HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

MyHPN Solutions HMO Platinum 1

Attachment A Benefit Schedule

Calendar Year Deductible (CYD):
$250 of EME per Member and $500 of EME per family.

The Calendar Year Out of Pocket Maximum includes the CYD and is $3,500 per Member and $7,000 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.

Covered Services and Limitations	Referral or Prior Auth. Required*	Plan Benefit
Medical Office Visits and Consultations in a Medical Office Setting		
• **Primary Care Services**	No	
Convenient Care Facility		Member pays $5 per visit.
Physician Extender or Assistant		Member pays $5 per visit.
Physician		Member pays $10 per visit.
• **Specialist Services**	Yes	Member pays $10 per visit.
Preventive Healthcare Services - *Services include various recommended exams, immunizations, diagnostic tests and screenings. Refer to the HPN Preventive Guidelines on the HPN website (www.healthplanofnevada.com) located under the "Members & Guests" tab or contact the Member Services Department (702-242-7300) for the complete list of covered Adult and Pediatric Preventive Services and Immunizations. These guidelines are updated in accordance with the Federal Government standards.*	No	Member pays $0 per visit.
Routine Lab and X-ray services provided and billed by the Physician's office. (*Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician's office.)*	Yes	
• Lab		Member pays $10 per visit.
• X-Ray		Member pays $20 per visit.

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Covered Services and Limitations	Referral or Prior Auth. Required*	Plan Benefit
Telemedicine Services *(Only available through select Providers.)*	No	Member pays $5 per visit.
Laboratory Services - Outpatient *Performed at an independent facility.*	Yes	Member pays $10 per visit.
Routine Radiological and Non-Radiological Diagnostic Imaging Services *Performed at a Free-Standing Diagnostic Center.*	Yes	Member pays $20 per visit.
Emergency Services	No	
• Urgent Care Facility		Member pays $25 per visit.
• Emergency Room Visit		Member pays $150 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.*		After CYD, HPN pays 90% of EME.
Ambulance Services		
• Emergency Transport	No	Member pays $100 per trip.
• Non-Emergency – HPN Arranged Transfers	Yes	Member pays $0.
Inpatient Hospital Facility Services (*Elective and Emergency Post-Stabilization Admissions)*	Yes	After CYD, HPN pays 90% of EME.
Outpatient Surgery at a Hospital Facility	Yes	After CYD, HPN pays 90% of EME.
Ambulatory Surgical Facility Services	Yes	After CYD, HPN pays 95% of EME.
Anesthesia Services	Yes	After CYD, HPN pays 90% of EME.
Physician Surgical Services – Inpatient and Outpatient		
• Inpatient or Outpatient Hospital Facility	Yes	After CYD, HPN pays 90% of EME.
• Ambulatory Surgical Facility	Yes	After CYD, HPN pays 95% of EME.
• Physician's Office Primary Care Physician (Includes all physician services related to the surgical procedure)	No	Member pays $10 per visit.
• Specialist (Includes all physician services related to the surgical procedure)	Yes	Member pays $10 per visit.

Covered Services and Limitations	Referral or Prior Auth. Required*	Plan Benefit
Gastric Restrictive Surgery Services *HPN provides a lifetime benefit maximum of one Medically Necessary surgery per Member.*		
• Physician Surgical Services	Yes	After CYD, HPN pays 90% of EME. Subject to maximum benefit.
• Physician Office Visit	Yes	Member pays $10 per visit.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	After CYD, HPN pays 90% of EME.
• Physician Surgical Services – Inpatient Hospital Facility	Yes	After CYD, HPN pays 90% of EME.
• 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	After CYD, HPN pays 90% of EME. Subject to maximum benefit.
• Procurement *Benefits for procurement procedures and/or services are limited to those deemed by HPN to be Medically Necessary and appropriate for an approved Organ Transplant in a single Transplant Benefit Period.*	Yes	After CYD, HPN pays 90% of EME.
• Retransplantation Services *Benefits are limited to one Medically Necessary Retranplantation per Member per type of transplant.*	Yes	After CYD, HPN pays 50% of EME. Subject to maximum benefit.
Post-Cataract Surgical Services • Frames and Lenses	Yes	$10 per pair of glasses. Subject to maximum benefit.
• Contact Lenses *Benefits are limited to one (1) pair of Medically Necessary glasses or set of contact lenses as applicable per Member per surgery.*	Yes	$10 per set of contact lenses. Subject to maximum benefit.
Home Healthcare Services (*does not include Specialty Prescription Drugs)* *Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drug.*		Member pays $15 per visit.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Plan Benefit
Hospice Care Services		
• Inpatient Hospice Facility	Yes	After CYD, HPN pays 90% of EME.
• Outpatient Hospice Services	Yes	Member pays $15 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		After CYD, HPN pays 90% of EME. Subject to maximum benefit.
◦ Outpatient		Member pays $15 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 $10 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	After CYD, HPN pays 90% of EME. 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 $10 per visit. Subject to maximum benefit.
Short-Term Rehabilitation and Habilitative Services		
• Inpatient Hospital Facility	Yes	After CYD, HPN pays 90% of EME.
• Outpatient	Yes	Member pays $10 per visit.
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 $75 or 50% of EME of purchase or monthly rental price, whichever is less. Subject to maximum benefit.
Genetic Disease Testing Services • Office Visit • Lab *Includes Inpatient, Outpatient and independent Laboratory Services.*	Yes	Member pays $10 per visit. Member pays $10 per test.

