Nevada

Welcome to the community

Nevada Medicaid and Check Up

January 2026

Health Plan of Nevada
A UnitedHealthcare Company

CSNV26MD0364670_001

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Notice of nondiscrimination

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

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

If you need these services, call the toll-free number **1-800-962-8074,** TTY **711.**

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

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

UHC_Civil_Rights@uhc.com

If you need help filing a complaint, call the toll-free number **1-800-962-8074,** TTY **711.**

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

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

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

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

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

This notice is available at:

https://myhpnmedicaid.com/content/dam/hpnv-public-sites/documents/UA-Non-Discrimination-Notice-And-Taglines.pdf

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Notice of availability of language assistance services and alternate formats

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Welcome

Welcome to Health Plan of Nevada Medicaid

Health Plan of Nevada Medicaid is the largest and most experienced health plan in Nevada. Please take a few minutes to review this Member Handbook. We're ready to answer any questions you may have. You can find answers to most questions at **MyHPNMedicaid.com.** Or you can call Member Services at **1-800-962-8074,** TTY **711,** 8:00 a.m.–6:00 p.m., Monday–Friday. The printed copy will be mailed within 5 business days.

You can also use our concierge, or personalized, in-person services. In-person service is available Monday–Friday, 10:00 a.m.–3:00 p.m., by appointment only. Please call us to schedule an appointment and a member of our team would be happy to assist you.

Our offices are located at:

2720 N. Tenaya Way, Suite 102
Las Vegas, NV 89128

THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN HEALTH PLAN OF NEVADA AND THE MEMBER.

This handbook is provided electronically. it is accessible, can be downloaded, saved and printed. If you would like a printed copy at no cost to you, please call Member Services at **1-800-962-8074,** TTY **711,** 8:00 a.m.–6:00 p.m., Monday–Friday.

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Getting started

We want you to get the most from your health plan right away. Start with these three easy steps:

1. **Call your Primary Care Provider (PCP) and schedule a checkup.** Regular checkups are important for good health. Your PCP's phone number should be listed in the PCP assignment letter that you recently received in the mail. The PCP listed in this letter is not the only provider that you can see. You can access care at any participating provider. If you don't know your PCP's number, or if you'd like help scheduling a checkup, call Member Services at **1-800-962-8074,** TTY **711.** Or stop by our offices for concierge, personalized, in-person services. We're here to help.

2. **Take your Health Survey.** This is a short and easy way to get a big picture of your current lifestyle and health. This helps us match you with the benefits and services available to you. Go to **MyHPNMedicaid.com** to complete the Health Survey today. Also, we will call you soon to welcome you to Health Plan of Nevada Medicaid. During this call, we can explain your health plan benefits. We can also help you complete the Health Survey over the phone. See page 17.

3. **Get to know your health plan.** Start with the Health Plan Highlights section on page 13 for a quick overview of your new plan. And be sure to keep this booklet handy, for future reference.

Oral interpretation services in languages other than English are available through our Member Services Department. Please call **1-800-962-8074** for help.

Hearing impaired members may contact us at 1-800-962-8074 by calling through the 711 relay service.

Visually impaired members may call our Member Services Department for help at **1-800-962-8074.** We can also give you documents in larger print for easier reading.

Your opinion matters

Do you have any ideas about how to make Health Plan of Nevada Medicaid better? You can give us suggestions on our policies and services. There are many ways you can tell us what you think.

- Call Member Services at **1-800-962-8074,** TTY **711**
- Join our Member Advisory Council. Every three months, the Medicaid team hosts an advisory council meeting with members to hear ideas on how we can improve our health plan. You can join by calling Member Services or email **HPNbenefits@uhc.com.**
- Visit us or write to us at:

  Health Plan of Nevada Medicaid
  2720 North Tenaya Way, Suite 102
  Las Vegas, Nevada 89128

Thank you for choosing Health Plan of Nevada Medicaid for your health plan

We're happy to have you as a member. Health Plan of Nevada Medicaid (HPN Medicaid) is the largest and most experienced health plan in Nevada. You've made the right choice for you and your family.

HPN Medicaid gives you access to many health care providers – doctors, nurses, hospitals and drugstores – so you have access to all the health services you need. We cover preventive care, checkups and treatment services. We're dedicated to improving your health and well-being.

Remember, answers to any questions you have are just a click away at **MyHPNMedicaid.com.** Or, you can call Member Services at **1-800-962-8074,** TTY **711,** 8:00 a.m.–6:00 p.m., Monday–Friday.

You can also use our concierge, or personalized, services. In-person service is available Monday–Friday, 10:00 a.m.–3:00 p.m., by appointment only. Please call us to schedule an appointment and a member of our team would be happy to assist you.

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Health Plan of Nevada
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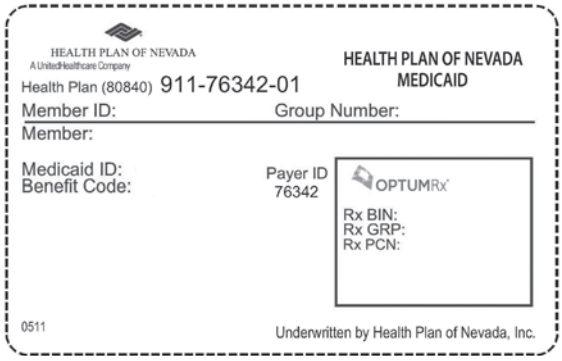
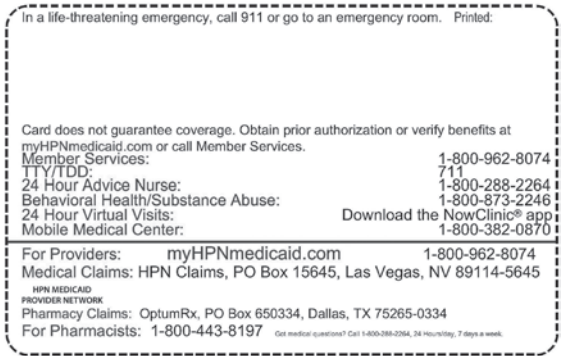
Health plan highlights

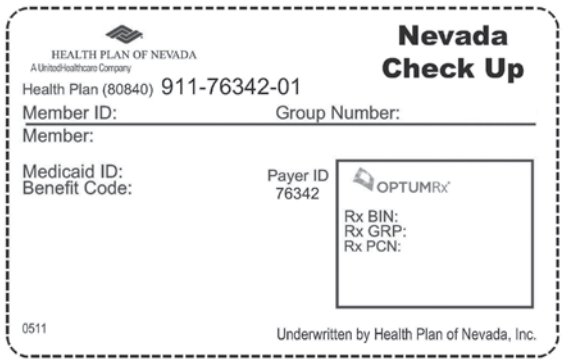
Health plan ID cards

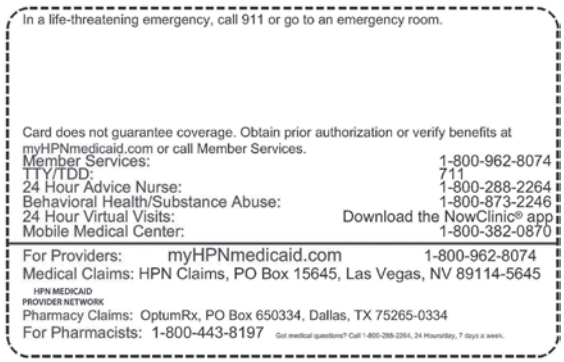
You will get a health plan ID card from Health Plan of Nevada Medicaid (HPN Medicaid) for each of your family members who receive Medicaid benefits. As a member, you should:

- Take both your health plan ID card and your State Medicaid ID card to your appointments
- Show it when you fill a prescription
- Have it ready when you call Member Services; this helps us serve you better
- Do not let someone else use your card(s). It is against the law.


HEALTH PLAN OF NEVADA
A UnitedHealthcare Company
HEALTH PLAN OF NEVADA
MEDICAID
Health Plan (80840) 911-76342-01
Member ID:
Group Number:
Member:
Medicaid ID:
Benefit Code:
Payer ID
76342
OPTUMRx
Rx BIN:
Rx GRP:
Rx PCN:
0511
Underwritten by Health Plan of Nevada, Inc.


In a life-threatening emergency, call 911 or go to an emergency room. Printed:
Card does not guarantee coverage. Obtain prior authorization or verify benefits at myHPNmedicaid.com or call Member Services.
Member Services: 1-800-962-8074
TTY/TDD: 711
24 Hour Advice Nurse: 1-800-288-2264
Behavioral Health/Substance Abuse: 1-800-873-2246
24 Hour Virtual Visits: Download the NowClinic® app
Mobile Medical Center: 1-800-382-0870
For Providers: myHPNmedicaid.com 1-800-962-8074
Medical Claims: HPN Claims, PO Box 15645, Las Vegas, NV 89114-5645
HPN MEDICAID PROVIDER NETWORK
Pharmacy Claims: OptumRx, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 1-800-443-8197


HEALTH PLAN OF NEVADA
A UnitedHealthcare Company
Nevada
Check Up
Health Plan (80840) 911-76342-01
Member ID:
Group Number:
Member:
Medicaid ID:
Benefit Code:
Payer ID
76342
OPTUMRx
Rx BIN:
Rx GRP:
Rx PCN:
0511
Underwritten by Health Plan of Nevada, Inc.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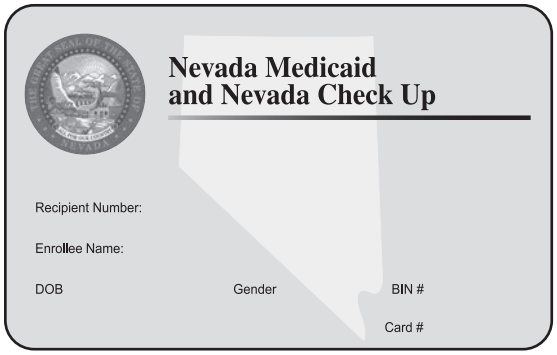
HPN MEDICAID PROVIDER NETWORK
Pharmacy Claims: OptumRx, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 1-800-443-8197

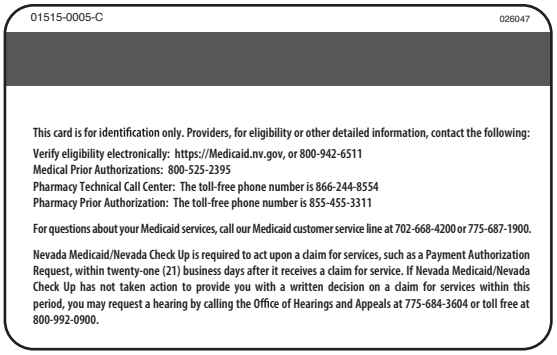
Lost your health plan ID card?

If you lose your ID card, you can print a new one at **MyHPNMedicaid.com,** or call Member Services at **1-800-962-8074,** TTY **711.**

Nevada State Medicaid ID card

You will also get a Medicaid ID card from the State for each of your family members who receive Medicaid benefits.





If you need a replacement or have not received your Medicaid ID card, please contact the Division of Social Services (DSS) for assistance. Please see contact information below:

- For Southern Nevada: **702-486-1646**
  - Option 1 for English, Option 2 for Spanish
  - Option 5 to speak to an Agent

Show both cards

Always show your health plan ID card and your State Medicaid ID card when you get care. This helps ensure you get all the benefits available to you. And prevents billing mistakes.

Discover your plan online

Manage your health care information 24/7 on MyHPNMedicaid.com

As a member of HPN Medicaid, you're just a click away from everything you need to take charge of your health benefits by registering on **MyHPNMedicaid.com.** The tools and new features can save you time and help you stay healthy. Using the site is free.

Great reasons to use MyHPNMedicaid.com

- Look up your benefits
- Find a doctor
- Find a hospital
- Take your Health Survey
- Learn how to stay healthy
- Find a behavioral health provider

Register in the Online Member Center on MyHPNMedicaid.com today

Registration is easy and fast. Sign up today! Just visit **MyHPNMedicaid.com** to access the Online Member Center. Select "Sign In" on the Home Page. Follow the simple prompts. You will need to provide your Medicaid ID number in order to register for an account. You're just a few clicks away from accessing your personal health plan information.

- Opt in to receive texts and emails about your plan
- Keep track of your medical history
- View your referrals and prior authorizations
- View claims history
- Review your explanation of benefits, including denial of payment to your doctor

All plan documents are available to you on the Online Member Center to save or print. You can also call Member Services at **1-800-962-8074,** TTY **711** to request a free printed copy of any plan documents if you are unable to access the Online Member Center.

MyHPN mobile app

Easily manage your health plan information on the go. Search for MyHPN in your app store and download the app. Then sign in with your One Healthcare ID. First-time users will need to create an account. Use the MyHPN app to find out who is on record as your primary care provider (PCP), talk with an advice nurse, video chat with a provider, search for a doctor or care location, access your digital health plan ID card, and check the status of a referral or prior authorization.

Benefits at a glance

As an HPN Medicaid member, you have a variety of health care benefits and services available to you. Here is a brief overview. You'll find a complete listing in the Benefits section.

Primary Care services

You are covered for all visits to your Primary Care Provider (PCP). Your PCP is the main doctor you will see for most of your health care. This includes checkups, treatment for colds and flu, health concerns and health screenings.

Behavioral Health services

You are covered for Mental Health and Substance Use Disorder Services. This includes inpatient and outpatient services. No PCP referral is required to access services. Find a complete list of Behavioral Health providers at **MyHPNMedicaid.com** or call 1-800-873-2246.

Large provider network

You can choose any PCP from our large network of providers. Our network also includes specialists, hospitals and drug stores — giving you many options for your health care. Find a complete list of network providers at **MyHPNMedicaid.com** or call **1-800-962-8074,** TTY **711.**

Telephone Advice Nurse

Our Telephone Advice Nurse Line gives you 24/7 telephone access to experienced registered nurses. They can give you information, support and education for any health-related question or concern. Call **1-800-288-2264.**

Specialist services

Your coverage includes services from specialists. Specialists are doctors or nurses who are highly trained to treat certain conditions. You may need a referral from your PCP first. See page 29.

Medicines

Your plan covers prescription drugs with no copays for members of all ages. Also covered: insulin, needles and syringes, birth control, and select over-the-counter products.

Hospital services

You're covered for hospital stays. You're also covered for outpatient services. These are services you get in the hospital without spending the night.

