HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

HMO 20-1A

Attachment A Benefit Schedule

The Calendar Year Out of Pocket Maximum is $6,850 per Member and $13,700 per family.

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

Please note: For all Inpatient and Outpatient admissions, including those for Emergency or Urgent Care, in addition to specified surgical Copayment/Cost-share amounts, Member is also responsible for all other applicable facility and professional Copayments/Cost-share as outlined in this Attachment A Benefit Schedule to the Evidence of Coverage (EOC).

Member is responsible for any and all amounts exceeding any stated maximum benefit amounts and/or any/all amounts exceeding the Plan's payment to Non-Plan Providers under this Plan. Further, such amounts do not accumulate to the calculation of the Calendar Year Out of Pocket Maximum.

Covered Services and Limitations	Referral or Prior Auth. Required (1)	Tier I HMO Plan Provider Benefit*
Medical Office Visits and Consultations		
Primary Care Services		
• Convenient Care Facility	No	Member pays $10 per visit.
• Physician Extender or Assistant	No	Member pays $10 per visit.
• Physician	No	Member pays $20 per visit.
Specialist Services	Yes	Member pays $40 per visit.
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/. 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.
Non-preventive Routine Lab and X-ray Services Copayment/Cost-share is in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office or at an independent facility.	Yes	
• Lab		Member pays $10 per visit.
• X-Ray		Member pays $20 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*
Telemedicine Services (Available through select contracted Providers)	No	Member pays $10 per visit.
Urgent Care Facility	No	Member pays $35 per visit.
Emergency Services		
• Emergency Room Facility (includes Physician Services)	No	Member pays $500 per visit; waived if admitted.
• Hospital Admission - Emergency Stabilization (includes Physician Services) Applies until patient is stabilized and safe for transfer as determined by the attending Physician.	No	Member pays $500 per admission.
Ambulance Services		
• Emergency Transport	No	Member pays $500 per trip.
• Non-Emergency - HPN Arranged Transfers	Yes	Member pays $0.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)	Yes	Member pays $500 per admission.
Outpatient Surgery at a Hospital Facility	Yes	Member pays $500 per surgery.
Ambulatory Surgical Facility Services	Yes	Member pays $100 per surgery.
Anesthesia Services	Yes	Member pays $150 per surgery.
Physician Surgical Services - Inpatient and Outpatient		
• Inpatient Hospital Facility	Yes	Member pays $100 per surgery.
• Outpatient Hospital Facility	Yes	Member pays $100 per surgery.
• Ambulatory Surgical Facility	Yes	Member pays $50 per surgery.
• Physician's Office		
Primary Care Physician (Includes all physician services related to the surgical procedure)	No	Member pays $20 per visit.
Specialist (Includes all physician services related to the surgical procedure)	Yes	Member pays $40 per visit.

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Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required (1)	Tier I HMO Plan Provider Benefit*
Gastric Restrictive Surgery Services HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.		
• Physician Surgical Services	Yes	Member pays $2,500 per surgery. Subject to maximum benefit.
• Physician's Office Visit	Yes	Member pays $40 per visit.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	Member pays $500 per admission.
• Physician Surgical Services - Inpatient Hospital Facility	Yes	Member pays $100 per surgery.
• Transportation, Lodging and Meals The maximum benefit per Member per Transplant Benefit Period for transportation, lodging and meals is $10,000. The maximum daily limit for lodging and meals is $200.	Yes	Member pays $0 per surgery. Subject to maximum benefit.
• Procurement The maximum benefit per Member per Transplant Benefit Period for Procurement of the organ/tissue is $15,000 of EME.	Yes	Member pays $0. Subject to maximum benefit.
• Retransplantation Services Benefits are limited to one (1) Medically Necessary Retransplantation per Member per type of transplant.	Yes	Member pays 50% of EME. Subject to maximum benefit.
Post-Cataract Surgical Services		
• 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 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) Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drug.	Yes	Member pays $20 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*
Hospice Care Services		
• Inpatient Hospice Facility	Yes	Member pays $500 per admission.
• Outpatient Hospice Services	Yes	Member pays $0 per visit.
• Inpatient and Outpatient Respite Services Benefits are limited to a combined maximum benefit of five (5) Inpatient days or five (5) Outpatient visits per Member per ninety (90) days of Home Hospice Care.	Yes	
◦ Inpatient		Member pays $500 per admission. Subject to maximum benefit.
◦ Outpatient		Member pays $40 per visit. Subject to maximum benefit.
• Bereavement Services Benefits are limited to a maximum benefit of five (5) group therapy sessions. Treatment must be completed within six (6) months of the date of death of the Hospice patient.	Yes	Member pays $20 per visit. Subject to maximum benefit.
Skilled Nursing Facility Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.	Yes	Member pays $500 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.
Manual Manipulation Applies to Medical-Physician Services and Chiropractic office visit. Subject to a maximum benefit of twenty (20) visits per Member per Calendar Year.	Yes	Member pays $20 per visit. Subject to maximum benefit.
Short-Term Rehabilitation and Habilitation Services (including but not limited to Physical, Speech and Occupational Therapy)		
• Inpatient Hospital Facility	Yes	Member pays $500 per admission. Subject to maximum benefit.
• Outpatient	Yes	Member pays $20 per visit. Subject to maximum benefit.
All Inpatient and Outpatient Short Term Rehabilitation and Habilitative Services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.		
Durable Medical Equipment Monthly rental or purchase at HPN's option. Purchases are limited to a single purchase of a type of DME, including repair and replacement, once every three (3) years.	Yes	Member pays $0. Subject to maximum benefit.

