



HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

HPN Solutions HMO 20

Attachment A Benefit Schedule

The Calendar Year Out of Pocket Maximum is \$6,000 per Member and \$12,000 per family.

The Out Of Pocket Maximum does not include; 1) amounts charged for non-Covered Services, 2) amounts exceeding applicable Plan benefit maximums or EME payments; or, 3) penalties for not obtaining any required Prior Authorization or for the Member otherwise not complying with HPN's Managed Care Program.

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
<p>Medical Office Visits and Consultations in a Medical Office Setting</p> <ul style="list-style-type: none"> • Primary Care Services <ul style="list-style-type: none"> Convenient Care Facility Physician Extender or Assistant Physician • Specialist Services <p>Preventive Healthcare Services - <i>Services include various recommended exams, immunizations, diagnostic tests and screenings. Refer to the HPN Preventive Guidelines on the HPN website (www.healthplanofnevada.com) located under the "Members & Guests" tab or contact the Member Services Department (702-242-7300) for the complete list of covered Adult and Pediatric Preventive Services and Immunizations. These guidelines are updated in accordance with the Federal Government standards.</i></p> <p>Routine Lab and X-ray services provided and billed by the Physician's office. <i>(Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician's office.)</i></p> <ul style="list-style-type: none"> • Lab • X-Ray 	<p>No</p> <p>Yes</p> <p>No</p> <p>Yes</p>	<p>Member pays \$10 per visit.</p> <p>Member pays \$10 per visit.</p> <p>Member pays \$20 per visit.</p> <p>Member pays \$40 per visit.</p> <p>Member pays \$0 per visit.</p> <p>Member pays \$10 per visit. Member pays \$25 per visit.</p>

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Telemedicine Services <i>(Only available through select Providers.)</i>	No	Member pays \$10 per visit.
Laboratory Services – Outpatient <i>Performed at an independent facility.</i>	Yes	Member pays \$10 per visit.
Routine Radiological and Non-Radiological Diagnostic Imaging Services <i>Performed at a Free-Standing Diagnostic Center.</i>	Yes	Member pays \$25 per visit.
Emergency Services <ul style="list-style-type: none"> • Urgent Care Facility • Emergency Room Visit • Hospital Admission – Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i> 	No No No	Member pays \$25 per visit. Member pays \$200 per visit; waived if admitted. Member pays \$500 per admission.
Ambulance Services <ul style="list-style-type: none"> • Emergency Transport • Non-Emergency – HPN Arranged Transfers 	No Yes	Member pays \$200 per trip. Member pays \$0.
Inpatient Hospital Facility Services <i>Elective and Emergency Post-Stabilization Admissions</i>	Yes	Member pays \$500 per admission.
Outpatient Surgery at a Hospital Facility	Yes	Member pays \$250 per surgery.
Ambulatory Surgical Facility Services	Yes	Member pays \$100 per surgery.
Anesthesia Services	Yes	Member pays \$150 per surgery.
Physician Surgical Services – Inpatient and Outpatient <ul style="list-style-type: none"> • Inpatient or Outpatient Hospital Facility • Ambulatory Surgical Facility • Physician’s Office Primary Care Physician (Includes all physician services related to the surgical procedure) Specialist (Includes all physician services related to the surgical procedure) 	Yes Yes No Yes	Member pays \$100 per surgery. Member pays \$50 per surgery. Member pays \$20 per visit. Member pays \$40 per visit.

