Health Plan of Nevada
A UnitedHealthcare Company

HPN Solutions HMO Silver 40/6000/0%

HIOS ID: 95865NV0010060

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 HPN Evidence of Coverage (EOC).

Calendar Year Deductible (CYD): Your CYD is $6,000 of EME per Member for Plan Providers. Your CYD is $12,000 of EME per family for Plan Providers. A Member may not contribute more than the individual amount toward the total family CYD.

Coinsurance: After satisfying your CYD, if any, your coinsurance for most Plan Provider services is 0% of EME.

The Calendar Year Out of Pocket Maximum includes the CYD, if any, and is $8,900 per Member and $17,800 per family. 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.

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.

The Member's medical Tier I 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.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

IMPORTANT:

- **Amounts exceeding coverage amounts/limits:** The 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 Out of Pocket Maximum.

- **Copayment/Cost-shares:** The Copayments/Cost-shares shown in the following Benefit Schedule apply as shown for Inpatient and Outpatient facilities and provider office visits. Additionally, the Member is responsible for all other applicable facility and professional Copayments/Cost-share as outlined in this Attachment A Benefit Schedule to the EOC.

- **Non-Plan Providers:** This plan does not provide coverage of any services received from a Non-Plan Provider except for Emergency Services or for Medically Necessary services that are not available through a Tier I HMO Provider.