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Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required (1)	Tier I HMO Plan Provider Benefit*
Genetic Disease Testing Services	Yes	
• Office Visit		Member pays $40 per visit.
• Lab Includes Inpatient, Outpatient and independent Laboratory Services.		Member pays $40 per visit.
Infertility Office Visit Evaluation Please refer to applicable surgical procedure Copayment/Cost-share and/or Coinsurance amount herein for any surgical infertility procedures performed.	Yes	Member pays $40 per visit.
Medical Supplies (Obtained outside of a medical office visit)	Yes	Member pays $0.
Other Diagnostic and Therapeutic Services Copayment/Cost-share is in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office or at an independent facility.		
• Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services.	Yes	Member pays $20 per day.
• Dialysis	Yes	Member pays $20 per day.
• Therapeutic Radiology	Yes	Member pays $20 per day.
• Complex Allergy Diagnostic Services (including RAST) and Serum Injections	Yes	Member pays $20 per visit.
• Otologic Evaluations	Yes	Member pays $20 per visit.
• 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.
• Positron Emission Tomography (PET) scans	Yes	Member pays $100 per test or procedure.
Prosthetic Devices Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.	Yes	Member pays $150 per device. Subject to maximum benefit.
Orthotic Devices Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.	Yes	Member pays $50 per device. Subject to maximum benefit.

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Covered Services and Limitations	Referral or Prior Auth. Required (1)	Tier I HMO Plan Provider Benefit*
Self-Management and Treatment of Diabetes		
• Education and Training	No	Member pays $20 per visit.
• Supplies (except for Insulin Pump Supplies)	No	Member pays $5 per therapeutic supply.
Insulin Pump Supplies	Yes	Member pays $10 per therapeutic supply.
• Equipment (except for Insulin Pump)	Yes	Member pays $20 per device.
Insulin Pump	Yes	Member pays $100 per device.
Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.		
Special Food Products and Enteral Formulas Special Food Products only are limited to a maximum benefit of one (1) thirty (30) day therapeutic supply per Member four (4) times per Calendar Year.	Yes	Member pays $0. Subject to maximum benefit.
Temporomandibular Joint Treatment	Yes	Member pays 50% of EME.
Mental Health and Severe Mental Illness Services		
• Inpatient Hospital Facility	Yes	Member pays $500 per admission.
• Outpatient Treatment	Yes	Member pays $20 per visit.
Substance Abuse Services		
• Inpatient Hospital Facility	Yes	Member pays $500 per admission.
• Outpatient Treatment	Yes	Member pays $20 per visit.
Hearing Aids Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.	Yes	Member pays $0. Subject to maximum benefit.
Applied Behavioral Analysis (ABA) for the treatment of Autism for Members up to age 22 Limited to two hundred fifty (250) visits not to exceed seven hundred fifty (750) total hours of therapy per Member per Calendar Year.	Yes	Member pays $20 per visit. Subject to maximum benefit.

A Member's Copayment/Cost-share will not be more than 50% of the allowed cost of providing any single service or supplying an item to a Member, after the deductible, if applicable, has been met. A Member may not contribute any more than the individual CYD amount toward the

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family CYD amount. A Member may not contribute any more than the individual Calendar Year Out of Pocket Maximum toward the family Calendar Year Out of Pocket Maximum amount.

(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 Abuse Services, all Covered Services not provided by the Member's Primary Care Physician require a Referral or a Prior Authorization in the form of a written referral authorization from HPN. Please refer to your HPN Evidence of Coverage for additional information.

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