Health Plan of Nevada
A UnitedHealthcare Company

# POS 15-30/1000_2500_30%/6850-3D

## Attachment A Benefit Schedule

Amounts which the Member is required to pay as shown below in the Benefit Schedule are based on Eligible Medical Expenses (EME) or the Recognized Amount, if applicable, as defined in the Evidence of Coverage.

**Tier I HMO Benefits** apply when you obtain or arrange for Covered Services through a Health Plan of Nevada, Inc. ("HPN") contracted Primary Care Physician. No claim forms are required and the Tier I HMO benefits provide a higher level of coverage with lower Out of Pocket expenses than the Tier II or Tier III level of benefits.

**Tier II Plan Provider Benefits** apply when a Member obtains Covered Services from a Provider who is independently contracted with HPN to provide Covered Services to Members enrolled in HPN Point-of-Service ("POS") plans. The Member's Out of Pocket expenses will be higher than when accessing the Tier I HMO benefits because in most cases the Member will be responsible for a Calendar Year Deductible ("CYD"), higher Coinsurance percentages and/or higher Copayments for some services. Claim forms are not usually required when using contracted Tier II Plan Providers. Further, certain services are not covered under this Tier; please reference the following pages for detailed benefit information.

In no event will your total Out of Pocket amount paid for Eligible Medical Expenses for Tier I and Tier II Covered Services exceed your Tier II Out of Pocket maximum.

**Tier III Non-Plan Provider Benefits** apply when a Member obtains Covered Services from a Non-Plan Provider. Out of Pocket expenses are the highest with this option because all benefits are subject to a higher CYD and higher Coinsurance percentage. Claim forms must be submitted for services received from Tier III Non-Plan Providers. Further, certain services are not covered under this Tier; please reference the following pages for detailed benefit information.

**Emergency Services:** The Tier I HMO level of benefits will apply to Emergency Services provided at any duly-licensed facility. Upon admission to a Tier III Non-Plan Provider Hospital and stabilization of the emergency condition and safe for transfer status as determined by the attending physician, the Plan may require transfer to a Tier I HMO contracted facility in order to continue paying benefits at the Tier I HMO level. Benefits for Prior Authorized post-stabilization and follow-up care received at a Tier II or Tier III hospital facility are subject to the applicable benefit tier.

**Calendar Year Deductible (CYD)**: Your CYD is $1,000 of EME per Member and $2,000 of EME per Family for Tier I HMO Plan Provider Services. Your CYD is $2,500 of EME per Member and $5,000 of EME per Family for Tier II Plan Provider Services. Your CYD is $5,000 of EME per Member and $10,000 of EME per Family for Non-Plan Provider Services. An Member may not contribute any more than the Individual CYD amount toward the Family CYD amount. Further, the stated CYD maximum amounts are separate for each tier of benefits and do not accumulate to one another.

**Copayments**: This Plan includes some fixed dollar copayment amounts (which are not subject to the CYD) for certain Covered Services. Unless otherwise specifically stated, Copayments are not subject to the CYD and do not accumulate towards the satisfaction of the CYD. Please reference the following pages for detailed Cost-share information.

**Coinsurance**: After meeting any applicable CYD, your Coinsurance, if applicable, for Tier II Covered Services is 30% of EME. Your Coinsurance for most Tier III Covered Services is 50% of EME.

**Calendar Year Out of Pocket Maximum**: Your Out of Pocket expenses are limited to a combined Calendar Year maximum of $6,850 of EME per Member and $13,700 of EME per Family when using Tier I HMO or Tier II Plan Providers. Your Out of Pocket expenses are limited to a Calendar Year Maximum of $15,000 of EME per Member and $30,000 of EME per Family when using Tier III Non-Plan Providers. A Member may not contribute any more than the individual Calendar Year Out Of Pocket Maximum amount toward the applicable Family Calendar Year Out of Pocket Maximum amount.

