorder treatment:	Regular cost-sharing	50
Prescription drugs:	Tier 1 = Retail $7, Mail order = $14; Tier 2 = Retail $35, Mail order = $70; Tier 3 = Retail $55, Mail order = $110; Tier 4 = Retail $100, Mail order = $200	54
Dental care:	No benefit	58
Vision care:	$10 per visit for one refraction annually and 50% of EME (Eligible Medical Expense) for costs associated with vision supplies	33
Special features:	Flexible benefits option, Telephone Advice Nurse Service, Services for the deaf and hearing impaired, Preventive Health/ Disease Management, Online Member Center	59
Protection against catastrophic costs (out of pocket maximum):	Nothing after $3,500/Self Only or $7,000/Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection.	22

2027 Rate Information for the Health Plan of Nevada, Inc.

To compare your FEHB health plan options please go to www. opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to **www. opm.gov/FEHBpremiums** or **www. opm.gov/Tribalpremium**.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Nevada					
High Option Self Only	NM1	$339.34	$113.11	$735.23	$245.08
High Option Self Plus One	NM3	$644.74	$214.91	$1,396.94	$465.64
High Option Self and Family	NM2	$804.19	$268.06	$1,742.41	$580.80