- **Referral or Prior Authorization 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 (EOC) for additional information.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit
Medical Office Visits, Primary Care, Consultation – Outpatient (Including Telemedicine Services)		
• Convenient Care	No	Member pays $20 per visit.
• Physician Assistant or Extender	No	Member pays $20 per visit.
• Physician	No	Member pays $40 per visit.
• Specialist	Yes	Member pays $80 per visit.
Preventive Care Services For a complete list of Preventive Services, including all FDA approved contraceptives, go to https://www.healthcare.gov/coverage/preventive-care-benefits/. 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.
Diagnostic Breast Cancer Imaging	Yes	Member pays $0 per visit.
Infertility Office Visit Evaluation Limited to 6 cycles of Artificial Insemination; per lifetime. Surgical cost-share applies to all surgical procedures.	Yes	Member pays $80 per visit.
Non-preventive Routine Lab and X-ray Services 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.		
• Lab	Yes	Member pays $40 per visit.
• X-Ray	Yes	Member pays $75 per visit.
Genetic Disease Testing Services		
• Office Visit	Yes	Member pays $80 per visit.
• Lab *Includes inpatient, outpatient, and independent lab services.*	Yes	Member pays $80 per visit.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit
Urgent Care NowClinic Virtual Visits (Available through NowClinic) Scheduled visits subject to applicable Office Visit Cost Share.	No	Member pays $0 per visit.
Urgent Care Facility	No	Member pays $35 per visit.
Emergency Services		
• Emergency Room Facility (Includes Physician Services) Copay, if any, is waived if admitted.	No	After CYD, Member pays $1,000 per visit.
• Hospital Admission - Emergency Stabilization (Includes Physician Services) *Applies until patient is stabilized and safe for transfers as determined by the attending Physician.*	No	After CYD, Member pays 0% of EME.
Ambulance Services		
• Emergency Transport (Ground/Air)	No	After CYD, Member pays 0% of EME.
• Non-Emergency (HPN Arranged Transfer)	Yes	Member pays $0 per trip.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions) Includes Inpatient Physician Fees/Medical Services and Inpatient Physician Surgical Services	Yes	After CYD, Member pays 0% of EME.
Gastric Restrictive Surgery Services Lifetime benefit maximum of one (1) Medically Necessary surgery per Covered Person.	Yes	After CYD, Member pays 0% of EME.
• Physician's Office Visit	Yes	Member pays $80 per visit.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit
Outpatient Facility and Physician Surgical Services		
Outpatient Facility Surgery - Hospital based (Per Surgery)	Yes	After CYD, Member pays $300 per visit.
• Outpatient Hospital Physician Surgical Services (Per Surgery)	Yes	After CYD, Member pays $200 per visit.
Ambulatory Surgical Facility Services (ASC) (Per Surgery)	Yes	After CYD, Member pays $300 per visit.
• ASC Physician Surgical Services (Per Surgery)	Yes	After CYD, Member pays $200 per visit.
Professional Office Surgical Services		
• Primary Care Physician Treatment and Surgical Services	Yes	Member pays $40 per visit.
• Specialist Treatment and Surgical Services	Yes	Member pays $80 per visit.
Anesthesia Services	Yes	After CYD, Member pays 0% of EME.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	After CYD, Member pays 0% of EME.
• Physician Surgical Services	Yes	After CYD, Member pays 0% of EME.
• Transportation, Lodging and Meals *The maximum benefit per Covered Person per Transplant Benefit Period for transportation, lodging and meals is $10,000. The maximum daily limit for lodging and meals is $200.*	Yes	After CYD, Member pays 0%.
Mental Health/Severe Mental Illness and Substance-Related/Addictive Disorder Services		
• Inpatient Hospital Facility	Yes	After CYD, Member pays 0% of EME.
• Outpatient Office-based Individual and Group Therapy, and Medical Management (Including Telemedicine Services)	No	Member pays $40 per visit.
• All other Outpatient Treatment (Including Telemedicine Services)	Yes	Member pays $40 per visit.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit
Post Cataract Surgical Services • Frames and Lenses • Contact Lenses Limited to one pair of Medically Necessary glasses or set of contact lenses as applicable per Covered Person per surgery.	 Yes Yes	 Member pays $10 per pair of glasses. Member pays $10 per set of contact lenses.
Home Healthcare Services (Does not include Specialty Prescription Drugs)	Yes	Member pays $40 per visit.
Hospice Care Services • Inpatient Hospice Facility • Inpatient Respite *Respite Care limited to a combined max of 5 inpatient and/or outpatient visits per 90 days of Home Hospice.* • Outpatient Hospice Services • Outpatient Respite *Respite Care limited to a combined max of 5 inpatient and/or outpatient visits per 90 days of Home Hospice.* • Bereavement Services *Bereavement limited to 5 group therapy sessions within 6-months of the death of a Covered Hospice Patient.*	 Yes Yes Yes Yes Yes	 After CYD, Member pays 0% of EME. After CYD, Member pays 0% of EME. Member pays $40 per visit. Member pays $40 per visit. Member pays $40 per visit.
Skilled Nursing Facility 100 days per Covered Person per Calendar Year.	Yes	After CYD, Member pays 0% of EME.
Residential Treatment Center	Yes	After CYD, Member pays 0% of EME.
Manual Manipulation Applies to Medical-Physician Services and Chiropractic office visit. Limited to 20 visits per Covered Person per Calendar Year.	Yes	Member pays $40 per visit.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit
Short-Term Habilitation Services • Inpatient Hospital Facility • Outpatient Limited to 120 combined Inpatient days and Outpatient visits per Calendar Year.	Yes Yes	After CYD, Member pays 0% of EME. Member pays $40 per visit.
Short-Term Rehabilitation Services • Inpatient Hospital Facility • Outpatient Limited to 120 combined Inpatient days and Outpatient visits per Calendar Year.	Yes Yes	After CYD, Member pays 0% of EME. Member pays $40 per visit.
Other Diagnostic and Therapeutic Services 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. • **Medically Necessary therapeutic treatment and drug services** (Includes, but not limited to anti-cancer or non-cancer related, drug services) • **Diagnostic Testing** (Includes, but not limited to Complex Allergy Diagnostic Services (including RAST), Serum Injections and Otologic Evaluations) • **Dialysis** • **Therapeutic Radiology** • **Complex Diagnostic Imaging (**MRI/CT/PET, pulmonary and vascular diagnostic and therapeutic services; complex neurological or psychiatric testing or therapeutic services)	Yes Yes Yes Yes Yes	Member pays $75 per visit. Member pays $75 per visit. Member pays $75 per visit. Member pays $75 per visit. After CYD, Member pays $500 per visit.
Durable Medical Equipment (DME) **(**Monthly rental or purchase at HPN option) Purchase/repair/replace of a single type limited to 1 per 3 years.	Yes	Member pays the lesser of $150 or 50% of EME.
Medical Supplies (Obtained outside of providers office)	Yes	After CYD, Member pays $0.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit
Prosthetic Devices Purchase/repair/replace of a single type limited to 1 per 3 years.	Yes	After CYD, Member pays 0% of EME.
Orthotic Devices Purchase/repair/replace of a single type limited to 1 per 3 years.	Yes	After CYD, Member pays 0% of EME.
Self-Management and Treatment of Diabetes		
• Education and Training	No	Member pays $40 per visit.
• Equipment (Except for Insulin Pump)	Yes	Member pays $20 per device.
• Insulin Pump	Yes	Member pays $100 per device.
• Supplies (Except for Insulin Pump Supplies)	No	Member pays $5 per therapeutic supply.
• Insulin Pump Supplies	Yes	Member pays $10 per therapeutic supply.
Special Food Products and Enteral Formulas	Yes	Member pays $0.
Temporomandibular Joint (TMJ) Treatment	Yes	After CYD, Member pays 50% of EME.
Hearing Aids Purchase/repair/replace of a single type limited to 1 per 3 years.	Yes	Member pays the lesser of $150 or 50% of EME.
Applied Behavioral Analysis (ABA) for the treatment of Autism Limited to a maximum of 1500 hours per Covered Person per Calendar Year.	Yes	Member pays $40 per visit.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