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<p>Gastric Restrictive Surgery Services <i>HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.</i></p> <ul style="list-style-type: none"> • Physician Surgical Services • Physician Office Visit 	Yes	<p>Member pays \$2,500 per surgery. Subject to maximum benefit.</p> <p>Member pays \$40 per visit.</p>
<p>Organ and Tissue Transplant Surgical Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Physician Surgical Services – Inpatient Hospital Facility • Transportation, Lodging and Meals <i>The maximum benefit per Member per Transplant Benefit Period for transportation, lodging and meals is \$10,000. The maximum daily limit for lodging and meals is \$200.</i> • Procurement <i>Benefits for procurement procedures and/or services are limited to those deemed by HPN to be Medically Necessary and appropriate for an approved Organ Transplant in a single Transplant Benefit Period.</i> • Retransplantation Services <i>Benefits are limited to one (1) Medically Necessary Retranplantation per Member per type of transplant.</i> 	Yes Yes Yes Yes Yes	<p>Member pays \$500 per admission.</p> <p>Member pays \$100 per surgery.</p> <p>Member pays \$0. Subject to maximum benefit.</p> <p>Member pays \$0.</p> <p>HPN pays 50% of EME. Subject to maximum benefit.</p>
<p>Post-Cataract Surgical Services</p> <ul style="list-style-type: none"> • Frames and Lenses • Contact Lenses <p><i>Benefits are limited to one (1) Medically Necessary pair of glasses or set of contact lenses as applicable per Member per surgery.</i></p>	Yes Yes	<p>\$10 per pair of glasses. Subject to maximum benefit.</p> <p>\$10 per set of contact lenses. Subject to maximum benefit.</p>
<p>Home Healthcare Services (does not include Specialty Prescription Drugs) <i>Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drugs.</i></p>	Yes	Member pays \$35 per visit.

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<p>Hospice Care Services</p> <ul style="list-style-type: none"> • Inpatient Hospice Facility • Outpatient Hospice Services • Inpatient and Outpatient Respite Services <i>Benefits are limited to a combined maximum benefit of five (5) Inpatient days or five (5) Outpatient visits per Member per ninety (90) days of Home Hospice Care.</i> <ul style="list-style-type: none"> • Inpatient • Outpatient • Bereavement Services <i>Benefits are limited to a maximum benefit of five (5) group therapy sessions. Treatment must be completed within six (6) months of the date of death of the Hospice patient.</i> 	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$500 per admission.</p> <p>Member pays \$0 per visit.</p> <p>Member pays \$500 per admission. Subject to maximum benefit.</p> <p>Member pays \$40 per visit. Subject to maximum benefit.</p> <p>Member pays \$20 per visit. Subject to maximum benefit.</p>
<p>Skilled Nursing Facility <i>Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.</i></p>	<p>Yes</p>	<p>Member pays \$300 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.</p>
<p>Manual Manipulation <i>Applies to Medical-Physician Services and Chiropractic office visit. Subject to a maximum benefit of twenty (20) visits per Member per Calendar Year.</i></p>	<p>Yes</p>	<p>Member pays \$20 per visit. Subject to maximum benefit.</p>
<p>Short-Term Rehabilitation and Habilitative Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient <p><i>All Inpatient and Outpatient Short Term Rehabilitation and Habilitative Services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.</i></p>	<p>Yes</p> <p>Yes</p>	<p>Member pays \$300 per admission. Subject to maximum benefit.</p> <p>Member pays \$20 per visit. Subject to maximum benefit.</p>
<p>Durable Medical Equipment <i>Monthly rental or purchase at HPN's option. Purchases are limited to a single purchase of a type of DME, including repair and replacement, every three (3) years.</i></p>	<p>Yes</p>	<p>Member pays \$0. Subject to maximum benefit.</p>

