

Health Plan of Nevada
A UnitedHealthcare Company 

HPN Solutions HMO Silver 25/3000/30%

HIOS ID: 95865NV0010053

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 \$3,000 of EME per Member for Plan Providers. Your CYD is \$6,000 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 30% of EME.

The Calendar Year Out of Pocket Maximum includes the CYD, if any, and is \$9,400 per Member and \$18,800 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.

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 EOC for additional information.

Benefit Schedule

| Covered Services and Limitations | Referral/ Prior Auth Required | Tier I HMO Provider Benefit |
|---|--|---|
| <p>Medical Office Visits, Primary Care, Consultation – Outpatient (Including Telemedicine Services)</p> <ul style="list-style-type: none"> • Convenient Care • Physician Assistant or Extender • Physician • Specialist <p>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/.</p> <p>If you have a question about whether or not a service is “Preventive”, please contact the HPN Member Services Department (1-800-777-1840).</p> | <p>No</p> <p>No</p> <p>No</p> <p>Yes</p> <p>No</p> | <p>Member pays \$10 per visit.</p> <p>Member pays \$10 per visit.</p> <p>Member pays \$25 per visit.</p> <p>Member pays \$85 per visit.</p> <p>Member pays \$0 per visit.</p> |
| <p>Diagnostic Breast Cancer Imaging</p> | <p>Yes</p> | <p>Member pays \$0 per visit.</p> |
| <p>Infertility Office Visit Evaluation Limited to 6 cycles of Artificial Insemination; per lifetime. Surgical cost-share applies to all surgical procedures.</p> | <p>Yes</p> | <p>Member pays \$85 per visit.</p> |
| <p>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.</p> <ul style="list-style-type: none"> • Lab • X-Ray | <p>Yes</p> <p>Yes</p> | <p>Member pays \$20 per visit.</p> <p>Member pays \$55 per visit.</p> |
| <p>Genetic Disease Testing Services</p> <ul style="list-style-type: none"> • Office Visit • Lab <i>Includes inpatient, outpatient, and independent lab services.</i> | <p>Yes</p> <p>Yes</p> | <p>Member pays \$85 per visit.</p> <p>Member pays \$85 per visit.</p> |

Benefit Schedule

| 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 | No | Member pays \$1,000 per visit, then subject to CYD. |
| <ul style="list-style-type: none"> • Emergency Room Facility (Includes Physician Services) Copay, if any, is waived if admitted. • Hospital Admission - Emergency Stabilization (Includes Physician Services) <i>Applies until patient is stabilized and safe for transfers as determined by the attending Physician.</i> | No | After CYD, Member pays 30% of EME. |
| Ambulance Services | No | After CYD, Member pays 30% of EME. |
| <ul style="list-style-type: none"> • Emergency Transport (Ground/Air) • 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 30% of EME. |
| Gastric Restrictive Surgery Services Lifetime benefit maximum of one (1) Medically Necessary surgery per Covered Person. | Yes | After CYD, Member pays 30% of EME. |
| <ul style="list-style-type: none"> • Physician's Office Visit | Yes | Member pays \$85 per visit. |

Benefit Schedule

| Covered Services and Limitations | Referral/ Prior Auth Required | Tier I HMO Provider Benefit |
|---|---|---|
| <p>Outpatient Facility and Physician Surgical Services</p> <p>Outpatient Facility Surgery - Hospital based (Per Surgery)</p> <ul style="list-style-type: none"> • Outpatient Hospital Physician Surgical Services (Per Surgery) <p>Ambulatory Surgical Facility Services (ASC) (Per Surgery)</p> <ul style="list-style-type: none"> • ASC Physician Surgical Services (Per Surgery) <p>Professional Office Surgical Services</p> <ul style="list-style-type: none"> • Primary Care Physician Treatment and Surgical Services • Specialist Treatment and Surgical Services | <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> | <p>Member pays \$300 per visit, then subject to CYD.</p> <p>Member pays \$150 per visit, then subject to CYD.</p> <p>Member pays \$100 per visit, then subject to CYD.</p> <p>Member pays \$100 per visit, then subject to CYD.</p> <p>Member pays \$25 per visit.</p> <p>Member pays \$85 per visit.</p> |
| <p>Anesthesia Services</p> | <p>Yes</p> | <p>Member pays \$250 per surgery.</p> |
| <p>Organ and Tissue Transplant Surgical Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Physician Surgical Services • Transportation, Lodging and Meals <i>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.</i> | <p>Yes</p> <p>Yes</p> <p>Yes</p> | <p>After CYD, Member pays 30% of EME.</p> <p>After CYD, Member pays 30% of EME.</p> <p>Member pays \$0 per visit.</p> |
| <p>Mental Health/Severe Mental Illness and Substance-Related/Addictive Disorder Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Office-based Individual and Group Therapy, and Medical Management (Including Telemedicine Services) • All other Outpatient Treatment (Including Telemedicine Services) | <p>Yes</p> <p>No</p> <p>Yes</p> | <p>After CYD, Member pays 30% of EME.</p> <p>Member pays \$60 per visit.</p> <p>Member pays \$0 per visit.</p> |