Laboratory services

Covered services include tests and X-rays that help find the cause of illness.

Well-child visits

All well-child visits and immunizations are covered by your plan.

Maternity and pregnancy care

You are covered for doctor visits before and after your baby is born. That includes hospital stays, birthing centers and homebirths. If needed, we also cover home visits after the baby is born.

Family planning

You are covered for services that help you manage the timing of pregnancies. These include birth control products and procedures.

Ocular care

Your vision benefits include routine eye exams and glasses. See pages 49 and 50.

Your Health Survey

A Health Survey is a short and easy survey that asks you simple questions about your lifestyle and your health. When you fill it out and mail it to us, we can get to know you better. And it helps us match you with the many benefits and services and some important community resources available to you.

Please take a few minutes to fill out the Health Survey at **MyHPNMedicaid.com.** Click on the Health Survey button on the right side of the page, after you register and/or log in. Or call Member Services at **1-800-962-8074,** TTY **711** to complete it by phone.

Member support

We want to make it as easy as possible for you to get the most from your health plan. As our member, you have many services available to you, including transportation and interpreters, if needed. And if you have questions, there are many places to get answers.

Website offers 24/7 access to plan details

Go to **MyHPNMedicaid.com** to sign up for web access to your Online Member Center account. This secure website keeps all of your health information in one place. In addition to plan details, the site includes useful tools that can help you:

- Find a provider or pharmacy
- Search for a medicine in the Preferred Drug List or Formulary
- Get benefit details
- Download a new Member Handbook

MyHPN mobile app

Easily manage your health plan information on the go. Search for MyHPN in your app store and download the app. Then sign in with your One Healthcare ID. First-time users will need to create an account. Use the MyHPN app to find out who is on record as your primary care provider (PCP), talk with an advice nurse, video chat with a provider, search for a doctor or care location, access your digital health plan ID card, and check the status of a referral or prior authorization.

Member Services is available 8:00 a.m.–6:00 p.m., Monday–Friday

Member Services can help with your questions or concerns. This includes:

- Understanding your benefits
- Finding a doctor or urgent care clinic
- Scheduling an appointment with your PCP

Call **1-800-962-8074,** TTY **711.** You can also use our concierge, or personalized, services. In-person service is available Monday–Friday, 10:00 a.m.–3:00 p.m., by appointment only. Please call us to schedule an appointment and a member of our team would be happy to assist you.

Our offices are located at:

2720 N. Tenaya Way, Suite 102
Las Vegas, NV 89128

Questions? Visit **MyHPNMedicaid.com,**
or call Member Services at **1-800-962-8074,** TTY **711.**

Disease Management program

If you have a chronic health condition, like asthma or diabetes, you may benefit from our Disease Management program. We can help with a number of things, like scheduling doctor appointments and keeping all your providers informed about the care you get. To learn more, call **1-877-692-2059.**

Transportation services are available

Non-emergency transportation to medical and behavioral services is available to Medicaid recipients. If you need a ride to a doctor's appointment, make your reservation a week before your medical appointment is scheduled. To book your reservation, please call MTM at **1-844-879-7341,** 7:00 a.m.–5:00 p.m., Monday–Friday.

HPN Medicaid can help with your transportation needs. HPN Medicaid provides bus passes and door to door non-emergency rides. These can be used for doctor appointments, the pharmacy, DMV, accessing Social Service programs and picking up needed resources like food, clothing and baby needs. Members must be working with one of our case managers or registered in one of our programs to qualify. To learn more, sign in to **MyHPNMedicaid.com.**

We speak your language

If you speak a language other than English, we can provide translated printed materials. Or we can provide an interpreter who can help you understand these materials. You'll find more information about Interpretive Services and Language Assistance in the section called Other Plan Details. Or call Member Services at **1-800-962-8074,** TTY **711.**

Si usted habla un idioma que no sea inglés, podemos proporcionar materiales impresos traducidos. O podemos proporcionar un intérprete que puede ayudar a entender estos materiales. Encontrará más información acerca de servicios de interpretación y asistencia lingüística en la sección Otros detalles del plan. O llame a Servicios para Miembros al **1-800-962-8074,** TTY **711.**

Emergencies

In case of emergency, call **911**

Other important numbers

Medical Benefits **1-800-962-8074**
MTM Transportation Services Non-Emergency Transportation. **1-844-879-7341**
Telephone Advice Nurse Line **1-800-288-2264**
(available 24 hours a day, 7 days a week)
Pharmacy Benefits **1-800-962-8074**
Behavioral Health Services **1-800-873-2246**
NowClinic **1-877-550-1515**

Transitioning from another health plan

When you join HPN Medicaid, be sure to check and see if your current doctor is part of our Network. If not, you may be able to continue seeing your doctor while you choose a new one. If you are currently receiving care, make sure to let us know so we help you transition to our plan. If you are taking medicine that is not covered by our health plan, we may approve your prescription for the first 60 days on our plan. Be sure to discuss getting a new prescription from your doctor. For help or questions about treatment during the first 60 days, please contact Member Services at **1-800-962-8074,** TTY **711.**

You can start using your pharmacy benefit right away

Your plan covers a long list of medicines, or prescription drugs. Medicines that are covered are on the plan's Preferred Drug List or Formulary. The PDL is a subset of all drugs covered under the plan. Your doctor uses these lists to make sure the medicines you need are covered by your plan. HPN Medicaid may cover other medicines with prior approval. If your drug does need prior approval, your care provider can request it for you. You can find both the Preferred Drug List and the Formulary List online at **MyHPNMedicaid.com.** You search for a medicine name on the website. It's easy to start getting your prescriptions filled. Here's how:

1. Are your medicines included on the Preferred Drug List or Formulary?

Yes

If your medicines are included on the Preferred Drug List (PDL) or Formulary, you're all set. Be sure to show your pharmacist your State Medicaid ID card every time you get your prescriptions filled.

No

If your prescriptions are not on the Preferred Drug List (PDL) or Formulary, schedule an appointment with your doctor within the next 30 days. They may be able to help you switch to a drug that is on the Preferred Drug List or Formulary. Your doctor can also help you ask for an exception if they think you need a medicine that is not on the list.

Not sure

View the Preferred Drug List (PDL) or Formulary online at **MyHPNMedicaid.com.** You can also call Member Services. We're here to help.

2. Do you have a prescription?

When you have a prescription from your doctor, or need to refill your prescription, go to a network pharmacy. Show the pharmacist your HPN Medicaid health plan ID card and State Medicaid ID card. You can find a list of network pharmacies in the Provider Directory online at **MyHPNMedicaid.com**, or you can call Member Services.

Attention Pharmacist

Please process this Health Plan of Nevada Medicaid member's claim using:

BIN: 610494
Processor Control Number: 4700
Group: SIE

If you receive a message that the member's medication needs a prior authorization or is not on our formulary, please call HPN Medicaid Pharmacy Services at **1-800-443-8197, option #6.**

Going to the doctor

Your Primary Care Provider (PCP)

We call the main doctor you see a Primary Care Provider, or PCP. When you see the same PCP over time, it's easier to develop a relationship with them. Each family member can have their own PCP, or you may all choose to see the same person. You will see your PCP for:

- Routine care, including yearly checkups
- Coordinate your care with a specialist
- Treatment for colds and flu
- Other health concerns

You have options

You can choose between many types of network providers for your PCP. Some types of PCPs include:

- Family doctor (also called a general practitioner) – cares for children and adults
- Gynecologist (GYN) – cares for women
- Internal medicine doctor (also called an internist) – cares for adults
- Nurse Practitioner (NP) – cares for children and adults
- Obstetrician (OB) and midwives – care for pregnant women
- Pediatrician – cares for children
- Physician Assistant (PA) – cares for children and adults

Choosing your PCP

If you've been seeing a doctor before becoming an HPN Medicaid member, check to see if your doctor is in our network. If you're looking for a new PCP, consider choosing one who's close to your home or work. This may make it easier to get to appointments. You can also choose a PCP who aligns with your cultural, racial or gender preferences.

What is a Network Provider?

Network Providers have contracted with HPN Medicaid to care for our members. You don't need to call us before seeing one of these providers. There may be times when you need to get services outside of our network. If a needed and covered service is not available in-network, it will be covered out-of-network at no greater cost to you than if provided in-network. If you receive services out of network without authorization from HPN Medicaid, you may have to pay for those services. Call Member Services to learn if they are covered in full. You may have to pay for those services.

Availability of services

Your plan has a network of quality doctors, hospitals, and other care providers, all working together to help you get the best care. Check your plan's provider directory for a list of network providers. Providers can change through the year as we continue to build a quality network for you. You can find the most up to date provider directory at **MyHPNMedicaid.com.**

If you need help finding a provider, you can call Member Services at **1-800-962-8074,** TTY **711.** We're happy to help you find a network PCP that works for you. Let your Member Services Representative know if you have any location, language, or cultural preferences. A free paper copy of the provider directory can also be sent to you by calling Member Services.

Once you choose a PCP, call Member Services and let us know. We will make sure your records are updated. If you don't want to choose a PCP, HPN Medicaid can choose one for you, based on your location and language spoken. You can also make this change on the Online Member Center at **member.healthplanofnevada.com.**

Changing your PCP

It's important that you like and trust your PCP. You can change PCPs at any time. Call Member Services, go online, or stop by our offices and we can help you make the change.

Your Provider Directory

Find the most up to date information on network providers at **MyHPNMedicaid.com.** If the doctor you are seeing now is on the list, you can stay with them. If you want more information about any of the doctors in our network, or you need a hard copy of the provider directory mailed to you, call Member Services at **1-800-962-8074.**

Learn more about network doctors

You can learn information about network doctors, such as board certifications, medical school and residency program attended, and languages they speak, at **MyHPNMedicaid.com,** or by calling Member Services.

Annual checkups

The importance of your annual checkup

You don't have to be sick to go to the doctor. In fact, yearly checkups with your PCP can help keep you healthy. In addition to checking on your general health, your PCP will make sure you get the screenings, tests and shots you need. And if there is a health problem, it is usually much easier to treat when caught early.

Here are some important screenings. How often you get a screening is based on your age and risk factors. Talk to your doctor about what's right for you.

For women

- Pap smear – helps detect cervical cancer
- Breast exam/Mammography – helps detect breast cancer

For men

- Testes exam – helps detect testicular cancer
- Prostate exam – helps detect prostate cancer

Well-child visits

Well-child visits are a time for your PCP to see how your child is growing and developing. They will also give the needed screenings, like speech and hearing tests, and immunizations during these visits. These routine visits are also a great time for you to ask any questions you have about your child's overall well-being, including:

- Eating
- Sleeping
- Behavior
- Social interactions
- Physical activity

Checkup schedule

It's important to schedule your well-child visits for these ages:

3 to 5 days	15 months
1 month	18 months
2 months	24 months
4 months	30 months
6 months	3 years
9 months	4 years
12 months	Once a year after age 5

Here are shots the doctor will likely give, and how they protect your child:

- **Hepatitis A and Hepatitis B:** prevent two common liver infections
- **Rotavirus:** protects against a virus that causes severe diarrhea
- **Diphtheria:** prevents a dangerous throat infection
- **Tetanus:** prevents a dangerous nerve disease
- **Pertussis:** prevents whooping cough
- **HiB:** prevents childhood meningitis and severe lung and throat infections
- **Meningococcal:** prevents bacterial meningitis
- **Polio:** prevents a virus that causes paralysis
- **MMR:** prevents measles, mumps and rubella
- **Varicella:** prevents chickenpox
- **Influenza:** protects against the flu virus
- **Pneumococcal:** prevents ear infections, blood infections, pneumonia and bacterial meningitis
- **HPV:** protects against a sexually transmitted virus that can lead to cervical cancer in women and genital warts in men

Keeping your children healthy through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program

One of the most important things you can do to keep your children healthy is to make sure they get regular checkups. Have your child seen early and often; after five-years-old they should be seen yearly for a well-child exam and any shots they need. Your child's doctor will help you arrange the checkups and shots that are right for each child's age group. These services are free of charge. If you need help scheduling an appointment, call Member Services at **1-800-962-8074,** TTY **711.** Or you can come into our office for concierge/in-person services. In-person service is available Monday–Friday, 10:00 a.m.–3:00 p.m., by appointment only. Please call us to schedule an appointment and a member of our team would be happy to assist you.

Our office is located at:

2720 N. Tenaya Way, Suite 102
Las Vegas, NV 89128

Special checkups for children from the EPSDT program

Children under the age of 21 may receive well-child doctor visits as part of Nevada Medicaid's EPSDT program. These visits are offered to help your children stay healthy, provide required shots and to catch and treat health problems early. Included in the visit are the following:

- A health history
- A physical exam
- Immunizations (shots)
- Laboratory tests
- Health education
- Vision services
- Hearing services
- Other needed health care services and treatment

It is very important that you bring your children in to see the doctor when they are due for this special testing. HPN Medicaid will let you know when your children need to come in for these screenings. You will receive a postcard in the mail as a reminder.

Nevada Check Up Program

The Nevada Check Up Program is Nevada's version of the federal Children's Health Insurance Program (CHIP). It serves children ages zero through 18 years. The program is designed for families who do not qualify for Medicaid and whose incomes are at or below 200% of the Federal Poverty Level (FPL).

Nevada Check Up insurance is comprehensive health insurance covering medical, dental, vision, mental health services, therapies and hospitalization. Most Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up.

Dental benefit is provided by Liberty Dental. You can reach them by calling 888-401-1128, TTY 877-855-8039. The only cost to the Nevada Check Up enrollee is a quarterly premium. Enrollees are not required to pay co-payments, deductibles, or other charges for covered services. Quarterly premiums are due in January, April, July, and October and may be prorated based on eligibility determination date. American Indians who are members of federally recognized Tribes and Alaskan Natives are exempt from Nevada Check Up premiums.

Making an appointment with your PCP

Call your doctor's office directly. When you call to make an appointment, be sure to tell the office what you're coming in for. This will help make sure you get the care you need, when you need it. This is how quickly you can expect to be seen:

How long it should take to see your PCP:	
Urgent PCP appointments – when you have a sudden illness, injury or condition that is urgent	Within two (2) calendar days
Emergent care PCP appointments	Same day or directed to an Urgent Care Clinic by your PCP
Routine care – for appointments like wellness checkups, screenings, annual exams and vaccinations	Within 2 weeks or 14 days

Preparing for your PCP appointment

Before the visit

1. Go in knowing what you want to get out of the visit (relief from symptoms, a referral to a specialist, specific information, etc.).
2. Make note of any new symptoms and when they started.
3. Make a list of any drugs or vitamins you take on a regular basis.

