HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

MyHPN Silver 5

HIOS ID: 95865NV0030047

Attachment A Benefit Schedule

Calendar Year Deductible (CYD): $5,000 of EME per Member and $10,000 of EME per family.

The Calendar Year Out of Pocket Maximum includes the CYD and is $6,600 per Member and $13,200 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 Agreement of Coverage (AOC).

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*	Tier I HMO Plan Benefit [(1)] **
Medical Office Visits and Consultations		
Primary Care Services		
• Convenient Care Facility	No	Member pays $5 per visit.
• Physician Extender or Assistant	No	Member pays $5 per visit.
• Physician	No	Member pays $15 per visit.
Specialist Services	Yes	Member pays $85 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 $25 per visit.
• X-Ray		Member pays $50 per visit.

***Refer to the Limitations Section of the AOC for information regarding EME and benefit maximums.*

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Benefit [(1)] **
Telemedicine Services (Available through select contracted Providers)	No	Member pays $5 per visit.
Urgent Care Facility	No	Member pays $50 per visit.
Emergency Services		
• Emergency Room Facility (includes Physician Services)	No	Member pays $400 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	After CYD, Member pays 30% of EME.
Ambulance Services		
• Emergency Transport	No	After CYD, Member pays 30% of EME.
• Non-Emergency - HPN Arranged Transfers	Yes	Member pays $0.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)	Yes	After CYD, Member pays 30% of EME.
Outpatient Hospital Facility Services	Yes	After CYD, Member pays 30% of EME.
Ambulatory Surgical Facility Services	Yes	Member pays $150 per surgery.
Anesthesia Services	Yes	After CYD, Member pays 30% of EME.
Physician Surgical Services - Inpatient and Outpatient		
• Inpatient Hospital Facility	Yes	After CYD, Member pays 30% of EME.
• Outpatient Hospital Facility	Yes	After CYD, Member pays 30% of EME.
• 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 $15 per visit.
Specialist (Includes all physician services related to the surgical procedure)	Yes	Member pays $85 per visit.

***Refer to the Limitations Section of the AOC for information regarding EME and benefit maximums.*

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Benefit [(1)] **
Gastric Restrictive Surgery Services HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.		
• Physician Surgical Services	Yes	After CYD, Member pays 30% of EME. Subject to maximum benefit.
• Physician's Office Visit	Yes	Member pays $85 per visit.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	After CYD, Member pays 30% of EME.
• Physician Surgical Services - Inpatient Hospital Facility	Yes	After CYD, Member pays 30% 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, Member pays 30% of EME. 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	After CYD, Member pays 30% of EME. 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 $25 per visit.

***Refer to the Limitations Section of the AOC for information regarding EME and benefit maximums.*

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Benefit [(1)] **
Hospice Care Services		
• Inpatient Hospice Facility	Yes	After CYD, Member pays 30% 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, Member pays 30% 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 $15 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, Member pays 30% 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 $15 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	After CYD, Member pays 30% of EME.
• Outpatient	Yes	Member pays $15 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 $150 or 50% of EME of purchase or monthly rental price, whichever is less. Subject to maximum benefit.

***Refer to the Limitations Section of the AOC for information regarding EME and benefit maximums.*

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Benefit [(1)] **
Genetic Disease Testing Services	Yes	
• Office Visit		Member pays $85 per visit.
• Lab Includes Inpatient, Outpatient and independent Laboratory Services.		Member pays $85 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 $85 per visit.
Medical Supplies (Obtained outside of a medical office visit)	Yes	Member pays $0.
Other Diagnostic and Therapeutic Services Copayment/Cost-share amounts are 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 $15 per day.
• Dialysis	Yes	Member pays $15 per day.
• Therapeutic Radiology	Yes	Member pays $15 per day.
• Complex Allergy Diagnostic Services (including RAST) and Serum Injections	Yes	Member pays $15 per visit.
• Otologic Evaluations	Yes	Member pays $15 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 $300 per test or procedure.
• Positron Emission Tomography (PET) scans	Yes	Member pays $300 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 $500 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.

***Refer to the Limitations Section of the AOC for information regarding EME and benefit maximums.*

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Benefit [(1)] **
Self-Management and Treatment of Diabetes		
• Education and Training	No	Member pays $15 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, Member pays 50% of EME.
Mental Health and Severe Mental Illness Services		
• Inpatient Hospital Facility	Yes	After CYD, Member pays 30% of EME.
• Outpatient Treatment	Yes	Member pays $15 per visit.
Substance Abuse Services		
• Inpatient Hospital Facility	Yes	After CYD, Member pays 30% of EME.
• Outpatient Treatment	Yes	Member pays $15 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 $150 or 50% of EME of purchase price, whichever is less. 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 $15 per visit. Subject to maximum benefit.