Benefit Schedule

| Covered Services and Limitations | Referral/ Prior Auth Required | Tier I HMO Provider Benefit |
|--|--|--|
| <p>Post Cataract Surgical Services</p> <ul style="list-style-type: none"> • Frames and Lenses • Contact Lenses <p>Limited to one pair of Medically Necessary glasses or set of contact lenses as applicable per Covered Person per surgery.</p> | <p>Yes</p> <p>Yes</p> | <p>Member pays \$10 per pair of glasses.</p> <p>Member pays \$10 per set of contact lenses.</p> |
| <p>Home Healthcare Services (Does not include Specialty Prescription Drugs)</p> | <p>Yes</p> | <p>Member pays \$25 per visit.</p> |
| <p>Hospice Care Services</p> <ul style="list-style-type: none"> • Inpatient Hospice Facility • Inpatient Respite <i>Respite Care limited to a combined max of 5 inpatient and/or outpatient visits per 90 days of Home Hospice.</i> • Outpatient Hospice Services • Outpatient Respite <i>Respite Care limited to a combined max of 5 inpatient and/or outpatient visits per 90 days of Home Hospice.</i> • Bereavement Services <i>Bereavement limited to 5 group therapy sessions within 6-months of the death of a Covered Hospice Patient.</i> | <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> | <p>After CYD, Member pays 30% of EME.</p> <p>After CYD, Member pays 30% of EME.</p> <p>Member pays \$25 per visit.</p> <p>Member pays \$25 per visit.</p> <p>Member pays \$25 per visit.</p> |
| <p>Skilled Nursing Facility 100 days per Covered Person per Calendar Year.</p> | <p>Yes</p> | <p>After CYD, Member pays 30% of EME.</p> |
| <p>Residential Treatment Center</p> | <p>Yes</p> | <p>After CYD, Member pays 30% of EME.</p> |
| <p>Manual Manipulation Applies to Medical-Physician Services and Chiropractic office visit. Limited to 20 visits per Covered Person per Calendar Year.</p> | <p>Yes</p> | <p>Member pays \$25 per visit.</p> |

Benefit Schedule

| Covered Services and Limitations | Referral/ Prior Auth Required | Tier I HMO Provider Benefit |
|---|--|--|
| <p>Short-Term Habilitation Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient <p>Limited to 120 combined Inpatient days and Outpatient visits per Calendar Year.</p> | <p style="text-align: center;">Yes</p> <p style="text-align: center;">Yes</p> | <p>After CYD, Member pays 30% of EME.</p> <p>Member pays \$25 per visit.</p> |
| <p>Short-Term Rehabilitation Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient <p>Limited to 120 combined Inpatient days and Outpatient visits per Calendar Year.</p> | <p style="text-align: center;">Yes</p> <p style="text-align: center;">Yes</p> | <p>After CYD, Member pays 30% of EME.</p> <p>Member pays \$25 per visit.</p> |
| <p>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.</p> <ul style="list-style-type: none"> • 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) | <p style="text-align: center;">Yes</p> | <p>Member pays \$55 per visit.</p> <p>Member pays \$250 per visit, then subject to CYD.</p> |
| <p>Durable Medical Equipment (DME) (Monthly rental or purchase at HPN’s option) Purchase/repair/replace of a single type limited to 1 per 3 years.</p> | <p style="text-align: center;">Yes</p> | <p>After CYD, Member pays 0% of EME.</p> |