During the visit

When you are with the doctor, feel free to:

- Ask questions
- Take notes if it helps you remember
- Ask the doctor to speak slowly or explain anything you don't understand
- Ask for more information about any medicines, treatments or conditions

Telephone Advice Nurse – Your 24-hour health information resource

When you're sick or injured, it can be difficult to make health care decisions. You may not know if you should go to the emergency room, visit an urgent care center, make a provider appointment or use self-care. An experienced Telephone Advice Nurse can give you information to help you decide.

Nurses can provide information and support for many health situations and concerns, including:

- Minor injuries
- Common illnesses
- Self-care tips and treatment options
- Recent diagnoses and chronic conditions
- Choosing appropriate medical care
- Illness prevention
- Nutrition and fitness
- Questions to ask your provider
- How to take medication safely
- Men's, women's and children's health

You may just be curious about a health issue and want to learn more. Experienced registered nurses can provide you with information, support and education for any health-related question or concern.

The 24-hour Telephone Advice Nurse phone number is 1-800-288-2264. You can call the toll-free Telephone Advice Nurse number anytime, 24 hours a day, 7 days a week. And there's no limit to the number of times you can call.

Referrals and specialists

A referral is when your PCP says you need to go to another doctor who focuses on caring for a certain part of the body or treating a specific condition. This other doctor is called a specialist. It is a good idea to see your PCP before you see a specialist. Your PCP can help coordinate your medical needs. If your doctor wants you to see a specialist that you do not want to see, you can ask your PCP to give you another name. A couple of examples of specialists include:

- Cardiologist – for problems with the heart
- Pulmonologist – for problems with the lungs and breathing

You do not need a referral from your PCP for:

- Emergency services
- Behavioral health and substance use disorder services
- Intensive crisis stabilization services
- Sexually transmitted disease (STD) testing and treatment
- Family planning services
- OB/GYN services
- Services received at a Federally Qualified Health Center, Rural Health Center and/or Certified Community Behavioral Health Clinic
- Routine eye exams
- Education classes – including parenting, smoking cessation and childbirth

Member Advocate

The Member Advocate is another person at HPN Medicaid who can help you.
The Member Advocate can:

- Help you figure out how things work at HPN Medicaid. This may be things like filing a grievance, changing Care Coordinators or getting the care you need.
- Refer you to the right HPN Medicaid staff
- Help solve problems with your care

To reach the HPN Medicaid Member Advocate, call us at **1-800-962-8074,** TTY **711.**
Ask to speak with the Member Advocate.

Getting a second opinion

A second opinion is when you want to see a second doctor for the same health concern. You can get a second opinion from a network provider or non-network provider for any of your covered benefits. This is your choice. You are not required to get a second opinion. If the type of doctor needed is not available in-network for a second opinion, we will arrange for a second opinion out-of-network at no cost to you, as if the service was provided in-network.

Prior authorizations

In some cases, your provider must get permission from the health plan before giving you a certain service. This is called prior authorization. This is your provider's responsibility. If they do not get prior authorization, you will not be able to get those services.

A prior authorization may be needed

Some services that need prior authorization include:

- Hospital admissions
- Certain outpatient imaging procedures, including PET scan imaging procedures
- Some Durable Medical Equipment services
- Some prescription medications
- Weight loss surgery

You do not need prior authorization for advanced imaging services that take place in an emergency room, observation unit, urgent care facility or during an inpatient stay. You do not need a prior authorization for emergencies. You do not need prior authorization to see a women's health care provider for women's health services, family planning services, or if you are pregnant. You do not need prior authorization for services received at a Federally Qualified Health Center, Rural Health Center or a Certified Community Behavioral Health Clinic. You do not need prior authorization for tobacco cessation treatments.

Continued care if your PCP leaves the network

Sometimes PCPs leave the network. If this happens to your PCP, you will receive a letter from us letting you know. Sometimes HPN Medicaid will pay for you to get covered services from doctors for a short time after they leave the network. You may be able to get continued care and treatment when your doctor leaves the network if you are being actively treated for a serious medical problem. For example, you may qualify if you are getting chemotherapy for cancer or are at least six months pregnant when your doctor leaves the network. To ask for this, please call your doctor. Ask them to request an authorization for continued care and treatment from HPN Medicaid.

Behavioral Health services

Your mental health is just as important as your physical health. Your Behavioral Health coverage provides Mental Health, Substance Use Disorder services and online resources for members to maintain a balanced and healthy life.

Some of the services provided include:

- Mental health and substance use disorder services
- Inpatient and outpatient services
- Crisis intervention services 24-hours-a-day, 7-days-a-week
- Peer support services
- Care Management services

Member support

We want to make it as easy as possible for you to get the most from your behavioral health services.

Your behavioral health team is available 8:00 a.m.–6:00 p.m., Monday–Friday.
With crisis intervention services 24 hours a day, 7 days a week.

Your support team can help with your questions or concerns. This includes:

- Understanding your benefits
- Finding a doctor
- Scheduling an appointment with your behavioral health provider

To access services or find a Behavioral Health provider, you can visit **MyHPNMedicaid.com** or call your Behavioral Health team at 1-800-873-2246.

Making an appointment with your behavioral health provider

Call your providers office directly. When you call to make an appointment, be sure to tell the office what you're coming in for. This will help make sure you get the care you need, when you need it. If the provider you're trying to reach is with a patient, you may have to leave a message. They will return your call to schedule an appointment.

To access services or find a Behavioral Health provider, call your Behavioral Health team at 1-800-873-2246. Our team can also help you with scheduling an appointment with your behavioral health provider.

* A PCP referral or prior authorization is not required to access mental health and substance use disorder services.

Behavioral Health virtual visits

Behavioral health therapy is available anywhere that is convenient for you using a secure mobile app, webcam, chat or phone! With the NowClinic, you can talk to a mental health therapist just like you would in an office setting. NowClinic mental health providers can diagnose, provide therapy and care recommendations for most mental health issues.

NowClinic is also a part of your health plan benefits and there is no cost to you! NowClinic services are by appointment and are available to members that are 18 years of age or older who are seeking mental health services.* To secure an appointment, call the behavioral health team line at **702-364-1484** or 1-800-873-2246. Inform the team member answering your call that you are interested in NowClinic services. A team member can help you enroll or answer any questions you have about the NowClinic.

For any additional assistance or if you have any questions, please call the behavioral health team at **702-364-1484** or 1-800-873-2246. The conditions treated are subject to NowClinic provider discretion. NowClinic is not an appropriate format to address substance use disorders and can be addressed through our extensive network of providers. Please contact your Behavioral Health team at **702-364-1484** or 1-800-873-2246 for help.

* A PCP referral or prior authorization is not required to access in network mental health and substance use disorder services.

Prior authorizations for behavioral health services

In some cases, your provider must get permission from the health plan before giving you a certain service. This is called prior authorization. This is your provider's responsibility. If they do not get prior authorization, you will not be able to get those services or you will be responsible for the full cost of the service.

Some services that need prior authorization include:

- Inpatient admissions
- Psychological testing and/or evaluation prescribed by a physician
- Intensive outpatient treatment
- Rehabilitative services
- Out of network provider visits

You do not need prior authorization for emergency services, routine therapy services or medication management. You do not need prior authorization for intensive crisis stabilization services. You do not need prior authorization for services received at a Federally Qualified Health Center, Rural Health Center or a Certified Community Behavioral Health Clinic.

Continued care if your provider leaves the network

Sometimes providers leave the network. If this happens to your provider, you will receive a letter from us letting you know. Sometimes HPN Medicaid will pay for you to get covered services from doctors for a short time after they leave the network. You may be able to get continued care and treatment when your doctor leaves the network if you are being actively treated for a serious medical problem. To ask for this, please call your provider. Ask them to request an authorization for continued care and treatment from your behavioral health team.

Virtual visits

Get care 24/7 without leaving your home! With the NowClinic, you can talk to a NowClinic provider just like you would in an exam room. Just connect by secure mobile app, webcam, chat or phone.

NowClinic providers can diagnose, provide care recommendations and prescribe medication, if appropriate*, for common illnesses. No appointment is necessary and you can connect from the comfort of your home, work or anywhere else that is convenient for you within the state of Nevada.

NowClinic is a part of your health plan benefits and there is no cost to you!

To enroll, visit **NowClinic.com** or download the NowClinic mobile app for iOS® and Android℠ devices from the App Store℠ online store or Google Play™ store. You will need your Nevada state Medicaid ID card to complete the enrollment process.

NowClinic may be able to help with common illnesses such as:

- Allergies
- Bronchitis
- Cough, cold
- Earache
- Eye infection, pink eye, sty
- Fever, chills, runny nose
- Headache
- Laryngitis
- Nausea/vomiting
- Skin inflammation, rash
- Sore throat

For any additional assistance or if you have any questions, please call Member Services at **1-800-962-8074.**

* The conditions treated are subject to NowClinic provider discretion and may require a visual interaction such as a webcam. Video may be required for prescribing.

Urgent Care house call

Quick. Efficient. Convenient. Urgent care house calls include the tools necessary to provide advanced medical care in the comfort of your home. Home urgent care visits are good for migraine headaches, cuts that need stitches and skin infections, urinary tract infections, flu and pneumonia, dehydration, IV placements and IV fluids, asthma attacks, COPD and respiratory infections, and more. To review your symptoms with our medical team and check availability, call tour 24/7 advice nurse toll-free at **1-800-288-2264,** TTY **711.**

If you have a life-threatening situation, call 911 or go to the nearest hospital emergency room.

Transportation services – Non-emergency

Non-emergency transportation to medical and behavioral services is available to Medicaid recipients. If you need a ride to a doctor's appointment, make your reservation a week before your medical appointment is scheduled. To book your reservation, please call MTM at 1-844-879-7341, 7:00 a.m.–5:00 p.m., Monday–Friday. To learn more, sign in to **MyHPNMedicaid.com.**

HPN Medicaid can help with your transportation needs. HPN Medicaid provides bus passes and door to door non-emergency rides. These can be used for doctor appointments, the pharmacy, DMV, accessing Social Service programs and picking up needed resources like food, clothing and baby needs. Members must be working with one of our case managers or registered in one of our programs to qualify.

Emergency transportation

Emergency transportation is a covered benefit for HPN Medicaid members. If you have a medical emergency, call **911.** An ambulance will drive you to a hospital for emergency medical care. Remember to only call **911** for true medical emergencies.

Hospitals and emergencies

Emergency care

Hospital emergency rooms are there to offer emergency treatment for trauma, serious injury and life-threatening symptoms. Reasons to go to the ER include, but are not limited to:

- Serious illness
- Broken bones
- Heart attack
- Poisoning
- Severe cuts or burns
- Difficulty breathing

Don't wait

If you need emergency care, call **911** or go to the nearest hospital.

HPN Medicaid covers any emergency care you need throughout the United States and its territories. Within 24 hours after your visit, call Member Services at **1-800-962-8074,** TTY **711.** You should also call your PCP and let them know about your visit so they can provide follow-up care if needed.

What is an emergency?

An emergency medical condition is an illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm. If you are pregnant, it could mean harm to the health of you or your unborn baby.

Emergency services means covered inpatient or outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an emergency condition.

Post-stabilization care services

Post-stabilization care means covered services, related to an emergency medical condition, that are provided after the medical problem has been stabilized. Post-stabilization care services are provided in the hospital or after discharge to maintain and improve the member's condition.

Urgent Care

Urgent care clinics are there for you when you need to see a doctor for a non-life-threatening condition, but your PCP isn't available or it is after clinic hours. You can get care at a freestanding Urgent Care location, such as **Southwest Medical (SMA)** or **University Medical Center (UMC)** Quick Care clinics. Common health issues ideal for urgent care include:

- Sore throat
- Ear infection
- Minor cuts or burns
- Flu
- Low-grade fever
- Sprains

If you or your children have an urgent problem, call your PCP first. Your doctor can help you get the right kind of care. Your doctor may tell you to go to urgent care or the emergency room.

After office hours, call our Telephone Advice Nurse at **1-800-288-2264.** The nurse will help you decide the best place to get help.

Hospital services

There are times when your health may require you to go to the hospital. There are both inpatient and outpatient hospital services.

Outpatient services include X-rays, lab tests and minor surgeries. Your PCP will tell you if you need outpatient services. Your doctor's office can help you schedule them.

Inpatient services require you to stay overnight at the hospital. These can include serious illness, surgery or having a baby.

Inpatient services require you to be admitted (called a hospital admission) to the hospital. The hospital will contact HPN Medicaid and ask for authorization for your care. If the doctor who admits you to the hospital is not your PCP, you should call your PCP and let them know you are being admitted to the hospital.

Going to the hospital

You should go to the hospital only if you need emergency care or if your doctor told you to go.

No medical coverage outside of the United States

If you are outside of the United States and need medical care, any health care services you receive will not be covered by HPN Medicaid. Medicaid cannot pay for any medical services you get outside of the United States.

Out-of-area health care services

The HPN Medicaid service area covers metropolitan Clark County. When you are out of the service area during an emergency, you should seek attention at the nearest hospital emergency room. Make sure you tell them you are an HPN Medicaid member. Also, tell your doctor you went to an emergency room while you were away.

If you are being treated for a medical problem and going to be away for more than a few days, let your doctor know. If you have any questions while you are away, call Member Services at **1-800-962-8074.**

Pharmacy

Prescription drugs

Your benefits include prescription drugs

HPN Medicaid covers hundreds of prescription drugs from hundreds of pharmacies. A list of commonly covered drugs is on the Preferred Drug List (PDL) or Formulary. You can fill your prescription at any in-network pharmacy. All you have to do is show your HPN Medicaid health plan ID card and State Medicaid ID card.

Generic and brand-name drugs

HPN Medicaid requires all members to use generic drugs. Generic drugs have similar ingredients as brand-name drugs — they often cost less, but they work the same.

In some cases, a limited number of brand name drugs are covered. These are limited to certain classes (or types) of drugs. Some of these may require prior authorization by HPN Medicaid.

What is the Preferred Drug List or Formulary?

