Health Plan of Nevada
A UnitedHealthcare Company

HPN Solutions POS Silver 25/3500/5500/30%

HIOS ID: 95865NV0020021

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).

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 the 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 EME 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.

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

Calendar Year Deductible (CYD): Your CYD is $3,500 of EME per Member for Tier I Plan Providers. Your CYD is $7,000 of EME per family for Tier I Plan Providers.Your CYD is $5,500 of EME per Member for Tier II Plan Providers. Your CYD is $11,000 of EME per family for Tier II Plan Providers.Your CYD is $7,500 of EME per Member for Tier III Non-Plan Providers. Your CYD is $15,000 of EME per family for Tier III Non-Plan Providers. A Member may not contribute any more than the individual CYD amount toward the Family CYD amount.

The Tier II and Tier III CYDs are separate and do not accumulate to one another. Further, a Member may not contribute any more than the applicable Tier individual CYD amount toward the applicable Tier family CYD amount.

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 CYD, your Coinsurance, if applicable, for most Tier I Covered Services is 20% of EME. Your Coinsurance for most Tier II Covered Services is 30% of EME. Your Coinsurance for most Tier III Covered Services is 50% of EME.

The Calendar Year Out of Pocket Maximum: Your Calendar Year Out of Pocket expenses are limited to a Calendar Year maximum of $9,700of EME per Member and $19,400 of EME per family when using Tier I HMO Providers. Your Out of Pocket expenses are limited to a Calendar Year maximum of $9,950 of EME per Member and $19,900 of EME per Family when using Tier II Plan Providers. Your Out of Pocket expenses for Tier I HMO Providers accumulate toward both your Tier I and Tier II Out of Pocket Maximums. Your Out of Pocket expenses for Tier II Providers accumulate only to your Tier II Calendar Year Out of Pocket Maximum. In no event will your Out of Pocket expenses for Tier I and Tier II providers exceed your Tier II Out of Pocket Maximum. 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.

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 amount includes the CYD and coinsurance.

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 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.

Please read your HPN 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.

Refer to the Limitations section of the 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.

- **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.

- Tier I HMO benefits are provided by 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.

- 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.

- 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.

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

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Medical Office Visits, Primary Care, Consultation – Outpatient (Including Telemedicine Services)				
• Convenient Care	No	Member pays $10 per visit.	Member pays $20 per visit.	After CYD, Member pays 50% of EME.
• Physician Assistant or Extender	No	Member pays $10 per visit.	Member pays $20 per visit.	After CYD, Member pays 50% of EME.
• Physician	No	Member pays $25 per visit.	Member pays $40 per visit.	After CYD, Member pays 50% of EME.
• Specialist	Yes	Member pays $95 per visit.	Member pays $95 per visit.	After CYD, Member pays 50% of EME.
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.	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.
Infertility Office Visit Evaluation Limited to 6 cycles of Artificial Insemination; per lifetime. Surgical cost-share applies to all surgical procedures.	Yes	Member pays $95 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.

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

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
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 $30 per visit.	Member pays $30 per visit.	After CYD, Member pays 50% of EME.
• X-Ray	Yes	Member pays $75 per visit.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
Genetic Disease Testing Services				
• Office Visit	Yes	Member pays $95 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Lab *Includes inpatient, outpatient, and independent lab services.*	Yes	Member pays $95 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Urgent Care NowClinic Virtual Visits (Available through NowClinic) Scheduled visits subject to applicable Office Visit Cost Share.	No	Member pays $0 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Urgent Care Facility	No	Member pays $50 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.

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

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Emergency Services				
• Emergency Room Facility (Includes Physician Services) *Copay, if any, is waived if admitted.*	No	After CYD, Member pays 20% of EME.	After CYD, Member pays 20% of EME.	After CYD, Member pays 20% of EME.
• 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 20% of EME.	After CYD, Member pays 20% of EME.	After CYD, Member pays 20% of EME.
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.				
Ambulance Services				
• Emergency Transport (Ground/Air)	No	Member pays $250 per trip.	Paid under Tier I HMO Benefit	Paid under Tier I HMO Benefit
• Non-Emergency (HPN Arranged Transfers)	Yes	Member pays $0 per trip.	Member pays $0 per trip.	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 20% of EME.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
Gastric Restrictive Surgery Services Lifetime benefit maximum of one (1) Medically Necessary surgery per Covered Person.	Yes	After CYD, Member pays 20% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Physician's Office Visit	Yes	Member pays $95 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.