Pediatric Vision Services for Members up to age 19		
Covered Services and Limitations	**Referral/ Prior Auth Required**	**Tier I HMO Provider Benefit**
Vision Examinations One (1) vision examination, covered once every Calendar Year, by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.	No	Member pays $0 per visit.
Lenses One (1) pair of lenses will be covered once every Calendar Year when a prescription change is determined to be Medically Necessary. Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal and lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglasses.	No	Member pays $0 per visit.
Frames One (1) pair of frames, from the approved Formulary frame series, will be covered every Calendar Year. Charges for frames selected outside of the approved Formulary frame series are the responsibility of the Covered Person. Discounts for non-Formulary frames may be available through the Plan Provider.	No	Member pays $0 per visit.
Contact Lenses Contact lenses are covered once every Calendar Year in lieu of eyeglasses. Charges for contact lenses considered cosmetic in purpose shall be the responsibility of the Covered Person.	No	Member pays $0 per visit.
Low Vision Exam One comprehensive evaluation every five (5) Calendar Years.	Yes	Member pays $0 per visit.
Optional Lenses and Treatments • Standard Anti Reflective (AR) Coating • UV Treatment • Tint (Fashion, Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Photochromatic Transition Plastic (Other optional lenses and treatment services may be available to the Covered Person at a discount. Please consult with your provider)	No	Member pays $0 per visit.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

Pediatric Dental Services for Members up to age 19		
Covered Services and Limitations	**Referral/ Prior Auth Required**	**Tier I HMO Provider Benefit**
Diagnostic and Preventive • Oral exam every six (6) months • Periodic X-rays • Diagnostic procedures • Prophylaxis every six (6) months • Topical fluoride treatment every six (6) months • Sealants once per permanent molar • Space maintenance therapy	No	Member pays $0 per visit.
Restorative • Amalgam or composite fillings as needed • Crowns as needed • Sedative fillings	Yes	After CYD, Member pays 20% of EME.
Endodontics • Root canal therapy • Pulpal therapy	Yes	After CYD, Member pays 50% of EME.
Periodontics *Usually limited to Members at least fourteen (14) years of age*	Yes	After CYD, Member pays 50% of EME.
Prosthodontics • Partial and complete dentures *Limited to one unit every sixty (60) months*	Yes	After CYD, Member pays 50% of EME.
Orthodontics *Coverage provided for Medically Necessary services only*	Yes	After CYD, Member pays 50% of EME.
Oral Surgery (Includes Anesthesia) • Extractions	Yes	After CYD, Member pays 50% of EME.
Emergency Dental Services • Services or procedures necessary to control bleeding, relieve significant pain and/or eliminate acute infection. • Services or procedures required to prevent pulpal death and/or imminent loss of teeth.	No	After CYD, Member pays 50% of EME.

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.

Prescription Drug Products from a Network Retail Pharmacy, Network Mail Order Pharmacy, or 90 Day Retail Plan Network Pharmacy Your CYD for Prescription Drugs is $0, for both Non-Specialty and Specialty Drugs.	
Prescription Drug Tier	**Tier I HMO Benefit for Non-Specialty Drugs**
Tier I	Member pays $25 Per Designated Plan Pharmacy Therapeutic Supply.
Tier II	Member pays $50 Per Designated Plan Pharmacy Therapeutic Supply.
Tier III	Member pays $100 Per Designated Plan Pharmacy Therapeutic Supply.
Tier IV	Member pays $350 Per Designated Plan Pharmacy Therapeutic Supply.
Prescription Drug Tier	**Tier I HMO Benefit for Specialty Drugs**
Tier I	Member pays $25 Per Designated Plan Pharmacy Therapeutic Supply.
Tier II	Member pays $150 Per Designated Plan Pharmacy Therapeutic Supply.
Tier III	Member pays $400 Per Designated Plan Pharmacy Therapeutic Supply.
Member pays up to 2.5 times the applicable Tier Copayment per Pharmacy Therapeutic Supply.	
Please refer to the HPN Prescription Drug List (PDL) for the listing of Covered Drugs and for any covered drugs requiring Prior Authorization and/or Step Therapy as outlined in the Evidence of Coverage (EOC).	

Refer to the Limitations Section of the Evidence of Coverage (EOC) for information regarding EME and benefit maximums.