The **Preferred Drug List (PDL)** is a list of covered drugs under your plan. The PDL is a subset of all drugs covered under the plan. The full list of covered drugs is called the **Formulary.** You can find both the Preferred Drug List and the Formulary online at **MyHPNMedicaid.com.**

If the medicine your doctor is prescribing is not on the preferred drug list, HPN Medicaid may not pay for it or the medicine might require prior approval. If it does, your doctor may call our Pharmacy Services Department at **1-800-443-8197, option #6,** or send a Prior Authorization Fax to 1-800-997-9672. The form can be found at **MyHPNMedicaid.com.**

We will approve or deny the request within 24 hours. If a request is approved, you and your care provider will be informed of the decision in writing including the drug approval length of time. If a request is denied, you and your care provider will be informed of the decision in writing. The written decision notice will tell you how and when to appeal this decision and to file a complaint or grievance with HPN Medicaid.

Changes to the Preferred Drug List or Formulary

The list of covered drugs is reviewed by the State of Nevada on a regular basis and may change when new generic drugs are available.

Getting your prescription filled

As an HPN Medicaid member, you can get your prescriptions filled at any **Walmart, Sav-On, Albertsons, Vons, Safeway, Smiths, CVS/Target** or **Walgreens stores.** If you need help finding a drug store or pharmacy, ask at the doctor's office or call Member Services at **1-800-962-8074.**

Over-the-Counter (OTC) medicines

HPN Medicaid also covers many over-the-counter (OTC) medications. An in-network provider must write you a prescription for the OTC medication you need. The supply is limited to 30 days. Then all you have to do is take your prescription, HPN Medicaid health plan ID card, and State Medicaid ID card into any network pharmacy to fill the prescription. OTCs include:

- Pain relievers
- Cough medicine
- First-aid cream
- Cold medicine
- Contraceptives (other than birth control pills)
- Prenatal vitamins

Injectable medicines

Injectable medications are medicines given by shot, and they are a covered benefit. In some cases, you will need to get a prior authorization for an injectable medicine. In some cases, you will need to fill the medication at one of our Specialty Pharmacies.

"Specialty Drugs" are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by HPN Medicaid's Pharmaceutical & Therapeutics Committee that are either self-administered or administered by a health care Provider and used or obtained in either an outpatient or home setting. HPN Medicaid may direct you to a Designated Plan Pharmacy with whom HPN Medicaid has an arrangement to provide those Specialty Drugs.

Pharmacy home

Some HPN Medicaid members will be assigned a pharmacy home (Lock-in). In this case, members must fill prescriptions at a single pharmacy location. This is based on prior medication use, including overuse of pharmacy benefit, narcotics, pharmacy locations and other information.

Members of this program will be sent a letter with the name of the pharmacy they are required to use. If members want to change pharmacies, they can call Member Services at **1-800-962-8074,** TTY **711.**

Benefits

Benefits covered by Health Plan of Nevada Medicaid

Medical benefits

As a Health Plan of Nevada Medicaid (HPN Medicaid) member, you get all the basic Medicaid benefits at no cost to you. Your PCP will arrange your care. Many of these benefits are considered Medically Necessary, which means that the services are needed to achieve age-appropriate growth and development and the services allow you to attain, maintain, or regain function. Medically Necessary services or supplies are needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and they meet accepted standards of medicine. You will need to use an HPN Medicaid approved health care facility and medical provider for most of these services, including:

Benefit	Services included
Ambulance Services (for Emergency Services Only)	• Medically necessary air ambulance **Excludes:** Non-emergency medical transportation. For information about ground ambulance, see page 64, **Services you receive directly through Nevada Medicaid.**
Ambulatory Surgery Centers	• Medically necessary surgeries that can be performed on an outpatient basis where the member can safely return home within 24 hours or less **Excludes:** Cosmetic surgeries, fabric wrapping of abdominal aneurysm, transvenous catheter pulmonary embolectomy, extracranial-intracranial arterial bypass, breast reconstruction for cosmetic purposes only (allowed following mastectomy), stereotactic cingulotomy, LASIK and other eye surgeries to treat vision disorders, non-FDA approval implants, gender reassignment surgery, chochleostomy with neurovascular transplant for Meniere's Disease, non-medically necessary, non-effective or investigational surgeries or procedures.

Benefit	Services included
Applied Behavior Analysis (ABA)	• Must be diagnosed with Autism Spectrum Disorder (ASD) and medically necessary • Must be prior authorized **Excludes:** Services which do not meet medical necessity criteria, services used to reimburse parent/guardian for participation in the treatment plan, services given by the parent/guardian, services that are repetitive under an Individual Family Service Plan (IFSP) or an Individual Education Plan (IEP), vocational therapy, recreational therapy, respite services, child care services, services for education, equine therapy, hippotherapy, phone consultation services, care coordination and treatment planning billed independently of direct service and ABA services cannot be reimbursed on the same day as other rehabilitative mental health services. This is not an all-inclusive list.
Botulinum Toxin Type A (Botox)	• Injections are covered for certain spastic conditions including cerebral palsy, stroke, head trauma, spinal cord injuries and multiple sclerosis
Chiropractors	• Treatment limited to the following when referred through the Well-Baby/Well-Child (EPSDT) program: – Office visits – Physical therapy – X-ray – Spinal manipulation

Benefit	Services included
Clinical Trials	• Members of any age can participate in any phase of clinical trial • Members with a diagnosed illness are eligible for qualified clinical trials that test new medical items or services • Routine services or items that are a part of the clinical trial are covered **Excludes:** Trials that exclusively test toxicity or disease pathophysiology. Trials that test therapeutic interventions on healthy volunteers. Items or services that are not covered under Nevada Medicaid.
Cochlear Implants	• Hearing evaluation, surgical implantation of the device, follow-up care and service • Equipment and supplies with some limits • Repairs, adjustments and replacement with some limits • Damage or loss, insurance required at the time of implant
Diabetic Services	• Diabetes management training • Diabetic supplies with some limits • Insulin pump
Durable Medical Equipment	Equipment and supplies for medical purposes. • May include, but are not limited to: oxygen tank concentrators, ventilators, wheelchairs, crutches and canes, orthotic devices, prosthetic devices, pacemakers, incontinence and medical supplies • Prior authorization may be required **Excludes:** Deluxe equipment when standard equipment meets the need, motorized scooters, liquid oxygen, air conditioners, dehumidifiers, humidifiers, car seats, elevators, stair lifts, exercise equipment, household equipment, hygiene equipment, motorized lifts for vehicles, ramps, traction devices, TENS units and reachers. Replacement of lost, damaged or stolen equipment. This is not an all-inclusive list.

Benefit	Services included
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	• Limited to members under age 21 • Includes health and development history, unclothed exam, immunizations, lab procedures, health education, vision and hearing screenings
Emergency Room Services (In- and Out-of-Network)	• Hospital and physician services for medical emergencies • Post-stabilization services for medical emergency
End Stage Renal Disease	• Hemodialysis, peritoneal dialysis and other dialysis procedures • Certain nutritional supplies
Family Planning Services and Supplies	• Medical office visits • Counseling • Physical examinations • Birth control devices and supplies • Tubal ligations and vasectomies for eligible persons 21 years of age or older • Missed abortions **Excludes:** Infertility services, undoing of sterilization services, hysterectomies and abortions unless the mother's life is in danger if the fetus is carried to term or the pregnancy resulted from rape or incest.
Gastric Bypass Surgery	• Coverage for members who meet the criteria **Excludes:** Coverage for pregnant women, women less than 6 months partum, or women who plan to become pregnant within 18–24 months post gastric bypass surgery.
Gender Reassignment Services	• Coverage for members who meet the criteria **Excludes:** Surgery for members under 18 years of age, reversal surgeries or cosmetic surgeries or procedures.

Benefit	Services included
Hearing Aids and Services	• Hearing aid(s) and related supplies • Hearing aid testing and repairs • Replacement of broken/lost hearing aid(s) only if covered by insurance purchased with original hearing aid(s) • Replacement of lost or damaged ear mold(s) only for those under 21 **Excludes:** Eyeglass/hearing aid unit combined, replacement of ear molds for members 21 years of age and older, replacement of lost/broken hearing aid(s) if replacement is not covered by insurance purchased with original aid(s).
Home Health Care	• Skilled nursing services with limits • Physical therapy visits, occupational therapy visits, speech therapy visits, respiratory therapy visits • Registered dietician visits • Limited personal care services with a skilled service as ordered by a physician **Excludes:** Respite, homemaker, companion, social work or sitter service, and routine personal supplies.
Immunizations — Ages 0–21	• All childhood immunizations covered under EPSDT including Varicella, TDaP, Flu, Hepatitis A, B and C, HiB MMR, HPV, Pneumonia, Polio, Rotavirus and Meningitis and appropriate travel vaccines
Immunizations — Ages 21 and Over	• Tetanus, Rabies, Flu, Pneumonia, Hepatitis B, and HPV between the ages of 9–26 years old and appropriate travel vaccines

Benefit	Services included
Inpatient Hospital Services	• Acute care admissions including all necessary physician care, testing, surgery and anesthesia when ordered by a physician • Out-of-state inpatient hospital services for emergencies and when care is unavailable in service area • Observation stays up to 48 hours • Swing bed stays up to 45 days **Excludes:** Swing bed stays over 45 days, when medical condition or treatment needs do not meet acute care guidelines or services can be provided in a less restrictive setting, certain administrative days.
Inpatient and Outpatient Rehabilitation Services	• Physical, occupational or speech evaluations • Medically necessary physical, occupational or speech therapy with limits • High-dose oxygen treatment for wounds **Excludes:** Non-medically necessary therapy and personal comfort items.
Laboratory Services	Includes all medically necessary diagnostic tests. • There are some tests that may require prior authorization • Biomarker testing for the diagnosis, treatment, management and ongoing monitoring of cancer • You do not need prior authorization for emergencies • You do not need prior authorization to see a women's health provider for women's health or if you are pregnant **Excludes:** Post death exams, fertility tests and testing for the same drug with a blood and urine specimen at the same time.

Benefit	Services included
Medical Nutrition Therapy (MNT)	This therapy is provided by a Registered Dietitian to help manage diseases based on diet. You do not need prior authorization. A referral is needed and must include labs, medicines and information about current conditions. Includes the following benefits: • Initial nutrition and lifestyle assessment • One on one or group nutrition counseling • Follow-up intervention visits to monitor progress in managing diet • Reassessments as necessary during the 12 rolling month episode of care to assure compliance with the dietary plan • Four hours maximum in the first year • Two hours maximum per 12 rolling month period in subsequent years • Services may be provided in a group setting. The same service limitations apply in the group setting. • MNT is only covered for the management of diabetes, obesity, heart disease and hypertension related conditions • MNT may be provided through Telehealth services • Additional service limitations may apply
Medical Supplies	• Disposable medical supplies to treat a medical condition including diabetic syringes and needles, dressings, pads, diapers for members over age 3 (use of multiple types of briefs, diapers, pullons, or protective underwear in any size combination cannot exceed the maximum limit either 100 units or 186 units per month, depending on the item, without prior authorization), catheter and irrigation items, ostomy supplies, saline, sterile and nonsterile gloves • Authorize one month's supply at a time **Excludes:** Sanitary napkins, band-aids, cosmetics, personal hygiene items, rubbing alcohol, hydrogen peroxide, Neosporin and other topical preparations.

Benefit	Services included
Mental Health and Substance Use Disorder Services	• Inpatient Mental Health and Substance Use Disorder Services • Rehabilitative services • Outpatient counseling • Psychological testing and/or evaluation prescribed by a physician • Crisis intervention therapy • Case management services • Medication Assisted Treatment (MAT) Programs
Ocular Care for Members 0–21 Years of Age	• Exam and glasses every 12 months • Repairs and replacement for damaged eyeglasses • Lightweight lenses to balance the weight of the glasses • Glass or plastic lenses • Bifocals and trifocals in some instances • Contact lenses for treatment of a medical condition • Plastic or metal frame **Excludes:** Sunglasses or cosmetic lenses; contact lenses; replacement of lenses; blended or progressive multifocal lenses; ultra-lightweight plastic lenses for adults; cost of an extended warranty to repair/replace glasses/frames with ornamentation, eyeglass frames which attach to or act as a holder for hearing aids; any surgical procedure to improve vision, when vision is OK using glasses.

Benefit	Services included
Ocular Care for Members Age 21 and Older	• Exam and glasses every 12 months. Exception to 12-month rule: post cataract surgery, glaucoma, diabetes. • Repairs and replacement for damaged or lost eyeglasses (with prior authorization) • Lightweight lenses to balance the weight of the glasses • Glass or plastic lenses, tint when medically necessary • Safety lenses with vision in only one eye • Bifocals and trifocals in some instances • Contact lenses for treatment of a medical condition **Excludes:** Sunglasses or cosmetic lenses; contact lenses; replacement of lenses; blended or progressive multifocal lenses; ultra-lightweight plastic lenses for adults; cost of an extended warranty to repair/replace glasses/frames with ornamentation, eyeglass frames which attach to or act as a holder for hearing aids; any surgical procedure to improve vision, when vision is OK using glasses.
Orthotics	Items needed to straighten or correct a deformity such as braces, special shoes, elastic stockings, back support/corsets, splints, cervical collars, and burn garments.
Parenteral Therapy	• Fluids with vitamins and nutrients given through veins • Infusion pump one at a time • One supply kit and one administration kit per day **Excludes:** Nutritional aids for the elderly, infants with allergies who can use soy formula, diabetic diets and supplements to ulcer diets.

Benefit	Services included
Personal Care Services	Medically necessary help with: • Bathing, grooming or dressing • Toileting needs • Transferring and positioning persons who can't or have trouble walking • Help with eating Services may be provided in the home, locations outside the home or wherever the need for the service occurs. Must be performed in accordance with the approved service plan. Must be prior authorized – service limitations apply. Any changes that do not increase the total authorized hours can be made, for the member's convenience, within a single week without an additional authorization. **Excludes:** Tasks a person is able to perform on their own, services given by willing caregivers, tasks that aren't on the approved service plan, services to maintain a household and services given to a person other than the planned receiver.
Pharmacy (Generic drug required unless physician requests a brand name with prior authorization request)	• Drugs approved by the Food and Drug Administration and part of the Health Plan of Nevada Medicaid Drug List • Family planning items, such as condoms, diaphragms, oral contraceptives, foams and jellies • Over-the-counter drugs ordered by the doctor • Prenatal vitamins • Smoking cessation products **Excludes:** Appetite suppression or weight loss drugs, fertility drugs, drugs used for cosmetic purposes or hair growth, drugs being used for a diagnosis or at a dose/frequency that is not approved by the Food and Drug Administration (FDA), replacements for lost, stolen, broken or destroyed medications, medications for the treatment of erectile dysfunction or sexual dysfunction, non-FDA-approved medications, or unit dose packaging of prescription drugs.

