HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

HPN Solutions HMO 15 V2

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
Medical Office Visits and Consultations in a Medical Office Setting		
• **Primary Care Services**	No	
Convenient Care Facility		Member pays $5 per visit.
Physician Extender or Assistant		Member pays $5 per visit.
Physician		Member pays $15 per visit.
• **Specialist Services**	Yes	Member pays $25 per visit.
Preventive Healthcare Services - *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.*	No	Member pays $0 per visit.
Routine Lab and X-ray services provided and billed by the Physician's office. (*Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician's office.)*	Yes	
• Lab		Member pays $0 per visit.
• X-Ray		Member pays $0 per visit.

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Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Telemedicine Services *(Only available through select Providers.)*	No	Member pays $5 per visit.
Laboratory Services – Outpatient *Performed at an independent facility.*	Yes	Member pays $0 per visit.
Routine Radiological and Non-Radiological Diagnostic Imaging Services *Performed at a Free-Standing Diagnostic Center.*	Yes	Member pays $0 per visit.
Emergency Services		
• Urgent Care Facility	No	Member pays $30 per visit.
• Emergency Room Visit	No	Member pays $150 per visit; waived if admitted.
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	No	Member pays $300 per admission.
Ambulance Services		
• Emergency Transport	No	Member pays $0 per trip.
• Non-Emergency – HPN Arranged Transfers	Yes	Member pays $0.
Inpatient Hospital Facility Services *Elective and Emergency Post-Stabilization Admissions*	Yes	Member pays $300 per admission.
Outpatient Surgery at a Hospital Facility	Yes	Member pays $50 per surgery.
Ambulatory Surgical Facility Services	Yes	Member pays $50 per surgery.
Anesthesia Services	Yes	Member pays $0 per surgery.
Physician Surgical Services – Inpatient and Outpatient		
• Inpatient or Outpatient Hospital Facility	Yes	Member pays $0 per surgery.
• Ambulatory Surgical Facility	Yes	Member pays $0 per surgery.
• Physician's Office Primary Care Physician (Includes all physician services related to the surgical procedure)	No	Member pays $0 per visit.
Specialist (Includes all physician services related to the surgical procedure)	Yes	Member pays $25 per visit.

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Gastric Restrictive Surgery Services *HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.*	Yes	
• Physician Surgical Services		HPN pays 50% of EME. Subject to maximum benefit.
• Physician Office Visit		Member pays $25 per visit.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	Member pays $300 per admission.
• Physician Surgical Services – Inpatient Hospital Facility	Yes	Member pays $0 per surgery.
• Transportation, Lodging and Meals *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.*	Yes	Member pays $0. Subject to maximum benefit.
• Procurement *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.*	Yes	Member pays $0.
• Retransplantation Services *Benefits are limited to one (1) Medically Necessary Retransplantation per Member per type of transplant.*	Yes	HPN pays 50% of EME. Subject to maximum benefit.
Post-Cataract Surgical Services		
• Frames and Lenses	Yes	$10 per pair of glasses. Subject to maximum benefit.
• Contact Lenses *Benefits are limited to one (1) Medically Necessary pair of glasses or set of contact lenses as applicable per Member per surgery.*	Yes	$10 per set of contact lenses. Subject to maximum benefit.
Home Healthcare Services (*does not include Specialty Prescription Drugs)* *Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drugs.*	Yes	Member pays $0 per visit.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Hospice Care Services		
• Inpatient Hospice Facility	Yes	Member pays $300 per admission.
• Outpatient Hospice Services	Yes	Member pays $0 per visit.
• Inpatient and Outpatient Respite Services *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.*	Yes	
◦ Inpatient		Member pays $300 per admission. Subject to maximum benefit.
◦ Outpatient		Member pays $25 per visit. Subject to maximum benefit.
• Bereavement Services *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.*	Yes	Member pays $15 per visit. Subject to maximum benefit.
Skilled Nursing Facility *Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.*	Yes	Member pays $300 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.
Manual Manipulation *Applies to Medical-Physician Services and Chiropractic office visit. Subject to a maximum benefit of sixty (60) visits per Member per Calendar Year.*	Yes	Member pays $25 per visit. Subject to maximum benefit.
Short-Term Rehabilitation and Habilitative Services		
• Inpatient Hospital Facility	Yes	Member pays $300 per admission. Subject to maximum benefit.
• Outpatient *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.*	Yes	Member pays $25 per visit. Subject to maximum benefit.
Durable Medical Equipment *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.*	Yes	Member pays $100 or 50% of EME of purchase or monthly rental price, whichever is less. Subject to maximum benefit.

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Genetic Disease Testing Services • Office Visit • Lab *Includes Inpatient, Outpatient and independent Laboratory Services.*	Yes	Member pays $25 per visit. HPN pays 75% of EME.
Infertility Office Visit Evaluation *Please refer to applicable surgical procedure Copayment/Cost-share herein for any surgical infertility procedures performed.*	Yes	Member pays $25 per visit.
Medical Supplies	Yes	Member pays $0.
Other Diagnostic and Therapeutic Services *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.* • 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 CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services. • Positron Emission Tomography (PET) scans	Yes \	Member pays $15 per day. Member pays $15 per day. Member pays $15 per day. Member pays $15 per visit. Member pays $15 per visit. Member pays $15 per test or procedure. Member pays $475 per test.
Prosthetic Devices *Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.*	Yes	Member pays $750 per device. Subject to maximum benefit.
Orthotic Devices *Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.*	Yes	Member pays $50 per device. Subject to maximum benefit.

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Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Self-Management and Treatment of Diabetes		
• Education and Training	No	Member pays $15 per visit.
• Supplies (except for Insulin Pump Supplies)	No	Member pays $5 per therapeutic supply.
Insulin Pump Supplies	Yes	Member pays $10 per therapeutic supply.
• Equipment (except for Insulin Pump)	Yes	Member pays $20 per device.
Insulin Pump	Yes	Member pays $100 per device.
Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.		
Special Food Products and Enteral Formulas *Limited to a maximum benefit of one (1) thirty (30) day therapeutic supply per Member per Calendar Year for Special Food Products only.*	Yes	Member pays $0. Subject to maximum benefit.
Temporomandibular Joint Treatment	Yes	HPN pays 50% of EME.
Mental Health and Severe Mental Illness		
• Inpatient Hospital Facility	Yes	Member pays $300 per admission.
• Outpatient Treatment	Yes	Member pays $15 per visit.
Substance Abuse Services		
• Inpatient Hospital Facility	Yes	Member pays $300 per admission.
• Outpatient Treatment	Yes	Member pays $15 per visit.
Hearing Aids *Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.*	Yes	Member pays $100 or 50% of EME of purchase price, whichever is less. Subject to maximum benefit.
Applied Behavioral Analysis (ABA) for the treatment of Autism *Limited to two hundred fifty (250) visits not to exceed seven hundred fifty (750) total hours of therapy per Member per Calendar Year.*	Yes	Member pays $15 per visit. Subject to maximum benefit.

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.