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<p>Genetic Disease Testing Services</p> <ul style="list-style-type: none"> • Office Visit • Lab <i>Includes Inpatient, Outpatient and independent Laboratory Services.</i> 	Yes	<p>Member pays \$40 per visit.</p> <p>Member pays \$40 per test.</p>
<p>Infertility Office Visit Evaluation <i>Please refer to applicable surgical procedure Copayment/Cost-share herein for any surgical infertility procedures performed.</i></p>	Yes	Member pays \$40 per visit.
<p>Medical Supplies</p>	Yes	Member pays \$0.
<p>Other Diagnostic and Therapeutic Services <i>Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician's office or at an independent facility.</i></p> <ul style="list-style-type: none"> • Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services. • Dialysis • Therapeutic Radiology • Allergy Testing and Serum Injections • Otologic Evaluations • Other complex diagnostic imaging services such as Positron Emission Tomography (PET) scans, CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services. 	Yes	<p>Member pays \$20 per day.</p> <p>Member pays \$20 per day.</p> <p>Member pays \$20 per day.</p> <p>Member pays \$20 per visit.</p> <p>Member pays \$20 per visit.</p> <p>Member pays \$100 per test or procedure.</p>
<p>Prosthetic Devices <i>Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.</i></p>	Yes	Member pays \$750 per device. Subject to maximum benefit.
<p>Orthotic Devices <i>Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.</i></p>	Yes	Member pays \$50 per device. Subject to maximum benefit.

Benefit Schedule

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<p>Self-Management and Treatment of Diabetes</p> <ul style="list-style-type: none"> • Education and Training • Supplies (except for Insulin Pump Supplies) <ul style="list-style-type: none"> Insulin Pump Supplies • Equipment (except for Insulin Pump) <ul style="list-style-type: none"> Insulin Pump <p><i>Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.</i></p>	<p>No</p> <p>No</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$20 per visit.</p> <p>Member pays \$5 per therapeutic supply.</p> <p>Member pays \$10 per therapeutic supply.</p> <p>Member pays \$20 per device.</p> <p>Member pays \$100 per device.</p>
<p>Special Food Products and Enteral Formulas <i>Special Food Products only are limited to a maximum benefit of one (1) thirty (30) day therapeutic supply per Member four (4) times per Calendar Year.</i></p>	<p>Yes</p>	<p>Member pays \$0. Subject to maximum benefit.</p>
<p>Temporomandibular Joint Treatment</p>	<p>Yes</p>	<p>HPN pays 50% of EME.</p>
<p>Mental Health and Severe Mental Illness</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Treatment 	<p>Yes</p> <p>Yes</p>	<p>Member pays \$500 per admission.</p> <p>Member pays \$20 per visit.</p>
<p>Substance Abuse Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Treatment 	<p>Yes</p> <p>Yes</p>	<p>Member pays \$500 per admission.</p> <p>Member pays \$20 per visit.</p>
<p>Hearing Aids <i>Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.</i></p>	<p>Yes</p>	<p>Member pays \$0. Subject to maximum benefit.</p>
<p>Applied Behavioral Analysis (ABA) for the treatment of Autism <i>Limited to two hundred fifty (250) visits not to exceed seven hundred fifty (750) total hours of therapy per Member per Calendar Year.</i></p>	<p>Yes</p>	<p>Member pays \$20 per visit. Subject to maximum benefit.</p>

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A Member's Copayment/cost-share will not be more than 50% of the allowed cost of providing any single service or supplying an item to a Member, after the deductible, if applicable, has been met. A Member may not contribute any more than the individual CYD amount toward the family CYD amount. A Member may not contribute any more than the individual Calendar Year Out of Pocket Maximum toward the family Calendar Year Out of Pocket Maximum amount.

Please note: For all Inpatient and Outpatient admissions, including those for Emergency or Urgent Care, in addition to specified surgical Copayment/cost-share amounts, Member is also responsible for all other applicable facility and professional Copayments/cost-share as outlined in the Attachment A Benefit Schedule.

Member is responsible for any and all amounts exceeding any stated maximum benefit amounts and/or any/all amounts exceeding the Plan's payment to Non-Plan Providers under this Plan. Further, such amounts do not accumulate to the calculation of the Calendar Year Out of Pocket Maximum.

*Referral or Prior Auth. Required – Except as otherwise noted and, with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness and Substance Abuse Services, all Covered Services not provided by the Member's Primary Care Physician require a Referral or a Prior Authorization in the form of a written referral authorization from HPN. Please refer to your HPN Evidence of Coverage for additional information.