Health Plan of Nevada
A UnitedHealthcare Company

HPN BALANCE 20/1750

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 Evidence of Coverage.

Calendar Year Deductible (CYD): Your CYD is $1,750 of EME per Member and $3,500 of EME per family.

The **Calendar Year Out of Pocket Maximum** includes the CYD and is $7,000 per Member and $14,000 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.

Please note: For all Inpatient and Outpatient admissions, including those for Emergency or Urgent Care, in addition to specified surgical Copayment/Cost-share amounts, the 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).

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.

IMPORTANT NOTE: This plan does not provide any services received from a Non-Plan Provider except for Emergency Services or for Medically Necessary services that are not available through a Plan Provider.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Medical Office Visits/Consultations and Visits in an Outpatient Setting (including Telemedicine Services) **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.
Diagnostic Breast Cancer Imaging		Member pays $0 per visit.
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.	Yes	
• Lab		
Freestanding Diagnostic Center		Member pays $10 per visit.
Hospital Based Facility		After CYD, Member pays 20% of EME.
• X-Ray		
Freestanding Diagnostic Center		Member pays $10 per visit.
Hospital Based Facility		After CYD, Member pays 20% of EME.
Virtual Visits (Available through NowClinic or select contracted Providers)	No	Member pays $0 per visit.
Urgent Care Facility	No	Member pays $35 per visit.
Emergency Services		
• Emergency Room Facility (includes Physician Services)	No	After CYD, Member pays $1,000 per visit; waived if admitted through a Hospital Emergency Room Facility.
• 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 $1,000 per day not to exceed $3,000 per admission.

**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 Benefit*
Ambulance Services		
• Emergency Transport	No	After CYD, Member pays $1,000 per trip.
• Non-Emergency - HPN Arranged Transfers	Yes	Member pays $0.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)	Yes	After CYD, Member pays $1,000 per day not to exceed $3,000 per admission.
• Physician Fees and Medical Services	Yes	After CYD, Member pays $1,000 per day not to exceed $3,000 per admission.
Outpatient Hospital Facility Services	Yes	After CYD, Member pays $1,000 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.
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.

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

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	After CYD, Member pays $1,000 per day not to exceed $3,000 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.
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 is 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)	Yes	Member pays $20 per visit.
Hospice Care Services		
• Inpatient Hospice Facility	Yes	After CYD, Member pays $1,000 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		After CYD, Member pays $1,000 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.

**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 Benefit*
Skilled Nursing Facility Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.	Yes	After CYD, Member pays $1,000 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.
Residential Treatment Center	Yes	After CYD, Member pays $1,000 per admission; waived if admitted from an acute care facility.
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 Habilitation Services (including but not limited to Physical, Speech and Occupational Therapy) • Inpatient Hospital Facility • Outpatient All Inpatient and Outpatient Short-Term Habilitation Services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.	 Yes Yes	 After CYD, Member pays $1,000 per admission. Subject to maximum benefit. Member pays $20 per visit. Subject to maximum benefit.
Short-Term Rehabilitation Services (including but not limited to Physical, Speech and Occupational Therapy) • Inpatient Hospital Facility • Outpatient All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.	 Yes Yes	 After CYD, Member pays $1,000 per admission. Subject to maximum benefit. Member pays $20 per visit. Subject to maximum benefit.
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.
Genetic Disease Testing Services • Office Visit • Lab Includes Inpatient, Outpatient and independent Laboratory Services.	Yes	 Member pays $40 per visit. After CYD, Member pays 20% of EME.
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.

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

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required[1]	Tier I HMO Benefit*
Other Diagnostic and Therapeutic Services The 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 drug therapy or other Medically Necessary therapeutic drug services.	Yes	
Freestanding Diagnostic Center		Member pays 20% of EME.
Hospital Based Facility		After CYD, Member pays 20% of EME.
• Dialysis	Yes	
Freestanding Diagnostic Center		Member pays 20% of EME.
Hospital Based Facility		After CYD, Member pays 20% of EME.
• Therapeutic Radiology	Yes	
Freestanding Diagnostic Center		Member pays 20% of EME.
Hospital Based Facility		After CYD, Member pays 20% of EME.
• Complex Allergy Diagnostic Services (including RAST) and Serum Injections	Yes	
Freestanding Diagnostic Center		Member pays 20% of EME.
Hospital Based Facility		After CYD, Member pays 20% of EME.
• Otologic Evaluations	Yes	
Freestanding Diagnostic Center		Member pays 20% of EME.
Hospital Based Facility		After CYD, Member pays 20% of EME.
• 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	
Freestanding Diagnostic Center		Member pays 20% of EME.
Hospital Based Facility		After CYD, Member pays 20% of EME.
• Positron Emission Tomography (PET) scans	Yes	
Freestanding Diagnostic Center		Member pays 20% of EME.
Hospital Based Facility		After CYD, Member pays 20% of EME.
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.

**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 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.
Special Food Products and Enteral Formulas	Yes	Member pays $0.
Temporomandibular Joint Treatment	Yes	Member pays 50% of EME.
Mental Health and Severe Mental Illness Services		
• Inpatient Hospital Facility	Yes	After CYD, Member pays $1,000 per day not to exceed $3,000 per admission.
• Outpatient Office-based Individual and Group Therapy, and Medical Management Treatment (including Telemedicine Services)	No	Member pays $20 per visit.
• All other Outpatient Treatment (including Telemedicine Services)	Yes	Member pays $20 per visit.
Substance-Related and Addictive Disorder Services		
• Inpatient Hospital Facility	Yes	After CYD, Member pays $1,000 per day not to exceed $3,000 per admission.
• Outpatient Office-based Individual and Group Therapy, and Medical Management Treatment (including Telemedicine Services)	No	Member pays $20 per visit.
• All other Outpatient Treatment (including Telemedicine Services)	Yes	Member pays $20 per visit.
Hearing Aids Purchases are limited to a single purchase of a type of Hearing Aid per hearing impaired ear, 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 Limited to one thousand five hundred (1,500) total hours of therapy per Member per Calendar Year.	Yes	Member pays $20 per visit. Subject to maximum benefit.

The Member's 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. 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.

[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-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 Evidence of Coverage for additional information.

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