Once the Individual Out of Pocket Maximum is met, benefits for that Individual are payable at 100% of EME for the remainder of the Calendar Year. Once the Family Out of Pocket Maximum is met by two or more enrolled family members, benefits for the entire family are payable at 100% of EME for the remainder of the Calendar Year. Further, the stated Out of Pocket Maximum amounts are separate for each tier of benefits and do not accumulate to one another.

The Tier I and II Calendar Year Out of Pocket Maximum amounts include the CYD (if applicable), Copayments and Coinsurance. The Tier III Calendar Year Out of Pocket maximum amounts includes the CYD and coinsurance.

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

**Note: You are responsible for all amounts exceeding the applicable benefit maximums, EME payments to Tier III Non-Plan Providers and penalties for not complying with HPN's Managed Care Program. Further, such amounts do not accumulate to your applicable Calendar Year Out of Pocket Maximum.**

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Medical Office Visits/Consultations and Visits in an Outpatient Setting (including Telemedicine Services)** | | | | |
| **Primary Care Services** | | | | |
| • Convenient Care Facility | No | Member pays $10 per visit. | Member pays $25 per visit. | After CYD, Member pays 50% of EME. |
| • Physician Extender or Assistant | No | Member pays $10 per visit. | Member pays $25 per visit. | After CYD, Member pays 50% of EME. |
| • Physician | No | Member pays $15 per visit. | Member pays $30 per visit. | After CYD, Member pays 50% of EME. |
| **Specialist Services** | Yes | Member pays $30 per visit. | Member pays $60 per visit. | After CYD, Member pays 50% of EME. |
| **Preventive Healthcare Services** - For a complete list of Preventive Services, including all FDA approved contraceptives, go to http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/.<br><br>If you have a question about whether or not a service is "Preventive", please contact the HPN Member Services Department (1-800-777-1840). | No | Member pays $0 per visit. | Member pays $0 per visit. | After CYD, Member pays 50% of EME. |
| **Diagnostic Breast Cancer Imaging** | Yes | Member pays $0 per visit. | Member pays $0 per visit. | After CYD, Member pays 50% of EME. |

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Non-preventive Routine Lab and X-ray Services**<br>The 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. | Yes | | | |
| • Lab | | Member pays $10 per visit. | Member pays $25 per visit. | After CYD, Member pays 50% of EME. |
| • X-Ray | | Member pays $20 per visit. | Member pays $50 per visit. | After CYD, Member pays 50% of EME. |
| **Virtual Visits** (Available through NowClinic or select contracted Providers) | No | Member pays $0 per visit. | Virtual Visits are covered under the Tier I HMO benefit. | Virtual Visits are covered under the Tier I HMO benefit. |
| **Urgent Care Facility** | No | Member pays $40 per visit. | Urgent Care Facility Services are covered under the Tier I HMO benefit. | Urgent Care Facility Services are covered under the Tier I HMO benefit. |
| **Emergency Services** | | | | |
| • Emergency Room Facility (includes Physician Services) | No | After CYD, Member pays $1,000 per visit; waived if admitted through a Hospital Emergency Room Facility. | After CYD, Member pays $1,000 per visit; waived if admitted through a Hospital Emergency Room Facility. | After CYD, Member pays $1,000 per visit; waived if admitted through a Hospital Emergency Room Facility. |
| • Hospital Admission - Emergency Stabilization (includes Physician Services) Applies until patient is stabilized and safe for transfer as determined by the attending Physician.<br><br>NOTE: Member is responsible for all amounts exceeding any applicable maximum benefit and amounts exceeding the Plan's EME payment to Non-Plan Providers. As a result, the Member will be responsible for the difference between the amount billed by the Non-Plan Provider and the reimbursement amount determined by HPN, unless prohibited by law. Such amounts do not accumulate to the Calendar Year Out of Pocket Maximum. | No | After CYD, Member pays $1,000 per day not to exceed $3,000 per admission. | After CYD, Member pays $1,000 per day not to exceed $3,000 per admission. | After CYD, Member pays $1,000 per day not to exceed $3,000 per admission. |