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

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Outpatient Facility and Physician Surgical Services				
Outpatient Facility Surgery - Hospital based (Per Surgery)	Yes	After CYD, Member pays 20% of EME.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
• Outpatient Hospital Physician Surgical Services (Per Surgery)	Yes	After CYD, Member pays 20% of EME.	Member pays $300 per visit.	After CYD, Member pays 50% of EME.
Ambulatory Surgical Facility Services (ASC) (Per Surgery)	Yes	After CYD, Member pays 20% of EME.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
• ASC Physician Surgical Services (Per Surgery)	Yes	After CYD, Member pays 20% of EME.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
Professional Office Surgical Services				
• Primary Care Physician Treatment and Surgical Services	No	Member pays $25 per visit.	Member pays $40 per visit.	After CYD, Member pays 50% of EME.
• Specialist Treatment and Surgical Services	Yes	Member pays $95 per visit.	Member pays $95 per visit.	After CYD, Member pays 50% of EME.
Anesthesia Services	Yes	Member pays $150 per surgery.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
Organ and Tissue Transplant Surgical Services				
• Inpatient Hospital Facility	Yes	After CYD, Member pays 20% of EME.	Covered under Tier I HMO Benefit only	Covered under Tier I HMO Benefit only
• Physician Surgical Services	Yes	After CYD, Member pays 20% of EME.	Covered under Tier I HMO Benefit only	Covered under Tier I HMO Benefit only
• 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	Member pays $0 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.

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

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Mental Health/Severe Mental Illness and Substance-Related/Addictive Disorder Services				
• Inpatient Hospital Facility	Yes	After CYD, Member pays 20% of EME.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
• Outpatient Office-based Individual and Group Therapy, and Medical Management (Including Telemedicine Services)	No	Member pays $80 per visit.	Member pays $80 per visit.	After CYD, Member pays 50% of EME.
• All other Outpatient Treatment (Including Telemedicine Services)	Yes	Member pays 20% of EME.	After CYD, Member pays 30% of EME.	Member pays 50% per visit.
Post Cataract Surgical Services				
• Frames and Lenses	Yes	Member pays $10 per pair of glasses.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Contact Lenses Limited to one pair of Medically Necessary glasses or set of contact lenses as applicable per Covered Person per surgery for all covered tiers combined.	Yes	Member pays $10 per set of contact lenses.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Home Healthcare Services (Does not include Specialty Prescription Drugs) Subject to a combined Tier II and Tier III maximum benefit of sixty (60) visits per Covered Person per Calendar Year.	Yes	Member pays $25 per visit.	Member pays $40 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/ Prior Auth Required	Tier I HMO Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Hospice Care Services				
• Inpatient Hospice Facility	Yes	After CYD, Member pays 20% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Inpatient Respite *Respite Care limited to a combined max of 5 inpatient and/or outpatient visits per 90 days of Home Hospice.*	Yes	After CYD, Member pays 20% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Outpatient Hospice Services	Yes	Member pays $25 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Outpatient Respite *Respite Care limited to a combined max of 5 inpatient and/or outpatient visits per 90 days of Home Hospice.*	Yes	Member pays $25 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Bereavement Services *Bereavement limited to 5 group therapy sessions within 6-months of the death of a Covered Hospice Patient.*	Yes	Member pays $25 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Skilled Nursing Facility 100 days combined for all covered tiers.	Yes	After CYD, Member pays 20% of EME.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
Residential Treatment Center	Yes	After CYD, Member pays 20% of EME.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
Manual Manipulation Applies to Medical-Physician Services and Chiropractic office visit. Limited to 20 visits per Covered Person per Calendar Year for all covered tiers combined.	Yes	Member pays $25 per visit.	Member pays $40 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/ Prior Auth Required	Tier I HMO Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Short-Term Habilitation Services				
• Inpatient Hospital Facility	Yes	After CYD, Member pays 20% of EME.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
• Outpatient Limited to 120 combined Inpatient days and Outpatient visits per Calendar Year for all covered tiers combined.	Yes	Member pays $25 per visit.	Member pays $40 per visit.	After CYD, Member pays 50% of EME.
Short-Term Rehabilitation Services				
• Inpatient Hospital Facility	Yes	After CYD, Member pays 20% of EME.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
• Outpatient Limited to 120 combined Inpatient days and Outpatient visits per Calendar Year for all covered tiers combined.	Yes	Member pays $25 per visit.	Member pays $40 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/ Prior Auth Required	Tier I HMO Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
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)	Yes	Member pays $75 per visit.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
• **Diagnostic Testing** (Includes, but not limited to Complex Allergy Diagnostic Services (including RAST), Serum Injections and Otologic Evaluations)	Yes	Member pays $75 per visit.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
• **Dialysis**	Yes	Member pays $75 per visit.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
• **Therapeutic Radiology**	Yes	Member pays $75 per visit.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
• **Complex Diagnostic Imaging (**MRI/CT/PET, pulmonary and vascular diagnostic and therapeutic services; complex neurological or psychiatric testing or therapeutic services)	Yes	Member pays $350 per visit.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
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.	Yes	Member pays the lesser of $150 or 50% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Medical Supplies (Obtained outside of providers office)	Yes	Member pays $0 per visit.	After CYD, Member pays 30% of EME.	After CYD, Member pays 50% of EME.
Prosthetic Devices Purchase/repair/replace of a single type limited to 1 per 3 years.	Yes	Member pays $750 per device.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Orthotic Devices Purchase/repair/replace of a single type limited to 1 per 3 years.	Yes	Member pays $50 per device.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.