Benefit	Services included
Physician, Physician Assistant and Nurse Practitioner Services and Consultations **(Surgical and Non-Surgical)**	• Medically necessary primary care and specialist office visits • Urgent care services • Emergency room services • Services to diagnose and treat an illness or injury • Preventive services covered under EPSDT • Well-child care • Immunizations • Sports physicals • Well-woman care
Podiatry	• Office visits, home visits, hospital visits, emergency room visits, nursing home visits • Surgical procedures – Multiple surgeries – Fungal Infection procedures – Casting/strapping/tapping These procedures are covered when performed by a podiatrist for the treatment of fractures, dislocations, sprains, strains, and open wounds (related to podiatrist's scope of practice). • Infection and inflammation services – Trimming of nails, cutting or removal of corns and calluses are allowed if either infection or inflammation is present **Excludes:** Preventive care such as cleaning and soaking of feet, applying creams. Routine foot care in the absence of infection or inflammation. • Routine foot care includes the trimming of nails, cutting or removal of corns and calluses • Preventive care and routine foot care can be provided by Outpatient Hospitals, APRN, M.D., D.O, and PA/PA-C

Benefit	Services included
Pregnancy and Maternity Services	• Doctor or certified nurse midwife visits for prenatal care and testing • Specialist care for complications • Delivery services in a hospital or birthing center • After-delivery care • Treatment for pre-term labor • Treatment of incomplete, missed or septic abortions, when medically necessary • Abortions to end pregnancies resulting from rape or incest
Prostheses and Prosthetic Supplies	• Items necessary to replace missing body parts, such as false limbs and eyes • Adjustments and repairs • Replacement when ordered by a doctor **Excludes:** Routine testing and cleaning.
Radiology (X-Ray) Services	• Medically necessary X-ray services ordered by a doctor such as MRI or PET scans, ultrasounds • Bone Mineral Density every two years, when medically indicated • Mammograms yearly for women age 40 and older
Residential Treatment Centers (RTCs)	All medically necessary care for Medicaid and Nevada Check Up members admitted to an RTC.
Skilled Nursing Facility Care	All medically necessary care for the first 180 days. Nevada Medicaid covers the cost of care as of the 181st day. Skilled nursing care is given by licensed nurses who can provide help with at least three of the following: 1. Medication 2. Treatment or special needs 3. Assistance with activities of daily living 4. Supervision 5. Assistance with instrumental activities of daily living

Benefit	Services included
Surgical Services	• Medically necessary surgeries • Inpatient/Outpatient/Ambulatory facility services • Physician services • Surgical assistant services • Anesthesia services including nurse anesthetist • Circumcisions for newborns under 1 year of age, no prior authorization required • Circumcisions for non-newborns, prior authorization is required **Excludes:** Medically unnecessary cosmetic procedures to improve appearance.
Transportation	• Emergency transportation only (see Ambulance Services) • Cost of meals and lodging when traveling to and from medical services or while receiving medical care **Excludes:** Non-emergency transportation to medical services, transportation to non-covered services, travel to visit a hospitalized patient, transport of a deceased person, transports between facilities and cost of a car rental. **Note:** Least expensive form of transportation will be offered.
Transplants (Organ)	• Coverage limited to medically necessary kidney, liver, corneal and bone marrow transplants • Familial and unrelated bone marrow donor search and match services are covered • Meals and lodging to and from, and while receiving medical services and transportation to and from medical services • Please call MTM at 844-879-7341 for these services **Excludes:** Transplants for some illnesses and stages of illnesses, experimental organ transplants, organ transplants that will not make a difference in the patient's health, and unsafe organ transplants.

This is just a basic list of the covered medical services you may receive from HPN Medicaid. Services that are not allowed by the State of Nevada Medicaid Program are excluded from coverage.

The Nevada Medicaid webpage provides a fee-schedule search option to view a list of services the State of Nevada Medicaid Program covers. The website can be accessed at: https://dhcfp.nv.gov/resources/rates/feeschedules.

Keep in mind, you must have approval from your PCP and HPN Medicaid before you receive some health services. These include specialist visits and hospital stays. Your PCP or our Member Advocates are available to answer questions you may have about these services. Feel free to call Member Services at 1-800-962-8074 or schedule an appointment for concierge, in-person assistance. In-person service is available Monday–Friday, 10:00 a.m.–3:00 p.m., by appointment only. Please call us to schedule an appointment and a member of our team would be happy to assist you. Our offices are located at 2720 N. Tenaya Way, Suite 102, Las Vegas, NV 89128.

A special note about family planning services

Family planning services help people of childbearing age who do not want to get pregnant. These services include:

- Counseling
- Various kinds of birth control, including over-the-counter and prescription birth control supplies

You can get family planning services:

- From your PCP, or
- From any doctor, clinic or family planning center that takes Medicaid patients.

You do not have to get family planning services from a doctor in the HPN Medicaid Provider Directory. You do not need a referral from your PCP, but please bring your State Medicaid ID card with you. **Always tell your PCP when you are using birth control pills or other family planning methods.** Infertility services are not covered for Medicaid members.

A special note about mental health and substance abuse benefits

Mental health is as important as physical health. HPN Medicaid Behavioral Health provides Mental Health, Substance Abuse services and online resources for members to maintain a balanced and healthy life.

Some of the services provided by HPN Medicaid Behavioral Health include:

- Mental health and substance abuse services
- Inpatient and outpatient services
- Crisis intervention services 24-hours-a-day, 7-days-a-week

A PCP referral or prior authorization is not required to access in-network mental health and substance use disorder services. To access services and to obtain help in locating a provider near you, please contact us at **702-364-1484** or toll-free at **1-800 873-2246.**

It's important that you like and trust your therapist. You can change your therapist at any time. Call us and we can help you make the change.

If you are currently experiencing a life-threatening emergency, please call 911 or proceed to your nearest emergency room immediately.

Special added benefits for Health Plan of Nevada Medicaid members

HPN Medicaid provides several added benefits to assist each of our plan members in staying healthy and well. The following are examples of benefits for you.

- **Non-medical transportation**
  HPN Medicaid provides bus and/or door to door non-emergency rides to doctor appointments, the pharmacy, DMV, accessing Social Service programs and picking up needed resources like food, clothing and baby needs. Member must be working with one of our case managers or registered in one of our programs to qualify. Both Medicaid and Nevada Check Up members can qualify.

- **Member Services: 1-800-962-8074**
  Office Address: 2720 N. Tenaya Way, Suite 102, Las Vegas, NV 89128
  Our friendly staff will help with any questions you have about your benefits. They can help if you have a problem getting health care. You should also tell them about any suggestions or grievances you have.

- **Behavioral Health Team: 1-800-962-8074**
  As a health plan member, you can call our friendly behavioral health staff with any questions about your benefits or finding a behavioral health provider. You should also tell them about any suggestions or grievances you have.

- **24-hour Telephone Advice Nurse: 1-800-288-2264**
  Having a sick child or getting sick yourself can be very frightening in the middle of the night. But as an HPN Medicaid member, you can call our Telephone Advice Nurse. The nurse can tell you what you need to do for your problem and whether you need to follow up with your PCP. Also, you can call the nurse with questions that you don't think are serious enough to ask your doctor.

- **Smartphones**
  You can apply to receive a free smartphone with free monthly minutes. Depending on the plan you choose, you will have unlimited text messages and calls made to the 24-hour Telephone Advice Nurse will not count toward your free minutes. From time to time, you will receive text messages from us with Health Tips and Reminders. For more information, call Member Services at **1-800-962-8074.**

- **NowClinic**
  Get care 24/7 without leaving your home! With the NowClinic, you can talk to a NowClinic provider just like you would in an exam room. Just connect by secure mobile app, webcam, chat or phone. You do not need an appointment and you can easily connect from the comfort of your home, work or anywhere else that's convenient for you. For more information about the NowClinic, call Member Services at **1-800-962-8074.** For more information about the behavioral health NowClinic, call **1-800-873-2246.**

- **Disease Management**
  Let our team of Registered Nurses assist you in learning how to best self-manage your diabetes or asthma. Our diabetes disease management program includes weekly phone calls from a nurse specializing in diabetes who can help you better understand how to take your medications, the role healthy nutrition and exercise play in diabetes management, and the meaning of your lab results. The diabetes program is available to any adult with Type 1 or Type 2 diabetes. Our asthma disease management program allows you to speak with a registered nurse specializing in asthma to assist you in learning how to best self-manage your asthma at home. Learn how to take your asthma medicines correctly and identify your asthma triggers. The asthma program is available to anyone with asthma ages 5 and up. To make an appointment to speak with a registered nurse about your diabetes or asthma, please call our Disease Management Team at 1-877-692-2059.

- **Health education and wellness**
  As a Health Plan of Nevada member, you have access to our team of Registered Dietitians and Health Coaches to assist you in living your healthiest life possible. You can attend classes or speak to one of our Registered Dietitians or Health Coaches on topics like:
  - Cancer Nutrition
  - Diabetes
  - Exercise
  - Heart Health
  - Lactation
  - Nutrition and Fitness
  - Pregnancy
  - Tobacco Cessation
  - Weight Management
  - Healthy Nutrition for kids, ages 2–17
  - Prediabetes

  Please contact a Health Advocate at 1-800-720-7253 for more information or to schedule your free consultation or class. More information about our Health Education and Wellness offerings can be found on our webiste, **MyHPNMedicaid.com.** Click on the "I need help with ..." link and then click on "Health Education and Wellness."

Pregnancy care and services

Joyful Journeys Case Management Program is a special support program for people on Medicaid who are pregnant or have recently had a baby. It helps with many kinds of health needs like physical, emotional, and social — no matter what level of risk someone has.

Each person in the program gets help from a team of caring professionals. This team can include nurses, social workers, and community health workers. They look at your health, feelings, and living situation to help you get the services you need, such as:

- Help with doctor visits and care during pregnancy
- Support for mental health issues like feeling sad or worried
- Help with rides to medical appointments, finding baby supplies and finding safe housing

You can also get extra benefits like:

- Help with breastfeeding from certified experts
- Classes about having a healthy pregnancy and baby
- Gift cards for going to prenatal and postpartum checkups
- Free diapers if you quit smoking
- Support from doulas and birth partners
- Free breast pumps and grocery money through Instacart
- Help finding childcare through Wonderschool

If you want to join or refer someone to Joyful Journeys, you can call the Direct OB Line at 844-851-7830 or email **HPNOBTeam@uhc.com.**

Care for you during your pregnancy

Tell your doctor if you are planning to have a baby or if you are pregnant. If you think you might be pregnant but are not sure, your doctor can give you a quick, easy test to find out.

If you are pregnant, choose a doctor from the HPN Medicaid Provider Directory. If you need help, call Member Services at **1-800-962-8074.** We will help you choose a doctor specially trained to care for pregnant women and to deliver babies. You can also choose providers known as nurse midwives or doulas. A nurse midwife is a specially trained nurse who helps take care of people during pregnancy, childbirth, and after the baby is born. They are trained on how to stay healthy during pregnancy, how to deliver babies safely, and teach parents how to care for their newborns. Nurse Midwives work in hospitals, clinics, and sometimes at people's homes. A doula is like a pregnancy and childbirth coach or helper. They don't give

medical care like a doctor or nurse, but they do give emotional support, comfort, and information. All three of these providers can be a part of your health care team while you are pregnant.

Make an appointment to see your obstetrician right away for a complete checkup.
If you're pregnant or think you might be, start by choosing a doctor from our HPN directory. Need help? Call Member Services at **1-800-962-8074** – we'll help you find a provider who specializes in pregnancy care.

You have options, including obstetricians and midwives, both are trained to care for you during pregnancy, childbirth, and postpartum. They work in hospitals, clinics, and birthing centers, and can guide you on staying healthy and caring for your newborn.

You may also consider adding a doula to your care team. Doulas provide emotional support, comfort, and information throughout pregnancy and birth, though they don't offer medical care.

All three, obstetricians, midwives, and doulas, can be part of your support system to help ensure a healthy pregnancy and delivery.

Pregnancy and family support app – Tummy2Family

Manage your pregnancy through each milestone and trimester.
This app helps you stay healthy during every step of your pregnancy. It's easy to use – just enter your due date and birth date, and Tummy2Toddler sets up your pregnancy milestones.

Get parenting guidance through the stages of life from newborn to adulthood.
Focusing on family support, childhood development and parental health, the Tummy2Family app seamlessly transitions from pregnancy to parenthood.

Educational programs for moms-to-be

If you are pregnant, call our Obstetrical Case Management team at 1-844-851-7830. The registered nurses will answer any questions you may have and send you information on having a healthy pregnancy. You may also attend a free one on one session with a Certified Lactation Consultant (CLC) during or after pregnancy to discuss topics including:

- Nutrition
- Exercise
- Safety for you and the baby
- Proper weight gain
- Stress, emotions and hormonal changes
- Breastfeeding and formula feeding

Healthy pregnancy rewards program

You may receive up to $60 in rewards gift cards by signing up for the "Healthy Pregnancy Rewards Program" and completing qualifying prenatal and postpartum visits. Please contact the Obstetrical Case Management team at 1-844-851-7830 for more details.

A healthy prenatal visit schedule consists of 14 visits within your pregnancy. The guide below is a tool for reference.

9th month of pregnancy	1 prenatal visit is needed
8th month of pregnancy	5 prenatal visits are needed
7th month of pregnancy	7 prenatal visits are needed
6th month of pregnancy	8 prenatal visits are needed
5th month of pregnancy	9 prenatal visits are needed
4th month of pregnancy	11 prenatal visits are needed
3rd month of pregnancy	12 prenatal visits are needed
2nd month of pregnancy	13 prenatal visits are needed
1st month of pregnancy	14 prenatal visits are needed

Breastfeeding information

Breastfeeding provides health benefits for both babies and mothers. Breastfeeding can help lower a mother's risk of heart disease, ovarian cancer, Type 2 diabetes and Breast Cancer. Infants who are breastfed have reduced risks of: Asthma, Obesity, Ear and respiratory infections, Type 2 diabetes and Sudden infant death syndrome (SIDS).