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Ambulance Services** | | | Emergency Ambulance Services are covered under the Tier I HMO benefit. | Emergency Ambulance Services are covered under the Tier I HMO benefit. |
| • Emergency Transport | No | After CYD, Member pays $1,000 per trip. | | |
| • Non-Emergency - HPN Arranged Transfers | Yes | Member pays $0. | | |
| **Inpatient Hospital Facility Services** (Elective and Emergency Post-Stabilization Admissions) | Yes | After CYD, Member pays $1,000 per day not to exceed $3,000 per admission. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Physician Fees and Medical Services | Yes | After CYD, Member pays $1,000 per day not to exceed $3,000 per admission. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| **Outpatient Hospital Facility Services** | Yes | Member pays $500 per surgery. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| **Ambulatory Surgical Facility Services** | Yes | Member pays $100 per surgery. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| **Anesthesia Services** | Yes | Member pays $100 per surgery. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Physician Surgical Services - Inpatient and Outpatient** | | | | |
| • Inpatient Hospital Facility | Yes | Member pays $150 per surgery. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Outpatient Hospital Facility | Yes | Member pays $150 per surgery. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Ambulatory Surgical Facility | Yes | Member pays $100 per surgery. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Physician's Office | | | | |
| Primary Care Physician (Includes all physician services related to the surgical procedure) | No | Member pays $15 per visit. | Member pays $30 per visit. | After CYD, Member pays 50% of EME. |
| Specialist (Includes all physician services related to the surgical procedure) | Yes | Member pays $30 per visit. | Member pays $60 per visit. | After CYD, Member pays 50% of EME. |
| **Gastric Restrictive Surgery Services**<br>HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member. | | | Gastric Restrictive Surgery Services are covered under the Tier I HMO benefit. | Gastric Restrictive Surgery Services are covered under the Tier I HMO benefit. |
| • Physician Surgical Services | Yes | Member pays $2,500 per surgery. Subject to maximum benefit. | | |
| • Physician's Office Visit | Yes | Member pays $30 per visit. | | |

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Organ and Tissue Transplant Surgical Services** | | | Organ and Tissue Transplant Services are covered under the Tier I HMO benefit. | Organ and Tissue Transplant Services are covered under the Tier I HMO benefit. |
| • Inpatient Hospital Facility | Yes | After CYD, Member pays $1,000 per day not to exceed $3,000 per admission. | | |
| • Physician Surgical Services - Inpatient Hospital Facility | Yes | Member pays $150 per surgery. | | |
| • Transportation, Lodging and Meals<br>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 per surgery. Subject to maximum benefit. | | |
| **Post-Cataract Surgical Services** | | | Post-Cataract Surgical Services are covered under the Tier I HMO Benefit. | Post-Cataract Surgical Services are covered under the Tier I HMO Benefit. |
| • Frames and Lenses | Yes | Member pays $10 per pair of glasses. Subject to maximum benefit. | | |
| • Contact Lenses | Yes | Member pays $10 per set of contact lenses. Subject to maximum benefit. | | |
| Benefit is limited to one (1) pair of Medically Necessary glasses or set of contact lenses as applicable per Member per surgery. | | | | |
| **Home Healthcare Services (does not include Specialty Prescription Drugs)**<br>Subject to a combined Tier II and Tier III maximum benefit of sixty (60) visits per Member per Calendar Year. | Yes | Member pays $30 per visit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. | After CYD, Member pays 50% of EME. Subject to maximum benefit. |