***Refer to the Limitations Section of the AOC for information regarding EME and benefit maximums.*

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Benefit [(1)] **
Pediatric Vision Services for Members up to age 19		
Vision Examination 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. Subject to maximum benefit.
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. 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.

[(1)] Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these Providers.

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.

***Refer to the Limitations Section of the AOC for information regarding EME and benefit maximums.*

Benefit Schedule

*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.

***Refer to the Limitations Section of the AOC for information regarding EME and benefit maximums.*

4 Tier Outpatient Prescription Drug Rider to the HPN Individual Agreement of Coverage

THIS PRESCRIPTION DRUG BENEFIT RIDER CONTAINS A CALENDAR YEAR DEDUCTIBLE ("CYD").

$250 Prescription Drug Calendar Year Deductible per Member not to exceed $500 for all Members in a Family

The Prescription Drug Calendar Year Deductible (CYD) applies to Tiers II, III and IV.

Please refer to your Attachment A Benefit Schedule for the applicable CYD.

Please refer to the HPN Prescription Drug List (PDL) for the listing of Covered Drugs.

Plan Retail Prescription Drug Benefits

Tier I: Member pays
$20 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier II: After CYD, Member pays
$40 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier III: After CYD, Member pays
$70 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier IV: After CYD, Member pays
$250 Copayment per Designated Plan Pharmacy Therapeutic Supply

Plan Mail Order Prescription Drug Benefits

Member pays 2.5 times the applicable Tier Copayment per Plan Mail Order Pharmacy Therapeutic Supply

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.

This Prescription Drug Benefit Rider is issued in consideration of: (a) your election of coverage under this Rider, (b) your eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Prescription Drug Benefit Rider is a supplement to your Agreement of Coverage (AOC) and Attachment A Benefit Schedule issued by Health Plan of Nevada, Inc., and amends your coverage to include benefits for Covered Drugs. This coverage is subject to the applicable terms, conditions, limitations and exclusions contained in your HPN AOC and herein.

NOTE: A Member's Cost-share for oral cancer prescription drugs under this plan will not exceed the lessor of one hundred dollars ($100) per prescription or the amount of the Cost-share for an injected or infused cancer drug.

SECTION 1. Obtaining Covered Drugs

Benefits for Covered Drugs are payable under the terms of this Rider subject to the following conditions:

- A **Designated** Plan Pharmacy must dispense the Covered Drug, except as otherwise specifically provided in Section 1.2 herein.
- A Generic Covered Drug will be dispensed when available, subject to the prescribing Provider's "Dispense as written" requirements.
- Benefits for Specialty Covered Drugs as defined herein are payable subject to the applicable Tier I, II, III or IV Cost-share. If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, HPN may direct you to a Designated Plan Pharmacy with whom HPN has an arrangement to provide those Covered Drugs.

1.1 Designated Plan Pharmacy Benefit Payments

Benefits for Covered Drugs obtained at a Designated Plan Pharmacy are payable according to the applicable benefit tiers described below, subject to the Member obtaining any required Prior Authorization or meeting any applicable Step Therapy requirement.

(a). **Tier I –** is the low Cost-share option for Covered Drugs.

(b). **Tier II –** is the midrange Cost-share option for Covered Drugs.

(c). **Tier III –** is the high Cost-share option for Covered Drugs.

(d). **Tier IV –** is the highest Cost-share option for Covered Drugs.

(e). **Mandatory Generic benefit provision applies when:**

- a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. After satisfying any applicable CYD, the Member will pay the applicable Cost-share plus the difference between the Eligible Medical Expenses ("EME") of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Designated Plan Pharmacy for each

Therapeutic Supply.

(f). When a Drug is dispensed through the Mail Order Plan Pharmacy, benefits are subject to any applicable CYD and associated Tier Cost-share per Mail Order Therapeutic Supply.

1.2 Emergency or Urgently Needed Services Prescription Drugs

(a). **Dispensed by a Plan Pharmacy:** When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN AOC, the Member will pay to the Plan Pharmacy at the time the Covered Drug is dispensed, the CYD and Cost-share amount subject to the applicable Tier I, II, III or IV benefit.