Breast pump: Breast pumps and supplies are available for people nursing with infants up to 12 months of age. Both electric and manual pumps are covered, as well as disposable collection and storage bags for breast milk. .

- **Southern Nevada members:** A prescription is required from your OB provider. Fax it to Southwest Medical Durable Medical Equipment (DME) at **702-242-7703.**

If you have any questions or would like more information on how to receive a breast pump, please call toll-free **1-844-851-7830,** TTY **711.**

Why someone might need special help during pregnancy

Some pregnancies can be harder and need extra care. High Risk OB Case Management helps people who might have problems during pregnancy or when giving birth. This includes people who:

- Have health problems like diabetes, high blood pressure, or heart disease
- Are having more than one baby (like twins or triplets)
- Had problems in past pregnancies, like early births
- Are dealing with mental health issues or drug and alcohol problems
- Have trouble with safe housing, getting to doctor visits, or having enough food
- Are younger than 18 or older than 35 and are pregnant

For more information, call our High Risk OB Case Management team at **1-877-487-6659.**

Avoiding a premature birth

Premature babies have lots of health problems from birth and for many years later. To avoid having a premature baby, it is important to know about premature labor. Premature labor occurs before the 37th week of your pregnancy. The signs of premature labor are:

- Menstrual-like cramping
- Contractions
- Lower backache
- Abdominal, thigh or back pressure
- Increase or change in vaginal discharge
- Amniotic fluid (bag of water)

If you are having signs of pre-term labor, call your obstetrician right away. There are treatments available to stop pre-term labor which will help you have a full-term, healthy baby.

Delivering your baby

You should consult your doctor or midwife to determine the safest and most appropriate birth setting for you, based on your medical history and current pregnancy. While options like birthing centers or home births may be available, some deliveries are only safe in a hospital. Your provider can help guide you through these choices. To find a provider, visit **MyHPNMedicaid.com.**

Baby blues

Babies need lots of care, but so do you. Some women have postpartum depression after the baby is born. Some signs of postpartum depression are feeling sad, crying a lot, having trouble sleeping or just not feeling like yourself. If you have any of these symptoms, please call your doctor or call HPN Medicaid Behavioral Health at **1-800-873-2246.**

Birth control after the baby is born

Your body needs to rest after your pregnancy. Pregnancies too close together increase your chance of having a premature or low-birth-weight baby. It is recommended that you wait at least one year before becoming pregnant again. Talk to your doctor about birth control methods that are right for you.

A healthy start for your new baby

Your new baby automatically joins Health Plan of Nevada when he/she is born. **Make sure you call our Member Services department at 1-800-962-8074 to report the birth of your child as soon as you are home from the hospital. You must also call your case worker at the DSS Office to report the birth of your baby.** If you don't report the birth, you may be responsible to pay for your baby's medical care.

One of the most important things you will need to do right after childbirth is to choose a doctor for your baby. Your baby should receive a checkup within two weeks after birth and circumcisions for baby boys are usually a part of this visit.

Your baby will need more well-child visits during the first two years of life and immunizations are part of these visits. It is very important that your baby receive the recommended well-child visits and immunizations. More information on these visits and immunizations is provided in the next section, "Keeping your children healthy."

If you need help choosing a doctor for your baby, call Member Services at **1-800-962-8074** or visit our website for the most recent version of the provider directory at **MyHPNMedicaid.com.** Our staff will help you find a doctor for your baby. You may choose either a pediatrician or a family practice doctor. Please let us know your choice by calling **1-800-962-8074.** If we don't hear from you, we will assign your baby to a doctor. You can change your child's doctor by calling Member Services.

Care Management

If you have a chronic health condition, HPN Medicaid has a program to help you live with your condition and improve the quality of your life. These programs are voluntary and available to you. The programs give you important information about your health condition, medications, treatments and the importance of follow-up visits with your physician.

A team of registered nurses, social workers, and community health workers will work with you, your family, your PCP, other health care providers and community resources to design a plan of care to meet your needs in the most appropriate setting. They can also help you with making appointments with your doctor and reminding you about special tests that you might need.

You or your doctor can call us to ask if our care management programs could help you. If you or your doctor thinks a Care Manager could help you, or if you want more information about our care management programs, call Member Services at **1-800-962-8074.**

Services you receive directly through Nevada Medicaid

Some services that Medicaid pays for are not part of your HPN Medicaid benefit package. You will use your Medicaid card to get these services from any doctor, dentist or facility that takes Medicaid patients. You do not have to see your doctor or dentist first.

Some services you get directly through Medicaid are:

- **Home and community-based waiver services**
- **Emergency ground ambulance services** – When your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance
- **Non-emergency medical transportation** – For transportation to medical and dental care when it is not an emergency
- **ICF/ID services** (Intermediate Care Facility for Individuals with Intellectual Disabilities)
- **School-based health services** – For certain children who have an Individual Education Plan so they can get special care in the school
- **Indian Health Services and Tribal Clinics**
- **The cost of care you receive before becoming a Health Plan of Nevada member** – Nevada Medicaid will continue to decide whether to pay for health services you received while you were on Fee-for-Service Medicaid

- **The cost of care in a special facility** – Like an institution for people who are intellectually disabled
- **Services for people who need long-term care** – Like staying in a nursing home longer than 180 days
- **Transitional rehabilitative services** – Helps injured or disabled people learn or relearn skills needed for daily living
- **Dental services** – Services to check for and correct problems with your teeth. This service is provided by Liberty Dental. Please call them at 888-401-1128, TTY 877-855-8039 with questions about dental coverage or to find a dentist.

If you have questions about these services, please contact your Nevada Social Services caseworker at 1-800-992-0900.

Other plan details

Finding a network provider

We make finding a network provider easy. To find a network provider or a pharmacy close to you:

Visit **MyHPNMedicaid.com** for the most up-do-date information.
Click on "Find a Doctor/Pharmacy."

Call Member Services at **1-800-962-8074,** TTY **711.** We can look up network providers for you.Or, if you'd like, we can send you a Provider Directory in the mail.

Provider Directory

You have a directory of providers available to you in your area. The directory lists names, addresses, phone numbers, professional qualifications, specialty and board certification status of our in-network providers.

Provider information changes often. Visit our website for the most up-to-date listing at **MyHPNMedicaid.com.** To search for a provider, click on "Find a Doctor/Pharmacy" to use our online searchable directory.

If you would like a printed copy of our directory, please call Member Services at **1-800-962-8074,** TTY **711,** and we will mail one to you for free within 5 business days.

Medicaid estate recovery

When you enroll in a Managed Care Organization (MCO), are age 55 or older and are subject to Medicaid estate recovery upon death, please note that all premium payments (capitation fees) made by Medicaid to the MCO are subject to recovery by Medicaid per Section 3810 of the Center for Medicaid and Medicare's State Medicaid Manual, and will be included in addition to any other Medicaid payments as a claim against your estate. Medicaid cannot recover from the estates of deceased Medicaid recipients if there is a surviving spouse, a child under the age of 21, or a disabled or blind child of any age. Also Medicare Part A and B copayments paid after January 1, 2010, are not recoverable.

If you get a bill for services

It is very important that you follow the rules when getting medical care so you are not billed for services. You must get care from the doctors and other medical providers listed in the HPN Medicaid Provider Directory. You must get a referral from your PCP to see a specialist or get certain services. The only exception is during a medical emergency.

It is also important to know your benefits. If you get medical care that is not a Medicaid benefit, you may be billed for those services. For example, if you pick a pair of glasses that cost more than the benefit, you will need to pay the difference. Your provider will ask you to sign a statement saying you will pay for the service. If you sign it and get the service, you have to pay the bill and will not be reimbursed by HPN Medicaid or state Medicaid.

Services received outside the country are not covered Medicaid benefits. HPN Medicaid will not pay for these services. **You may also get a bill for medical care your newborn receives, if you don't tell your caseworker you had a baby.**

Other health insurance (Coordination of Benefits – COB)

If you or anyone in your family has other health insurance, you must call Member Services and tell us about it. For example, if you have a health plan at work or if your children have insurance with their other parent, call Member Services.

If you have other insurance, HPN Medicaid and your other plan will share the cost of your care. This is called **Coordination of Benefits.** Together, both plans will pay no more than 100 percent of the bill.

If we pay the full bill and another party should pay part, we will contact the other plan. For example, if you are hurt in a car accident, auto insurance may pay some of your bills. You will not get a bill for covered services. We get the bill. If you get the bill by mistake, call Member Services at **1-800-962-8074,** TTY **711.**

Updating your information

To ensure that the personal information we have for you is correct, please tell your DWSS eligibility worker if and when any of the following changes:

- Marital status
- Address
- Member name
- Phone number
- You become pregnant
- Family size (new baby, death, etc.)
- Other health insurance

Please call Social Services (DSS) if any of this information changes. HPN Medicaid needs up-to-date records to tell you about new programs, to send you reminders about healthy checkups, and to mail you member newsletters and other important information.

- For Southern Nevada: **702-486-1646**
  - Option 1 for English, Option 2 for Spanish
  - Option 5 to speak to an Agent

Other insurance

If you have any other insurance, call Member Services and let us know.

- If you are an HPN Medicaid member, your other health insurance will have to pay your health care bills first
- When you get care, always show both your State Medicaid ID card and your member ID card from your other insurance

Informed consent

Consent means you say "yes" to treatment. Informed consent means:

- The treatment was explained to you and you understand
- You say yes before getting any treatment
- You may need to say yes in writing
- If you do not want the treatment, your PCP will tell you about other options
- You have the right to say yes or no

Privacy of records

HPN Medicaid takes privacy issues and laws seriously. Safeguards are in place to protect information about you. We don't share private information without your written okay unless there is a legal reason.

Protecting the privacy of your health information

By law, we must keep your health information (HI) private. We may also collect information about your race, ethnicity and language (REL) as well as sexual orientation and gender identity (SOGI). We guard this REL and SOGI data with the same protections as your HI. This information may be oral, written or electronic. Our employees and service providers only get access to your data when needed for certain purposes. We have the right to use your data for activities such as payment, treatment or managing your care. This includes sharing your data with your medical provider or facilities such as a hospital. We may also use this information to create special programs, evaluate health disparities and design marketing materials to invite you to a disease management, wellness or other program. Your REL and SOGI data will never be used for denial of services, coverage and benefits. It will also never be disclosed to unauthorized individuals.

If you have questions about how we use and protect your health, REL and SOGI information, please call Member Services at **1-800-962-8074,** TTY **711.**

How we pay our providers

HPN Medicaid pays our network PCPs, specialists, hospitals and all other types of providers every time they see one of our members. This is known as fee-for-service. If you have any questions on provider reimbursements or incentive programs, you can call Member Services at **1-800-962-8074,** TTY **711.**

Utilization management

HPN Medicaid does not want you to get too little care or care you don't need. We also have to make sure that the care you get is a covered benefit. Decisions about care are based only on appropriateness of care and coverage. We use a process called utilization management (UM). It helps us make sure you get the right care, at the right time and in the right place.

Only doctors and pharmacists do UM. We do not reward anyone for saying no to needed care. We do not give incentives to our reviewers for decisions that result in not enough care. If you have questions about UM, talk to our Medicaid Case Management staff. Call during normal business hours. TTY 711 and language help are available.

Quality program

Our Quality program can help you stay healthy by working with your doctor. It reminds you to get preventive tests and shots. We send reminders to you and your providers. These include lead tests, Pap tests, mammograms and shots to prevent diseases like polio, mumps, measles and chickenpox.

HPN Medicaid uses HEDIS® (Healthcare Effectiveness Data and Information Set) standards to help measure how we are doing with our quality program. HEDIS gives performance scores to help people compare managed care plans. HEDIS studies many areas, such as prenatal care and disease prevention.

HPN Medicaid wants to make sure you are happy with the services you get from your doctor and from us. To do this, we look at CAHPS® data. CAHPS stands for Consumer Assessment of Healthcare Providers and Systems. This survey asks questions to see how happy you are with the care you get. If you get a member survey in the mail, please fill it out and return it to us.

HPN Medicaid looks at the results of HEDIS and CAHPS. Then we share the results with our providers. We work with providers to make sure services add to your health care in a positive way.

If you want to know more about the Quality program, call Member Services at **1-800-962-8074,** TTY **711.**

Patient safety and protection from discrimination

Patient safety is very important to us. Although we do not direct care, we want to make sure that our members get safe care. We track quality-of-care, develop guidelines on safe care and give information on patient safety. We also work with hospitals, doctors and others to improve coordination between sites of care. If you want more information, call Member Services at **1-800-962-8074,** TTY **711.**

Clinical practice guidelines and new technology

HPN Medicaid gives our providers clinical guidelines. These have information on the best way to provide care for some conditions. Each guideline is a standard of care in the medical profession. This means other doctors agree with that approach.

If you have any questions about HPN Medicaid's clinical guidelines or would like a copy of the guidelines, call Member Services at **1-800-962-8074,** TTY **711.** You can also find the clinical guidelines on our website at **MyHPNMedicaid.com.**

New technology assessment

Some medical practices and treatments are not yet proven to be effective. New practices, treatments, tests and technologies are reviewed nationally by HPN Medicaid to decide on coverage. They are reviewed by a committee of HPN Medicaid doctors, nurses, pharmacists and guest experts. They make the final decision about coverage. If you want more information, call us at **1-800-962-8074,** TTY **711.**

Advance Directives

Nevada law states you have the right to make decisions about your health care if you are 18 years of age and older as long as you are able to do so. If you become sick, your doctor will tell you what is wrong with you, the types of treatment you can choose and what might happen if you do not get care. You have the right to refuse care, even if your doctor feels you need it in order to save your life.

Sometimes when people are very sick, they are not able to make decisions or tell doctors what they want. For example, if there is no hope that they will get well again, some people don't want the doctor to keep them alive by feeding them through a tube or putting them on machines. If you feel this way, **it is very important that you tell your doctor and family what your wishes are while you are still healthy and able to tell them. This is done by a written "advance directive."**

There are different types of advance directives:

- **A "Living Will"** is a written statement that tells the doctor and your family what kind of health care you want, or do not want, if you become unable to tell them
- **A "Durable Power of Attorney for Health Care"** is a signed document that names someone you choose to make health care decisions for you if you cannot make your own decisions
- **A Do Not Resuscitate (DNR) order** is an instruction given to your doctor that you do not want life-saving measures taken on your behalf if your heart or breathing stops

An advance directive must be in writing and you must sign it. It must also be signed by a notary public or by two other people as witnesses. Make sure your family and your PCP have copies so they will know how to help you. Your Advanced Directive will be kept in your medical record.