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Hospice Care Services** | | | Hospice Care Services are covered under the Tier I HMO benefit. | Hospice Care Services are covered under the Tier I HMO benefit. |
| • Inpatient Hospice Facility | Yes | After CYD, Member pays $1,000 per admission. | | |
| • Outpatient Hospice Services | Yes | Member pays $0 per visit. | | |
| • Inpatient and Outpatient Respite Services<br>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 | | After CYD, Member pays $1,000 per admission. Subject to maximum benefit. | | |
| ◦ Outpatient | | Member pays $15 per visit. Subject to maximum benefit. | | |
| • Bereavement Services<br>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**<br>Subject to a combined Tier I, II and III maximum benefit of one hundred (100) days per Member per Calendar Year. | Yes | After CYD, Member pays $1,000 per admission; waived if admitted from an acute care facility. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. | After CYD, Member pays 50% of EME. Subject to maximum benefit. |
| **Residential Treatment Center** | Yes | After CYD, Member pays $1,000 per admission; waived if admitted from an acute care facility. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Manual Manipulation**<br>Applies to Medical-Physician Services and Chiropractic office visit. Subject to a combined Tier I, II and III maximum benefit of twenty (20) visits per Member per Calendar Year. | Yes | Member pays $15 per visit. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. | After CYD, Member pays 50% of EME. Subject to maximum benefit. |
| **Short-Term Habilitation Services** (including but not limited to Physical, Speech and Occupational Therapy) | | | | |
| • Inpatient Hospital Facility | Yes | After CYD, Member pays $1,000 per admission. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. | After CYD, Member pays 50% of EME. |
| • Outpatient | Yes | Member pays $15 per visit. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. | After CYD, Member pays 50% of EME. Subject to maximum benefit. |
| All Inpatient and Outpatient Short-Term Habilitation Services are subject to a combined Tier I, II and III maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year. | | | | |
| **Short-Term Rehabilitation Services** (including but not limited to Physical, Speech and Occupational Therapy) | | | | |
| • Inpatient Hospital Facility | Yes | After CYD, Member pays $1,000 per admission. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. | After CYD, Member pays 50% of EME. |
| • Outpatient | Yes | Member pays $15 per visit. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. | After CYD, Member pays 50% of EME. Subject to maximum benefit. |
| All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a combined Tier I, II and III maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year. | | | | |
| **Durable Medical Equipment**<br>Monthly rental or purchase at HPN's option. Purchases are limited to a single purchase of a type of DME, including repair and replacement, once every three (3) years. | Yes | Member pays $0. Subject to maximum benefit. | Durable Medical Equipment is covered under the Tier I HMO benefit. | Durable Medical Equipment is covered under the Tier I HMO benefit. |

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Genetic Disease Testing Services**<br>• Office Visit<br>• Lab<br>Includes Inpatient, Outpatient and independent Laboratory Services. | Yes | Member pays $30 per visit.<br>Member pays $30 per visit. | Genetic Disease Testing Services are covered under the Tier I HMO benefit. | Genetic Disease Testing Services are covered under the Tier I HMO benefit. |
| **Infertility Office Visit Evaluation**<br>Please refer to applicable surgical procedure Copayment/Cost-share and/or Coinsurance amount herein for any surgical infertility procedures performed. | Yes | Member pays $30 per visit. | Infertility Office Visit Evaluations are covered under the Tier I HMO benefit. | Infertility Office Visit Evaluations are covered under the Tier I HMO benefit. |
| **Medical Supplies**<br>(Obtained outside of a medical office visit) | Yes | Member pays $0. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| **Other Diagnostic and Therapeutic Services**<br>The Copayment/Cost-share amounts are 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 drug therapy or other Medically Necessary therapeutic drug services. | Yes | Member pays $20 per day. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Dialysis | Yes | Member pays $20 per day. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Therapeutic Radiology | Yes | Member pays $20 per day. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Complex Allergy Diagnostic Services (including RAST) and Serum Injections | Yes | Member pays $20 per visit. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Otologic Evaluations | Yes | Member pays $20 per visit. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Other complex diagnostic imaging services including: CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; and complex neurological or psychiatric testing or therapeutic services. | Yes | Member pays $100 per test or procedure. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Positron Emission Tomography (PET) scans | Yes | Member pays $100 per test or procedure. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Prosthetic Devices**<br>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 $150 per device. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. | After CYD, Member pays 50% of EME. Subject to maximum benefit. |
| **Orthotic Devices**<br>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. | After CYD, Member pays 30% of EME. Subject to maximum benefit. | After CYD, Member pays 50% of EME. Subject to maximum benefit. |
| **Self-Management and Treatment of Diabetes** | | | Self-Management and Treatment of Diabetes are covered under the Tier I HMO benefit. | Self-Management and Treatment of Diabetes are covered under the Tier I HMO benefit. |
| • 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. | | |
| **Special Food Products and Enteral Formulas** | Yes | Member pays $0. | Special Food Products and Enteral Formulas are covered under the Tier I HMO benefit. | Special Food Products and Enteral Formulas are covered under the Tier I HMO benefit. |
| **Temporomandibular Joint Treatment** | Yes | Member pays 50% of EME. | TMJ Treatment is covered under the Tier I HMO benefit. | TMJ Treatment is covered under the Tier I HMO benefit. |