(b). **Dispensed by a Non-Plan Pharmacy:** When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN AOC, the Member will pay to the Non-Plan Pharmacy at the time the Covered Drug is dispensed, the full cost of the Covered Drug subject to Section 1.3 below

1.3 Non-Plan Pharmacy Benefit Payments

(a). In order that claims for Covered Drugs obtained at a Non-Plan Pharmacy be eligible for benefit payment, the Member must complete and submit a Pharmacy Reimbursement Claim Form with the prescription label and register receipt to HPN or its designee.

(b). Benefit payments are subject to the limitations and exclusions set forth in the HPN AOC and this Rider as follows:

1. When any Covered Drug is dispensed, the benefit payment will be subject to HPN's EME and any applicable CYD and corresponding Tier I, II, III or IV Cost-share. The Member is responsible for any amounts exceeding HPN's benefit payment. .

2. The Mandatory Generic benefit provision applies when any Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The benefit payment is subject to HPN's EME of the Generic Covered Drug less the applicable tier copayment. The Member is responsible for any amounts exceeding HPN's benefit payment.

3. No benefits are payable if HPN's EME of the Covered Drug is less than the applicable Cost-share.

1.4 Mail Order Plan Pharmacy Benefit Payments

(a). Benefits for Covered Drugs are available when dispensed by an HPN Mail Order Plan Pharmacy subject to the applicable Mail Order benefit..

(b). Information on how to obtain Mail Order Drugs is provided in the Mail Order Brochure provided after

enrollment with HPN.

SECTION 2. Limitations

2.1 Prior Authorization or Step Therapy may be required for certain Covered Drugs.

2.2 A pharmacy may refuse to fill or refill a prescription order when in the professional judgment of the pharmacist the prescription should not be filled.

2.3 Benefits for prescriptions for Mail Order Drugs submitted following HPN's receipt of notice of Member's termination will be limited to the appropriate Therapeutic Supply from the date such notice of termination is received to the Effective Date of termination of the Member.

2.4 Benefits are not payable if the Member is directed to a Designated Plan Pharmacy and chooses not to obtain the Covered Drug from that Designated Plan Pharmacy.

2.5 If HPN determines that the Member may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, the Member's selection of Plan Pharmacies may be limited. If this happens, HPN may require the Member to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if the Member uses the assigned single Plan Pharmacy. If a selection is not made by the Member within thirty-one (31) days of the date of notification, then HPN will select a single Plan Pharmacy for the Member.

SECTION 3. Exclusions

No benefits are payable for the following drugs, devices and supplies as well as for any complications resulting from their use except when prescribed in connection with the treatment of Diabetes:

3.1 Prescription Drug furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

3.2 Prescription Drugs for any condition, Injury, Illness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

3.3 Devices of any type, including those prescribed by a licensed Provider, except for prescription contraceptive devices.

3.4 Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

3.5 Any product dispensed for the purpose of appetite suppression or weight loss.

3.6 Medications used for cosmetic purposes.

3.7 Prescription Drug Products when prescribed to treat infertility.

3.8 Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

3.9 Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs.

3.10 Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the HPN AOC.

3.11 Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members.

3.12 Prescription Drugs dispensed prior to the Member's Effective Date of coverage or after Member's termination date of coverage under the Plan.

3.13 Prescription Drugs, including Covered Drugs, dispensed by a Non-Plan Provider, except in the case of Emergency Services and Urgently Needed Services.

3.14 Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless HPN has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that HPN has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and HPN may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

3.15 General vitamins, except the following which require a prescription order or refill: prenatal vitamins; vitamins with fluoride; and single entity vitamins.

3.16 Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury except for Prescription Drug Products that are enteral formulas prescribed for the treatment of inherited metabolic diseases as defined by state law.

3.17 Any Prescription Drug for which the actual charge to the Member is less than the amount due under this Rider.

3.18 Any refill dispensed more than one (1) year from the date of the latest prescription order or as permitted by applicable law of the jurisdiction in which the drug is dispensed.

3.19 Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.

3.20 Medical supplies unless listed on the PDL or Prior Authorized by HPN.

3.21 Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

3.22 Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

3.23 Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier III or IV).

3.24 Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.

3.25 Experimental or investigational or unproven services and medications; medication used for experimental indications and/or dosage regimens determined by the Plan to be experimental, investigational or unproven except when prescribed for the treatment of cancer or other life-threatening diseases or conditions, chronic fatigue syndrome, cardiovascular disease, surgical musculoskeletal disorder of the spine, hip and knees, and other diseases or disorders which are not life threatening or study approved by the Plan.

3.26 A Prescription Drug that contains an active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to a Covered Drug may be excluded as determined by the Plan.

3.27 Prescription Drugs dispensed outside the United States, except as required for emergency treatment.

3.28 Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission.

