



HPN Solutions HMO 25 Direct Access - State of Nevada V2

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.

The **Calendar Year Out of Pocket Maximum** is \$5,000 per Member and \$10,000 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 Medically Necessary services that are not available through a Plan Provider.

**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*
<p>Medical Office Visits/Consultations and Visits in an Outpatient Setting (including Telemedicine Services)</p> <p>Primary Care Services</p> <ul style="list-style-type: none"> Physician Extender or Assistant Physician <p>Specialist Services</p> <ul style="list-style-type: none"> With Referral Without Referral <p>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/.</p> <p>If you have a question about whether or not a service is “Preventive”, please contact the HPN Member Services Department (1-800-777-1840).</p>	<p>No</p> <p>No</p> <p>Yes</p> <p>No</p> <p>No</p>	<p>Member pays \$15 per visit.</p> <p>Member pays \$25 per visit.</p> <p>Member pays \$25 per visit. Member pays \$40 per visit.</p> <p>Member pays \$0 per visit.</p>
<p>Non-preventive Routine Lab and X-ray Services</p> <p>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.</p> <ul style="list-style-type: none"> Lab X-Ray 	<p>Yes</p>	<p>Member pays \$0 per visit.</p> <p>Member pays \$0 per visit.</p>
<p>Virtual Visits (Available through NowClinic or select contracted Providers)</p>	<p>No</p>	<p>Member pays \$0 per visit.</p>
<p>Urgent Care Facility</p>	<p>No</p>	<p>Member pays \$50 per visit.</p>
<p>Emergency Services</p> <ul style="list-style-type: none"> Emergency Room Facility (includes Physician Services) Hospital Admission - Emergency Stabilization (includes Physician Services) Applies until patient is stabilized and safe for transfer as determined by the attending Physician. 	<p>No</p> <p>No</p>	<p>Member pays \$600 per visit; waived if admitted through a Hospital Emergency Room Facility.</p> <p>Member pays \$600 per admission.</p>
<p>Ambulance Services</p> <ul style="list-style-type: none"> Emergency Transport Non-Emergency - HPN Arranged Transfers 	<p>No</p> <p>Yes</p>	<p>Member pays \$0 per trip.</p> <p>Member pays \$0.</p>
<p>Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)</p> <ul style="list-style-type: none"> Physician Fees and Medical Services 	<p>Yes</p> <p>Yes</p>	<p>Member pays \$600 per admission.</p> <p>Member pays \$600 per admission.</p>

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Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required ¹	Tier I HMO Benefit*
Outpatient Hospital Facility Services	Yes	Member pays \$350 per surgery.
Ambulatory Surgical Facility Services	Yes	Member pays \$50 per surgery.
Anesthesia Services	Yes	Member pays \$0 per surgery.
Physician Surgical Services - Inpatient and Outpatient <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Hospital Facility • Ambulatory Surgical Facility • Physician's Office <ul style="list-style-type: none"> Primary Care Physician (Includes all physician services related to the surgical procedure) Specialist (Includes all physician services related to the surgical procedure) <ul style="list-style-type: none"> • With Referral • Without Referral 	 Yes Yes Yes No Yes No	 Member pays \$0 per surgery. Member pays \$0 per surgery. Member pays \$0 per surgery. Member pays \$0 per visit. Member pays \$25 per visit. Member pays \$45 per visit.
Gastric Restrictive Surgery Services HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member. <ul style="list-style-type: none"> • Physician Surgical Services • Physician's Office Visit 	 Yes Yes	 Member pays 50% of EME. Subject to maximum benefit. Member pays \$25 per visit.
Organ and Tissue Transplant Surgical Services <ul style="list-style-type: none"> • Inpatient Hospital Facility • Physician Surgical Services - Inpatient Hospital Facility 	 Yes Yes	 Member pays \$600 per admission. Member pays \$0 per surgery.

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Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required ¹	Tier I HMO Benefit*
<ul style="list-style-type: none"> 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.
<p>Post-Cataract Surgical Services</p> <ul style="list-style-type: none"> Frames and Lenses Contact Lenses <p>Benefit is limited to one (1) pair of Medically Necessary glasses or set of contact lenses as applicable per Member per surgery.</p>	<p>Yes</p> <p>Yes</p>	<p>Member pays \$10 per pair of glasses. Subject to maximum benefit.</p> <p>Member pays \$10 per set of contact lenses. Subject to maximum benefit.</p>
<p>Home Healthcare Services (does not include Specialty Prescription Drugs)</p>	Yes	Member pays \$0 per visit.
<p>Hospice Care Services</p> <ul style="list-style-type: none"> Inpatient Hospice Facility Outpatient Hospice Services 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. ◦ Inpatient 	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$600 per admission.</p> <p>Member pays \$0 per visit.</p> <p>Member pays \$600 per admission. Subject to maximum benefit.</p>