Covered Services and Limitations	Referral or Prior Auth. Required*	Plan Benefit
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 $10 per visit.
Medical Supplies	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.*	Yes	
• Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services.		Member pays $10 per day.
• Dialysis		Member pays $10 per day.
• Therapeutic Radiology		Member pays $10 per day.
• Complex Allergy Diagnostic Services (including RAST) and Serum Injections		Member pays $10 per visit.
• Otologic Evaluations		Member pays $10 per visit.
• Other complex diagnostic imaging services such as Positron Emission Tomography (PET) scans, CT Scan and MRI); vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.		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 $100 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 $20 per device. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Plan Benefit
Self-Management and Treatment of Diabetes		
• Education and Training	No	Member pays $10 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	After CYD, HPN pays 50% of EME.
Mental Health and Severe Mental Illness Services		
• Inpatient Hospital Facility	Yes	After CYD, HPN pays 90% of EME.
• Outpatient Treatment	Yes	Member pays $10 per visit.
Substance Abuse Services		
• Inpatient Hospital Facility	Yes	After CYD, HPN pays 90% of EME.
• Outpatient Treatment	Yes	Member pays $10 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 $75 or 50% of EME of purchase or monthly rental price, whichever is less. Subject to maximum benefit.
Applied Behavioral Analysis (ABA) for the treatment of Autism *Limited to two hundred fifty (250) visits per Member not to exceed seven hundred fifty (750) total hours of therapy per Member per Calendar Year.*	Yes	Member pays $10 per visit. Subject to maximum benefit.

Covered Services and Limitations	Referral or Prior Auth. Required*	Plan Benefit
Pediatric Vision Services for Members up to age 19		
Vision Examination *One (1) vision examination by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be covered once every calendar year.*	No	Member pays $0 per visit. Subject to maximum benefit.
Lenses *One (1) pair of lenses will be covered once every calendar year when a prescription change is determined 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. Subject to maximum benefit.
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 Member. Discounts for non- Formulary frames may be available through the Plan Provider.*	No	Member pays $0 per visit. Subject to maximum benefit.
Contact Lenses *Contact lenses are covered once every calendar year in lieu of eye glasses. Charges for contact lenses considered to be cosmetic in purposes shall be the responsibility of the Member.*	No	Member pays $0 per visit. Subject to maximum benefit.
Low Vision Exam *One comprehensive evaluation every five (5) years.*	Yes	Member pays $0 per visit. Subject to maximum benefit.
Optional Lenses and Treatments • Standard Anti-Reflective (AR) Coating • UV Treatment • Tint (Fashion & Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Photocromatic/Transitions Plastic *(Other optional lenses and treatment services may be available to the Member at a discount. Please consult with your Provider.)*	No	Member pays $0.
Pediatric Dental Services for Members up to age 19		
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	HPN pays 100% of EME.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Plan Benefit
Pediatric Dental Services for Members up to age 19 (continued)		
Restorative • Amalgam or composite fillings as needed • Crowns as needed • Sedative fillings	Yes	After CYD, HPN pays 80% of EME.
Endodontics • Root canal therapy • Pulpal therapy	Yes	After CYD, HPN pays 50% of EME.
Periodontics *Usually limited to Members at least fourteen (14) years of age.*	Yes	After CYD, HPN pays 50% of EME.
Prosthodontics • Partial and complete dentures *Limited to one unit once every sixty (60) months.*	Yes	After CYD, HPN pays 50% of EME.
Orthodontics *Coverage provided for Medically Necessary Services only.*	Yes	After CYD, HPN pays 50% of EME.
Oral Surgery (includes Anesthesia) • Extractions	Yes	After CYD, HPN 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, HPN pays 50% of EME.

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 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.

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 the Attachment A Benefit Schedule.

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.

*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 Agreement of Coverage for additional information.