You may change your advance directive at any time. Put the change in writing in the same way that you did the first time. Make sure your doctor and family knows about the change. Make sure the date is on it so others will know which directive is the most recent. If you need to, you can have both types of advance directives. And if you choose, **you do not have to have an advance directive.** It is totally up to you.

We want to know what kind of medical care you want. If you want to make an advance directive, a lawyer can write one for you. If you can't see a lawyer, the people in your PCP's office have forms and can help you. Or, you can call our Member Services staff at **1-800-962-8074.**

Federal and State law allow your doctor, or even an entire institution, like a hospital, to object to your advance directive because of moral or religious beliefs. Each doctor or institution may object to different advance directives. If this happens, your doctor is required by Nevada law to inform you and transfer your care to another doctor. If you have questions or need help finding a doctor, please contact Member Services at **1-800-962-8074.**

If you have a complaint about the Advance Directive information, please call Nevada Medicaid at **1-800-360-6044** or **1-877-453-7669.**

Health Plan of Nevada Medicaid does not discriminate on the basis of whether members have or do not have advance directives.

Fraud, waste and abuse (FWA)

Fraud is lying with the knowledge that the lie could result in a benefit to someone. Waste and abuse are practices that result in unnecessary cost to health programs, or payment for services that are not medically necessary. HPN Medicaid makes every effort to identify, prevent and investigate fraud, waste and abuse (FWA). It is also your right and responsibility to inform us if you notice FWA. Please call our Health Care Fraud Tip Line at 1-866-242-7727 or email at **HPNFWA@sierrahealth.com** if you are aware of any of the following:

- Falsifying claims/encounters
- Alteration of claim
- Double billing
- Billing for services not provided
- Denying access to services/benefits
- Failure to refer for needed services
- Member eligibility fraud
- Physical abuse
- Mental abuse
- Emotional abuse
- Neglect
- Failure to report third party liability
- Misrepresentation of medical condition
- And other types of fraud, waste or abuse

You may also write to:

Health Plan of Nevada Medicaid
P.O. Box 15645
Las Vegas, NV 89114-5645
Attn: Medicaid Compliance Officer

What to do if you have an appeal or a grievance

How Member Services can help you:

Call and talk to a Member Advocate whenever you have a problem of any kind with HPN Medicaid or any of our doctors, providers or services. The phone number is **1-800-962-8074.**

Our Member Services team is here to help you. We can help you fill out the forms and get ready for the hearing. This help includes different ways for you to understand information such as interpreters and aids if you are deaf or blind. You have the right as an HPN Medicaid member to file an appeal or grievance.

Appeals

You have the right to file an **appeal** within 60 days of receiving a notice for any of the following issues:

- The covered services you requested were denied or limited
- The covered services you were receiving are reduced, suspended or stopped
- Part or all of the payment for a service you received is denied
- Your request for covered services was not responded to timely
- HPN Medicaid does not resolve your grievance or appeal timely

There are two kinds of appeals you can file:

Standard (30 days) – You can ask for a standard appeal. We will send you a letter letting you know we received your appeal **within five calendar days.** We must give you a written decision no later than 30 days after we get your appeal. We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you. If you disagree with the extended time frame, you may file a grievance with HPN Medicaid.

Expedited (72-hour review) – You may ask for an expedited appeal if your doctor believes that your health could be seriously harmed by waiting too long for a decision and is willing to support this.

We must decide on an expedited appeal no later than 72 hours after we get your appeal. We may extend this time by up to 14 days if you request an extension, or if we request an extension from the State, in order to obtain additional information and the extension benefits you.

If you disagree with the extended time frame, you may file a grievance with HPN Medicaid. We will call you whenever possible to let you know the decision. If we are unable to contact you, we will send you a written notice of our decision within two days of making the decision. If you would like your provider to ask for an appeal on your behalf, HPN Medicaid must receive written consent from you.

If we decide your request for an expedited appeal does not meet the criteria, we will change it to a standard appeal. We will let you know verbally, whenever possible, and send you written notice within two calendar days. If any doctor asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, we may give you an expedited appeal. Your doctor will need to provide medical records or a letter to support this request.

Who may file an appeal:

- You, the adult member
- The parent or guardian of a minor member
- A person named by you as your authorized representative
- A provider acting for you as your authorized representative

You **must** give written permission for someone to file an appeal for you. They would be your authorized representative.

What do I include with my appeal?

You can call Member Services to file an appeal, or write to Member Services with your name, address, member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish or you may authorize another adult to do so on your behalf. We will consider any additional information submitted as long as it is provided before a decision is made on your appeal.

How to file a standard appeal: You or your authorized representative can call to file an oral appeal, mail or hand-deliver your written appeal to:

Health Plan of Nevada Medicaid
2720 North Tenaya Way
P.O. Box 14865
Las Vegas, NV 89114-4865

In-person service is available Monday–Friday, 10:00 a.m.–3:00 p.m., by appointment only. Please call us to schedule an appointment and a member of our team would be happy to assist you.

Standard appeals may be filed by calling our Member Services Department at **1-800-962-8074,** 8:00 a.m.–6:00 p.m., Monday–Friday.

How to file an expedited appeal: You or your doctor acting on your behalf, or your authorized representative should contact us by telephone or fax:

Fax #: **702-266-8813**

TTY/TTD: **1-800-349-3538**

Toll-Free: **1-800-962-8074**

If your doctor is acting on your behalf, your written consent must be sent to HPN Medicaid.

Appeal form

This form is to help you file an appeal. You can fill out the form and send it to us or call Member Services at **1-800-962-8074** to file an appeal.

Health Plan of Nevada Medicaid
Attn: Customer Response and Resolution Department
P.O. Box 14865
Las Vegas, NV 89145

Your request to file an appeal must be received within 60 days from the date on the denial letter.

Please print

Member Name _____

Member ID _____

Address _____

City _____ State _____ ZIP Code _____

Telephone Number _____

Description of Denied Service _____

Date of Denial _____

Share information you would like considered in your appeal and why you feel the plan should approve your request:

_____

_____

_____

_____

Please attach any evidence you would like us to consider during the appeal process.

Authorized Representative (if you have one) _____
Please complete the Appointment of an Authorized Representative form.

Member's Signature _____ Date _____

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Appointment of an Authorized Representative form

You may have someone act on your behalf in an appeal. The person you list below will be your authorized representative. We cannot speak with anyone on your behalf until we receive your written approval. Please send your written approval to:

Health Plan of Nevada Medicaid
Attn: Customer Response and Resolution Department
P.O. Box 14865
Las Vegas, NV 89145

I, _____ want the following person to act for me in my appeal.
(Member Name printed)

I understand that Personal Health Information related to my appeal may be given to my authorized representative.

A. Please print the name of your authorized representative _____

Relationship of the representative to the member _____

B. Address of authorized representative:

P.O. Box/Street/Apartment # _____

City _____ State _____ ZIP Code _____

Telephone Number _____

C. Brief description of the appeal being submitted by your authorized representative:

_____

_____

D. Authorized Representative Signature _____ Date _____

E. Member Signature _____ Date _____

Relationship to member: ☐ Self ☐ Parent ☐ Guardian

This form is valid during the appeal indicated in item **C.** Once the appeal is complete, this form is no longer valid.

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State Fair Hearing

If you still do not agree with our decision, after all of HPN Medicaid's appeals have been completed, you or your authorized representative can ask for a **State Fair Hearing** by contacting the Nevada Medicaid Hearings Unit at **1-775-684-3604** or mail your request to 9850 Double R Blvd., Suite 200, Reno, NV 89521. You must ask for this hearing within 90 days of receiving the final Appeal Notice from HPN Medicaid. You must give written permission for someone to request a State Fair Hearing for you. You may also request a State Fair Hearing if we fail to make our decision in a timely manner that is within the time frames described in this section.

If you need information or help, call the State Medicaid Office at:

Las Vegas: **702-668-4200** or **1-800-992-0900**

All other areas: **1-866-569-1746**

If you need legal assistance, call the Legal Services Program:

Clark County: **702-386-0404** or **1-866-432-0404**

https://nevadalegalservices.org/contact/

If you need information or help, call HPN Medicaid at:

Toll-Free: **1-800-962-8074**

TTY/TTD 711: **1-800-349-3538**

We can help you through the grievance and appeals process. Interpreter services are available. We can help you or your representative get a ride to the hearing. **We are available from 8:00 a.m.–6:00 p.m., Monday–Friday.** You have a right to review your case file, including medical records and any other documents and records used during the appeals process.

Expedited Fair Hearing

An expedited State Fair Hearing can be requested if the time allowed for a standard State Fair Hearing may put a person's life, health or ability to function at risk. The request must be submitted with all of the medical information that shows why a faster process is needed. A request for the rushed Fair Hearing can be made online, by telephone, in person or in writing.

Continuation of service

If you would like to appeal a Notice of Action or Adverse Determination you have received from HPN Medicaid, you can request to have covered services you are receiving continued during the appeal or State Fair Hearing process.

You will need to make the request for continuation of covered services within ten (10) calendar days of the date of the Notice of Action if your Appeal or State Fair Hearing involves the following:

- The termination of covered services,
- The suspension of covered services, or
- The reduction of covered services.

Your request for continuation of covered services can be made as long as the continued covered services were ordered by an authorized provider. Your request will be considered as long as the original periods covered by the original authorization have not expired or your request has not exceeded the intended effective date of HPN Medicaid's proposed action.

If your covered benefits are continued by HPN Medicaid pending the outcome of an Appeal or State Fair Hearing, they will be continued until one of the following occurs:

- You withdraw your Appeal or State Fair Hearing;
- Ten (10) calendar days pass after the notice of action is mailed (unless the enrollee requests an Appeal or State Fair Hearing and continuation of benefits until the hearing decision is reached);
- The hearing officer issues an adverse decision to the enrollee; or
- The time period governing service limits of a previously authorized service have been met.

If you do not win your appeal or State Fair Hearing, you may be required to pay for the services that you received during the Appeal and State Fair Hearing process.

Grievances

You have the right to file a **grievance** if you have an issue with:

- Services you received through HPN Medicaid
- The care or services you received from one of our doctors or other health care providers
- You disagree with our decision to extend the time frame up to 14 days to resolve your appeal
- You disagree with our decision to process your appeal as standard, instead of expedited
- You may file a grievance in three ways:
  - Call us at **1-800-962-8074**
  - Write to:
    Health Plan of Nevada Medicaid
    P.O. Box 14865
    Las Vegas, NV 89114
  - File a grievance directly with the state

You can also file a grievance with the state. They will send the information to us to resolve. We take your grievance seriously and will try to get it settled to your satisfaction. If you need help filing a grievance, just call our Member Services Department at **1-800-962-8074.** Our representatives will be happy to help you. You must give written permission for someone to file a grievance for you, even your doctor. Oral interpreter services are also available. Once we receive your grievance, the following will occur:

- We will send you a letter within five calendar days. It will tell you that we have received your grievance. Our staff may also contact you to make sure they understand the situation.
- **Within 45 days** of the day we receive your grievance, we will send you a letter letting you know the outcome. We may extend this time up to 14 calendar days if additional information is needed and the extension will benefit you.

Member rights and responsibilities

If you have any questions, call us at 1-800-962-8074, TTY **711.**

Health Plan of Nevada Medicaid members have the right:

- To be treated with respect and dignity and every effort made to protect their privacy
- The freedom to select a primary care physician including specialists as their PCP if the recipient has a chronic condition from HPN Medicaid's extensive provider list including the right to refuse care from specific practitioners. Members may contact Customer Service for assistance in making a selection or changes.
- To be provided the opportunity to voice grievances appeals about the plan and/or the care provided and to pursue resolution of the grievance or appeal
- To receive information about the plan, its services, its providers, and members' rights and responsibilities in a manner and format that is easily understood and in languages (other than English) that are commonly used in the service area
- To participate with their primary care physician in the decision-making process regarding health care, including the right to refuse treatment
- To have timely access to care and services, taking into account the urgency of their medical needs. The member has the right to direct contact with qualified clinical staff. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.
- To have a candid discussion of available treatment options and alternatives for your conditions, regardless of cost or benefit coverage
- To ensure they are free to exercise their rights without HPN Medicaid, the HPN Medicaid providers or Nevada Medicaid treating the member adversely
- To have direct access to women's health services for routine and preventive care. Female members have access to the necessary providers for women's routine and preventive health care services. This is in addition to the member's designated PCP, if that source is not a women's health specialist. Customer Service can assist with this selection.
- To have direct access to medically necessary specialist care, in conjunction with an approved treatment plan developed with the primary care physician/dentist. Required authorizations should be for an adequate number of direct access visits.

- To have access to emergency health care services in cases where a "prudent layperson" acting reasonably would have believed that an emergency existed. Emergency care is available twenty-four (24) hours per day, seven (7) days per week. The member has access to emergency services after business hours and on weekends. Members and providers have the right to direct contact with qualified clinical staff. Unrestricted access to emergency services whether in or out-of-network.
- To have adequate and timely services outside the network, if HPN Medicaid's network is unable to provide necessary services covered under your contract
- To have a second opinion, at no cost, from a qualified health care professional within the network or arrangements made for you to obtain one outside the network
- To formulate Advance Directives
- To have access to medical records in accordance with applicable state and federal laws, including the ability to request and receive a copy of medical records, and request that the medical records be amended or corrected, as specified in federal regulation
- To have available oral interpretation services free of charge for all non-English languages
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulation on the use of restraints and seclusion
- To make recommendations regarding the organization's members' rights and responsibilities policies
- To continuation of on-going care corresponding to a plan of care at the time of enrollment

Health Plan of Nevada Medicaid members have the responsibility:

- To know how HPN Medicaid's Managed Care Program operates
- To cooperate with those providing health care services, including providers and health plan staff
- To provide, to the extent possible, information that HPN Medicaid and its providers need in order to provide the best care possible
- To follow instructions and guidelines given by those providing healthcare services
- To take responsibility for maximizing health habits and to follow the health care plan that the member, physician and HPN Medicaid have agreed upon
- To consult with a primary care physician and HPN Medicaid before seeking non-emergency care in the service area. We encourage members to consult their physician and HPN Medicaid when receiving urgently needed care while temporarily outside the HPN Medicaid service area.