3.29 Covered Drugs that are not FDA approved for a specific diagnosis.

3.30 Drugs and medicine approved by the FDA for experimental or investigational use or any drug that has been approved by the FDA for less than one (1) year unless Prior Authorized by HPN.

3.1 Unit dose packaging of Prescription Drugs.

SECTION 4. Glossary

4.1 **"Brand Name Drug"** is a Prescription Drug which is marketed under or protected by:

- a registered trademark;
- or a registered trade name;
- or a registered patent.

4.2 **"Compound"** means to form or create a Medically Necessary customized composite product by combining two (2) or more

different ingredients according to a Physician's specifications to meet an individual patient's need.

4.3 **"Covered Drug"** is a Brand Name or Generic Prescription Drug or diabetic supply or equipment which:

- can only be obtained with a prescription;
- has been approved by the Food and Drug Administration ("FDA") for general marketing, subject to 3.31 herein;
- is dispensed by a licensed pharmacist;
- is prescribed by a Plan Provider, except in the case of Emergency Services and Urgently Needed Services;
- is a Prescription Drug that does not have an over-the-counter Therapeutic Equivalent available; and
- is not specifically excluded herein.

4.4 **"Copayment" or "Cost-share"** means the amount the Member pays when a Covered Service is received.

4.5 **"Designated Plan Pharmacy"** means a pharmacy that has entered into an agreement with HPN to provide specific Covered Drugs and/or supplies to Members. The fact that a pharmacy is a Plan Pharmacy does not mean that it is a Designated Plan Pharmacy. For the purposes of the Prescription Drug Benefit Rider, please refer to the HPN PDL on the website or contact Member Services for the specific Designated Plan Pharmacy for your Covered Drug and/or supply/equipment.

4.6 **"Dispensing Period"** as established by HPN means 1) a predetermined period of time; or 2) a period of time up to a predetermined age attained by the Member that a specific Covered Drug is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition.

4.7 **"Eligible Medical Expense (EME)"** for purposes of this Rider, means the Plan Pharmacy's contracted cost of the Covered Drug to HPN but not more than the actual charge to the Member.

4.8 **"Generic Drug"** is an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.

4.9 **"Mail Order Plan Pharmacy"** is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide certain Tier III and Tier IV Drugs to Members by mail.

4.10 **"Non-Plan Pharmacy"** is a duly licensed pharmacy that does not have an independent contractor agreement with HPN to provide Covered Drugs to Members.

4.11 **"Plan Pharmacy"** is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide Covered Drugs to Members. Unless otherwise specified as Mail Order Plan Pharmacy herein, Plan Pharmacy services

are retail services only and do not include Mail Order services.

4.12 **"Prescription Drug List (PDL)"** means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by HPN.

4.13 **"Prescription Drug"** is any drug required by federal law or regulation to be dispensed upon written prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.

4.14 **"Specialty Drugs"** are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by HPN's P&T Committee that are either self-administered or administered by a healthcare Provider and used or obtained in either an outpatient or home setting.

4.15 **"Step Therapy"** is a program for Members who take Prescription Drugs for an ongoing medical condition, such as arthritis, asthma or high blood pressure, which ensures the Member receives the most appropriate and cost-effective drug therapy for their condition. The Step Therapy program requires that before benefits are payable for a high cost Covered Drug that may have initially been prescribed, the Member try a lower cost first-step Covered Drug. If the prescribing Physician has documented with HPN why the Member's condition cannot be stabilized with the first-step Covered Drug, HPN will review a request for Prior Authorization to move the Member to a second-step drug, and so on, until it is determined by HPN that the prescribed Covered Drug is Medically Necessary and eligible for benefit payment.

4.16 **"Therapeutic Equivalent"** means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.

4.1 **"Therapeutic Supply"** is the maximum quantity of a Covered Drug for which benefits are available for the applicable Drug Fee or the applicable Coinsurance amount and may be less than but shall not exceed a 30-day retail supply or 90- day mail order supply.

Coverage Policies and Guidelines

HPNs Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on HPN's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug to a certain tier by considering a number of factors including but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug's acquisition cost including, but not limited to, available rebates and assessments of the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others; therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed, or according to whether it was prescribed by a Specialist Physician.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: the tier status of a Prescription Drug may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug.

Questions about HPN's PDL should be directed to the Member Services Department at 1-800-777-1840 or the PDL and the Pharmacy Reimbursement Claim Form is available at http://www.uhcnevada.com/ which leads to HPN's portal www.myhpnonline.com.