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Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required ¹	Tier I HMO Benefit*
<ul style="list-style-type: none"> ◦ Outpatient • 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	<p>Member pays \$25 per visit. Subject to maximum benefit.</p> <p>Member pays \$25 per visit. Subject to maximum benefit.</p>
<p>Skilled Nursing Facility Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.</p>	Yes	Member pays \$600 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.
<p>Residential Treatment Center Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.</p>	Yes	Member pays \$600 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.
<p>Manual Manipulation Applies to Medical-Physician Services and Chiropractic office visit.</p> <p>Subject to a maximum benefit of twenty (20) visits per Member per Calendar Year.</p> <ul style="list-style-type: none"> • With Referral • Without Referral 	Yes No	<p>Member pays \$25 per visit. Subject to maximum benefit.</p> <p>Member pays \$45 per visit. Subject to maximum benefit.</p>
<p>Short-Term Habilitation Services (including but not limited to Physical, Speech and Occupational Therapy)</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient <p>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.</p>	Yes Yes	<p>Member pays \$600 per admission. Subject to maximum benefit.</p> <p>Member pays \$25 per visit. Subject to maximum benefit.</p>
<p>Short-Term Rehabilitation Services (including but not limited to Physical, Speech and Occupational Therapy)</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility 	Yes	Member pays \$600 per admission. Subject to maximum benefit.

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Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required ¹	Tier I HMO Benefit*
<ul style="list-style-type: none"> • Outpatient <p>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.</p>	Yes	Member pays \$25 per visit. Subject to maximum benefit.
<p>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.</p>	Yes	Member pays \$0. Subject to maximum benefit.
<p>Genetic Disease Testing Services</p> <ul style="list-style-type: none"> • Office Visit <ul style="list-style-type: none"> • With Referral • Without Referral • Lab Includes Inpatient, Outpatient and independent Laboratory Services. 	Yes No Yes	Member pays \$25 per visit. Member pays \$45 per visit. Member pays 25% of EME.
<p>Infertility Office Visit Evaluation Please refer to applicable surgical procedure Copayment/Cost-share and/or Coinsurance amount herein for any surgical infertility procedures performed.</p> <ul style="list-style-type: none"> • With Referral • Without Referral 	Yes No	Member pays \$25 per visit. Member pays \$45 per visit.
<p>Medical Supplies (Obtained outside of a medical office visit)</p>	Yes	Member pays \$0.
<p>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.</p> <ul style="list-style-type: none"> • Anti-cancer drug therapy, non-cancer related drug therapy or other Medically Necessary therapeutic drug services. • Dialysis • Therapeutic Radiology • Complex Allergy Diagnostic Services (including RAST) and Serum Injections 	Yes Yes Yes Yes	Member pays \$25 per day. Member pays \$25 per day. Member pays \$25 per day. Member pays \$25 per visit.

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Benefit Schedule

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<ul style="list-style-type: none"> • Otologic Evaluations • 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. • Positron Emission Tomography (PET) scans 	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$25 per visit.</p> <p>Member pays \$100 per test or procedure.</p> <p>Member pays \$100 per test or procedure.</p>
<p>Prosthetic Devices Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.</p>	Yes	Member pays \$750 per device. Subject to maximum benefit.
<p>Orthotic Devices Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.</p>	Yes	Member pays \$50 per device. Subject to maximum benefit.
<p>Self-Management and Treatment of Diabetes</p> <ul style="list-style-type: none"> • Education and Training • Supplies (except for Insulin Pump Supplies) <ul style="list-style-type: none"> Insulin Pump Supplies • Equipment (except for Insulin Pump) <ul style="list-style-type: none"> Insulin Pump 	<p>No</p> <p>No</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$25 per visit.</p> <p>Member pays \$5 per therapeutic supply.</p> <p>Member pays \$10 per therapeutic supply.</p> <p>Member pays \$20 per device.</p> <p>Member pays \$100 per device.</p>
<p>Special Food Products and Enteral Formulas</p>	Yes	Member pays \$0.
<p>Temporomandibular Joint Treatment</p>	Yes	Member pays 50% of EME.
<p>Mental Health and Severe Mental Illness Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Treatment (including Telemedicine Services) 	<p>Yes</p> <p>Yes</p>	<p>Member pays \$600 per admission.</p> <p>Member pays \$25 per visit.</p>
<p>Substance-Related and Addictive Disorder Services</p>		

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Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required¹	Tier I HMO Benefit*
<ul style="list-style-type: none"> Inpatient Hospital Facility 	Yes	Member pays \$600 per admission.
<ul style="list-style-type: none"> Outpatient Treatment (including Telemedicine Services) 	Yes	Member pays \$25 per visit.
<p>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.</p>	Yes	Member pays \$0. Subject to maximum benefit.
<p>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.</p>	Yes	Member pays \$25 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.

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