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

| Covered Services and Limitations | Referral or Prior Auth Required[1] | Tier I HMO Plan Provider Benefit* | Tier II Plan Provider Benefit* | Tier III Non-Plan Provider Benefit* |
|---|---|---|---|---|
| **Mental Health and Severe Mental Illness Services** | | | | |
| • Inpatient Hospital Facility | Yes | After CYD, Member pays $1,000 per day not to exceed $3,000 per admission. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Outpatient Office-based Individual and Group Therapy, and Medical Management Treatment (including Telemedicine Services) | No | Member pays $15 per visit. | Member pays $30 per visit. | After CYD, Member pays 50% of EME. |
| • All other Outpatient Treatment (including Telemedicine Services) | Yes | Member pays $15 per visit. | Member pays $30 per visit. | After CYD, Member pays 50% of EME. |
| **Substance-Related and Addictive Disorder Services** | | | | |
| • Inpatient Hospital Facility | Yes | After CYD, Member pays $1,000 per day not to exceed $3,000 per admission. | After CYD, Member pays 30% of EME. | After CYD, Member pays 50% of EME. |
| • Outpatient Office-based Individual and Group Therapy, and Medical Management Treatment (including Telemedicine Services) | No | Member pays $15 per visit. | Member pays $30 per visit. | After CYD, Member pays 50% of EME. |
| • All other Outpatient Treatment (including Telemedicine Services) | Yes | Member pays $15 per visit. | Member pays $30 per visit. | After CYD, Member pays 50% of EME. |
| **Hearing Aids**<br>Purchases are limited to a single purchase of a type of Hearing Aid per hearing impaired ear, including repair and replacement, once every three (3) years. | Yes | Member pays $0. Subject to maximum benefit. | Hearing Aid Services are covered under the Tier I HMO benefit. | Hearing Aid Services are covered under the Tier I HMO benefit. |
| **Applied Behavioral Analysis (ABA) for the treatment of Autism**<br>Limited to one thousand five hundred (1,500) total hours of therapy per Member per Calendar Year. | Yes | Member pays $15 per visit. Subject to maximum benefit. | ABA Services are covered under the Tier I HMO benefit. | ABA services are covered under the Tier I HMO benefit. |

Please read your HPN Evidence of Coverage (EOC) and all other applicable Endorsements, Riders and Attachments, if any, to determine the governing contractual provisions for this Plan and to understand how EME payments to Providers are determined. Plan Providers have agreed to accept HPN's Reimbursement Schedule as payment in full for Covered Services, less any applicable Deductibles, Coinsurance and/or Copayments that are payable by you.

The Member's medical Tier I 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.

**Please note:** For Inpatient and Outpatient admissions, in addition to specified surgical Copayments and/or Coinsurance amounts, Member is also responsible for all other applicable facility and professional Copayments and/or Coinsurance amounts as outlined in the Attachment A Benefit Schedule.

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*

Member is responsible for any/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 Copayment and Coinsurance Maximums.

Tier I HMO benefits are provided by Health Plan of Nevada, Inc. (HPN), a Health Maintenance Organization (HMO). No benefits will be paid if Medically Necessary Covered Services are provided without Prior Authorization for those services covered which require Prior Authorization and are available only under the Tier I HMO benefit.

Tier II and Tier III benefits are underwritten by HPN. If Medically Necessary Covered Services are provided without the required Prior Authorization, benefits are reduced to 50% of what the Member would have received with Prior Authorization.

[1]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-Related and Addictive Disorder 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.

**Refer to the Limitations Section of the EOC for information regarding EME and benefit maximums.*