Benefit Schedule

| Covered Services and Limitations | Referral/ Prior Auth Required | Tier I HMO Provider Benefit |
|---|--|--|
| Medical Supplies (Obtained outside of providers office) | Yes | Member pays \$0 per visit. |
| Prosthetic Devices Purchase/repair/replace of a single type limited to 1 per 3 years. | Yes | Member pays \$750 per device. |
| Orthotic Devices Purchase/repair/replace of a single type limited to 1 per 3 years. | Yes | Member pays \$50 per device. |
| Self-Management and Treatment of Diabetes | | |
| • Education and Training | No | Member pays \$25 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 | After CYD, Member pays 0% of EME. |
| Applied Behavioral Analysis (ABA) for the treatment of Autism Limited to a maximum of 800 hours per Covered Person per Calendar Year. | Yes | Member pays \$25 per visit. |

Benefit Schedule

| Pediatric Vision Services for Members up to age 19 | | |
|--|--|------------------------------------|
| Covered Services and Limitations | Referral/ Prior Auth Required | Tier I HMO Provider Benefit |
| <p>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.</p> | No | Member pays \$0 per visit. |
| <p>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.</p> | No | Member pays \$0 per visit. |
| <p>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.</p> | No | Member pays \$0 per visit. |
| <p>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.</p> | No | Member pays \$0 per visit. |
| <p>Low Vision Exam One comprehensive evaluation every five (5) Calendar Years.</p> | Yes | Member pays \$0 per visit. |
| <p>Optional Lenses and Treatments</p> <ul style="list-style-type: none"> • Standard Anti Reflective (AR) Coating • UV Treatment • Tint (Fashion, Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Photochromatic Transition Plastic <p>(Other optional lenses and treatment services may be available to the Covered Person at a discount. Please consult with your provider)</p> | No | Member pays \$0 per visit. |

Benefit Schedule

| 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Amalgam or composite fillings as needed • Crowns as needed • Sedative fillings | Yes | After CYD, Member pays 20% of EME. |
| Endodontics <ul style="list-style-type: none"> • Root canal therapy • Pulpal therapy | Yes | After CYD, Member pays 50% of EME. |
| Periodontics <i>Usually limited to Members at least fourteen (14) years of age</i> | Yes | After CYD, Member pays 50% of EME. |
| Prosthodontics <ul style="list-style-type: none"> • Partial and complete dentures <i>Limited to one unit every sixty (60) months</i> | Yes | After CYD, Member pays 50% of EME. |
| Orthodontics <i>Coverage provided for Medically Necessary services only</i> | Yes | After CYD, Member pays 50% of EME. |
| Oral Surgery (Includes Anesthesia) <ul style="list-style-type: none"> • Extractions | Yes | After CYD, Member pays 50% of EME. |
| Emergency Dental Services <ul style="list-style-type: none"> • 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. |

Benefit Schedule

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|--|---|
| 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 \$600 per individual, up to \$1,200 per family, and CYD applies to Tiers II - IV, for both Non-Specialty and Specialty Drugs. | |
| Prescription Drug Tier | Tier I HMO Benefit for Non-Specialty Drugs |
| Tier I | Member pays \$15 Per Designated Plan Pharmacy Therapeutic Supply. |
| Tier II | After CYD, Member pays \$50 Per Designated Plan Pharmacy Therapeutic Supply. |
| Tier III | After CYD, Member pays \$100 Per Designated Plan Pharmacy Therapeutic Supply. |
| Tier IV | After CYD, Member pays \$350 Per Designated Plan Pharmacy Therapeutic Supply. |
| Prescription Drug Tier | Tier I HMO Benefit for Specialty Drugs |
| Tier I | Member pays \$15 Per Designated Plan Pharmacy Therapeutic Supply. |
| Tier II | After CYD, Member pays \$150 Per Designated Plan Pharmacy Therapeutic Supply. |
| Tier III | After CYD, 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 EOC. | |