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

Covered Services and Limitations	Referral/ Prior Auth Required	Tier I HMO Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Self-Management and Treatment of Diabetes				
• Education and Training	No	Member pays $25 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Equipment (Except for Insulin Pump)	Yes	Member pays $20 per device.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Insulin Pump	Yes	Member pays $100 per device.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Supplies (Except for Insulin Pump Supplies)	No	Member pays $5 per therapeutic supply.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
• Insulin Pump Supplies	Yes	Member pays $10 per therapeutic supply.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Special Food Products and Enteral Formulas	Yes	Member pays $0.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Temporomandibular Joint (TMJ) Treatment	Yes	Member pays 50% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Hearing Aids Purchase/repair/replace of a single type limited to 1 per 3 years.	Yes	Member pays the lesser of $100 or 50% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
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.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.

Refer to the Limitations section of the 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**	**Tier II Plan Provider Benefit**	**Tier III Non-Plan 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.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
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.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
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.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
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.	Covered under Tier I HMO Benefit only	Covered under Tier I HMO Benefit only.
Low Vision Exam One comprehensive evaluation every five (5) Calendar Years.	Yes	Member pays $0 per visit.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
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.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.

Refer to the Limitations section of the 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**	**Tier II Plan Provider Benefit**	**Tier III Non-Plan 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.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Restorative • Amalgam or composite fillings as needed • Crowns as needed • Sedative fillings	Yes	After CYD, Member pays 30% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Endodontics • Root canal therapy • Pulpal therapy	Yes	After CYD, Member pays 50% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Periodontics *Usually limited to Members at least fourteen (14) years of age*	Yes	After CYD, Member pays 50% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Prosthodontics • Partial and complete dentures *Limited to one unit every sixty (60) months*	Yes	After CYD, Member pays 50% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Orthodontics *Coverage provided for Medically Necessary services only*	Yes	After CYD, Member pays 50% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
Oral Surgery (Includes Anesthesia) • Extractions	Yes	After CYD, Member pays 50% of EME.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.
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.	Covered under Tier I HMO Benefit only.	Covered under Tier I HMO Benefit only.

Refer to the Limitations section of the 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 $500 per individual, up to $1,000 per family, and CYD applies to Tiers III - IV, for both Non-Specialty and Specialty Drugs.**	
Prescription Drug Tier	**Tier I HMO Benefit for Non-Specialty Drugs**
Tier I	Member pays $30 Per Designated Plan Pharmacy Therapeutic Supply.
Tier II	Member pays $75 Per Designated Plan Pharmacy Therapeutic Supply.
Tier III	After CYD, Member pays 20% of EME.
Tier IV	After CYD, Member pays 20% of EME.
Prescription Drug Tier	**Tier I HMO Benefit for Specialty Drugs**
Tier I	Member pays $30 Per Designated Plan Pharmacy Therapeutic Supply.
Tier II	Member pays $150 Per Designated Plan Pharmacy Therapeutic Supply.
Tier III	After CYD, Member pays 20% of EME.
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.	

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