- To obtain a written referral from a physician before going to a specialist
- To obtain prior authorization from HPN Medicaid and a physician for any routine or elective surgery, hospitalization, or diagnostic procedures
- To be on time for appointments and provide timely notification when canceling any appointment a member cannot keep
- To avoid knowingly spreading disease
- To recognize the risks and limitations of medical care and the health care professional
- To be aware of the health care provider's obligation to be reasonably efficient and equitable in providing care to other patients in the community
- To show respect for other patients, health care providers and plan representatives
- To abide by administrative requirements of HPN Medicaid, health care providers, and government health benefit programs
- To report wrongdoing and fraud to appropriate resources or legal authorities
- To know their medications
- To address medication refill needs at the time of an office appointment. To report all side effects of medications to their primary care provider and to notify their primary care provider/dentist if they stop taking their medications.
- To ask questions during an appointment regarding physical complaints, medications, any side effects, etc.
- To participate in understanding their health problems and developing mutually agreed upon treatment goals
- To report any on-going care corresponding to a plan of care at the time of enrollment
- To report any third-parties responsible for payment of services

How do I request disenrollment from my plan?

Disenrollment

If you are new to Medicaid or if you lose coverage for 2 months or more, you can switch health plans within the first 90 days of enrollment. To switch health plans within the first 90 days of enrollment, contact Nevada Medicaid. After 90 days, you will be locked into your health plan until the next open enrollment period or you must show good cause for switching health plans. The open enrollment period is October each year or as determined by the State of Nevada.

After this 90-day period, you will be "locked in" to your health plan. You may submit your request for disenrollment to HPN Medicaid verbally or in writing. HPN Medicaid will determine if there is "good cause" for switching plans.

"Good cause" can include:

- Moving outside Clark County
- Disruptions in long term services and supports because a provider left the network
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Contract, lack of access to Providers experienced in dealing with the member's health care needs

Switching to a different health plan because a provider or facility is not in network is not considered "good cause." You can call HPN Medicaid Member Services at **1-800-962-8074** to learn more or to request disenrollment.

You may also complete the Good Cause Disenrollment form at **https://dhcfp.nv.gov/Members/BLU/MCO_Good_Cause_Disenrollment/** and email your request for disenrollment to **GP_Medicaid@uhc.com.**

Information to include in your request for disenrollment is:

- Member name
- Member Medicaid number
- Member Social Security number
- Member date of birth
- Head of household name
- Head of household Medicaid number
- Head of household Social Security number
- Head of household date of birth
- Current contact information
  - Address and telephone number
- The plan you want to switch to

HPN Medicaid will make a disenrollment decision as quickly as your health requires. After receiving your request, HPN Medicaid will make a decision within 14 calendar days. If approved, you will be disenrolled no later than the first day of the second month following the request. When you request to change health plans for Good Cause, you can give the name of the health plan you want to switch to, or the State can choose for you.

We hope you will want to stay with Health Plan of Nevada Medicaid as long as you are on Medicaid, and that you will let us know how we can serve you better.

If you are no longer on Medicaid

You must be on Medicaid to be enrolled in the HPN Medicaid plan. If you lose your coverage and are disenrolled from HPN Medicaid, the Nevada Medicaid office will let us know. Once you are reinstated, you may be auto-assigned as follows: by family affiliation (if other family members are enrolled into a certain health plan); by history (if you were previously enrolled with HPN Medicaid, you will be assigned back to us); or randomly assigned.

Nevada Check Up premium payments are due on the first day of each quarter – January 1, April 1, July 1 and October 1. Failure to pay the quarterly premium will result in loss of insurance coverage under Nevada Check Up.

When you should contact us

As you look through this handbook, you will probably notice that we urge you to call us or your doctor often. We are better able to help you when you stay in touch with us. You may ask us for:

- A provider list
- Your rights and responsibilities as a member of HPN Medicaid
- Information on grievances and appeals
- Benefits, including how to get them
- Prior authorization requirements
- Family planning services
- After-hours and emergency services information, including how, where and when to get services
- Referral to specialists
- Post-stabilization services
- How to get Medicaid benefits that are not available through HPN Medicaid
- Information on the structure and operations of our health plan
- Information regarding quality performance indicators
- Enrollee satisfaction survey results
- Physician incentive plans

Here are some examples of when you should contact us (call Member Services at 1-800-962-8074):

- When you are already getting care when you join HPN Medicaid
- With any questions about your HPN Medicaid benefits
- If you need an updated or printed copy of this handbook
- If you want to change your/your child's PCP
- Whenever you move, even if you still live within the HPN Medicaid service area. Let us know if you plan to leave the service area for more than a month, or move away.
- If your phone number changes
- If you are pregnant, or have a baby
- If you are covered by any health benefits, in addition to your HPN Medicaid. For example, tell us:
  - If you have a health insurance policy
  - If you get workers' compensation for a problem that happened on the job
  - If you receive an insurance payment after being in an accident
  - If you are in a car accident or hurt through no fault of your own
- If you have a problem getting the health care you need
- With an issue or concern about HPN Medicaid or one of our doctors or other health care providers
- If you think you want to leave the HPN Medicaid plan
- If you have a suggestion you think would improve HPN Medicaid services or programs

When we might contact you

From time to time, we will send you important information that you should keep with this handbook — like news about:

- Changes to your HPN Medicaid benefits or plan;
- Changes to the list of doctors and network of providers you can use; or
- Information about our special programs and benefits.

We may also call you or send you a survey form to ask how you like the HPN Medicaid plan and what you think of your doctor and other health services. What you think is very important to us.

We may also send you a letter if you are hurt or injured in a motor vehicle accident through no fault of your own. This letter will ask you to call us and let us know if there is another insurance company that might help pay for your medical care. We call this situation Third Party Liability. All we ask is that you call us and let us know if there is another insurance company; we will contact them. If there isn't, we will pay for the medical care. You are not responsible for the cost of this care.

Health care terms

Health care made simple

A basic understanding of these words will make it easier for you to use your health plan:

Appeal – A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.

Copayment – A payment paid by you in order to receive medical care.

Durable Medical Equipment (DME) – Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency Medical Condition – An emergency means your life could be threatened or you could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. It you are pregnant, it could mean harm to the health of you or your unborn baby.

Emergency Medical Transportation – Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.

Emergency Room Care – A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.

Emergency Services – Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.

Excluded Services – Services that are not covered under the Medicaid benefit.

Grievance – A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Habilitation Services and Devices – Services and devices that help you keep, learn, or improve skills and functioning for daily living.

Health Insurance – Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.

Home Health Care – Health care services a person receives in the home including nursing care, home health aide services and other services.

Other plan details

Hospice Services – A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization – The act of placing a person in a hospital as a patient.

Hospital Outpatient Care – Care or treatment that does not require an overnight stay in a hospital.

Medically Necessary – This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Nevada Medicaid coverage rules.

Network – A directory of doctors, health care professionals, hospitals, and health care facilities that a plan has contracted with to provide medical care to its members.

Non-Participating Provider – A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan.

Participating Provider – Providers, hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports that are contracted with your health plan. Participating providers are also "in-network providers" or "plan providers."

Physician Services – Care provided to you by an individual licensed under state law to practice medicine, surgery, behavioral health.

Plan – Plan refers to a Managed Care Organization offering medical services to its members.

Pre-Authorization – A decision by your plan or Nevada Medicaid that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification.

Premium – A monthly payment a health plan receives to provide you with health care coverage.

Prescription Drug Coverage – Prescription drugs or medications covered (paid) by your health plan. Some over-the -counter medications are covered.

Prescription Drugs – A drug or medication that, by law, can be obtained only by means of a physician's prescription.

Primary Care Physician – The doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.

Primary Care Provider – Physicians who practice general medicine, family medicine, general internal medicine, general pediatrics, or osteopathic medicine. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often, they are the first person you should contact if you need health care. Physicians who practice obstetrics and gynecology may function as PCPs for the duration of the health plan member's pregnancy.

Provider – A person who is authorized to give health care or services. Examples of providers include doctors, nurses, behavioral health providers, nursing homes and specialists.

Rehabilitation Services and Devices – Treatment you get to help you recover from an illness, accident, or major operation to restore you to the best possible functional level.

Skilled Nursing Care – Assessments, judgments, interventions and evaluations of intervention, which require the training and experience of a licensed nurse. Skilled Nursing care includes, but is not limited to:

1. Performing assessments to determine the basis for action or the need for action;
2. Monitoring fluid and electrolyte balance;
3. Suctioning of the airway;
4. Central venous catheter care;
5. Mechanical ventilation; and
6. Tracheotomy care.

Specialist – A doctor who provides health care for a specific disease or part of the body.

Urgent Care – Care when you need to see a doctor and your doctor is not able to see you or the office is closed. Care is needed for a sudden illness, injury, or condition that is not an emergency but needs to be treated right away.

Health Plan Notices of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2025

By law, we[1] must protect the privacy of your health information ("HI"). We must send you this notice. It tells you:

- How we may use your HI.
- When we can share your HI with others.
- What rights you have for your HI.

By law, we must follow the terms of our current notice.

HI is information about your health or medical services. We have the right to make changes to this notice of privacy practices. If we make important changes, we will notify you by mail or e-mail. We will also post the new notice on our website. Any changes to the notice will apply to all HI we have. We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

How We Collect, Use, and Share Your Information

We collect, use and share your HI with:

- You or your legal or personal representative.
- Certain Government agencies. To check to make sure we are following privacy laws.

We have the right to collect, use and share your HI for certain purposes. This may be for your treatment, to pay for your care, or to run our business. We may use and share your HI as follows.

- **For Payment.** To process payments and pay claims. For example, we may tell a doctor whether we will pay for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment or Managing Care.** To help with your care. For example, we may share your HI with a hospital you are in, to help them provide medical care to you.
- **For Health Care Operations.** To run our business. For example, we may talk to your doctor to tell him or her about a special disease management or wellness program available to you. We may study data to improve our services.

- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** If you receive health insurance through your employer, we may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** To make health insurance underwriting decisions. We will not use your genetic information for underwriting purposes.
- **For Reminders on Benefits or Care.** We may send reminders about appointments you have and information about your health benefits.
- **For Communications to You.** We may contact you about your health insurance benefits, healthcare or payments.

We may collect, use, and share your HI as follows.

- **As Required by Law.** To follow the laws that apply to us.
- **To Persons Involved with Your Care.** A family member or other person that helps with your medical care or pays for your care. This also may be to a family member in an emergency. This may happen if you are unable to tell us if we can share your HI or not. If you are unable to tell us what you want, we will use our best judgment. If allowed, after you pass away, we may share HI with family members or friends who helped with your care or paid for your care.
- **For Public Health Activities.** For example, to prevent diseases from spreading or to report problems with products or medicines.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with certain entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings,** for example, to answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** To public health agencies or law enforcement, for example, in an emergency or disaster.
- **For Government Functions.** For military and veteran use, national security, or certain protection services.
- **For Workers' Compensation.** If you were hurt at work or to comply with employment laws.
- **For Research.** For example, to study a disease or medical condition. We also may use HI to help prepare a research study.

- **To Give Information on Decedents.** For example, to a coroner or medical examiner who may help identify the person who died, why they died, or to meet certain laws. We also may give HI to funeral directors.
- **For Organ Transplant.** For example, to help get, store or transplant organs, eyes or tissues.
- **To Correctional Institutions or Law Enforcement.** For persons in custody, for example: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates.** To give you services, if needed. These are companies that provide services to us. They agree to protect your HI.
- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
  1. Alcohol and Substance Use Disorder
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive or Sexual Health
  11. Sexually Transmitted Diseases

We will only use or share your HI as described in this notice or with your written consent. We will get your written consent to share psychotherapy notes about you, except in certain cases allowed by law. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain marketing mailings. If you give us your consent, you may take it back. To find out how, call the phone number on your health insurance ID card.

Your Rights

You have the following rights for your medical information.

- **To ask us to limit** our use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others that help with your care or pay for your care. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.** Your request to limit our use or sharing must be made in writing.

- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request as allowed by state and federal law. We take verbal requests but may ask you to confirm your request in writing. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy of certain HI.** You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. We will respond to your request in the time we must do so under the law. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of when we shared your HI in the six years prior to your request. This will not include when we shared HI for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website.
- **In certain states, you may have the right to ask that we delete your HI.** Depending on where you live, you may be able to ask us to delete your HI. We will respond to your request in the time we must do so under the law. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

Using Your Rights

- **To Contact your Health Plan.** If you have questions about this notice, or you want to use your rights, **call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at 1-866-633-2446, or TTY/RTT 711.
- **To Submit a Written Request.** Mail to:
  UnitedHealthcare Privacy Office
  MN017-E300, P.O. Box 1459, Minneapolis MN 55440
- **To File a Complaint or Grievance.** If you think your privacy rights have been violated, you may send a complaint or grievance at the address above.

You may also notify the Secretary of the U.S. Department of Health and Human Services. We will not take any action against you for filing a complaint.

[1] This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2.**

Financial Information Privacy Notice

THIS NOTICE SAYS HOW YOUR FINANCIAL INFORMATION MAY BE USED AND SHARED. REVIEW IT CAREFULLY.

Effective January 1, 2025

We[2] protect your "personal financial information" ("FI"). FI is non-health information. FI identifies you and is generally not public.

Information We Collect

- We get FI from your applications or forms. This may be name, address, age and social security number.
- We get FI from your transactions with us or others. This may be premium payment data.

Sharing of FI

We will only share FI as permitted by law.

We may share your FI to run our business. We may share your FI with our Affiliates. We do not need your consent to do so.

- We may share your FI to process transactions.
- We may share your FI to maintain your account(s).
- We may share your FI to respond to court orders and legal investigations.
- We may share your FI with companies that prepare our marketing materials.

Confidentiality and Security

We limit employee and service provider access to your FI. We have safeguards in place to protect your FI.

Questions About This Notice

Please **call the toll-free member phone number on health plan ID card** or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446, or TTY/RTT 711.

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Health Care Solutions, Inc.; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2.**

Notice of Availability of Language Assistance Services and Alternative Formats: https://www.uhc.com/communityplan/non-discrimination-notice

We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-962-8074,** TTY **711.** You can also visit our website at **MyHPNMedicaid.com.**

Health Plan of Nevada Medicaid
2720 North Tenaya Way, Suite 102
Las Vegas, Nevada 89128

MyHPNMedicaid.com

1-800-962-8074, TTY **711**

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