HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

HPN G V Medical Plan – HCR

Attachment A Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Medical – Physician Services and Physician Consultations		
• Office Visit/Consultation Primary Care Physician	No	$3 per visit
Specialist	Yes	$3 per visit
• Inpatient Visit/Consultation Primary Care Physician	Yes	No charge
Specialist	Yes	No charge
Laboratory Services *Copayment is in addition to the Physician office visit Copayment and applies to services rendered in a Physician's office or at an independent laboratory.*	Yes	No charge
Routine Radiological and Non-Radiological Diagnostic Imaging Services *Copayment is in addition to the Physician office visit Copayment and applies to services rendered in a Physician's office or at an independent radiological facility.*	Yes	No charge
Emergency Services *Within* the Service Area		
• Urgent Care Facility	No	$15 per visit

Legal Documents

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Emergency Services *Within* the Service Area (continued)		
• Emergency Room Visit	No	$75 per visit; waived if admitted
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	No	No charge
• Office Visit to Non-Plan Physician	No	$25 per visit
Emergency Services *Outside* the Service Area		
• Urgent Care Facility	No	$15 per visit
• Emergency Room Visit	No	$75 per visit; waived if admitted
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	No	No charge
• Office Visit	No	$25 per visit
Ambulance Services		
• Emergency – Ground Transport	No	$50 per trip
• Emergency – Air Transport	No	50% of EME per trip
• Non-Emergency – HPN Arranged Transfers	Yes	No charge
Inpatient Hospital Facility Services *Elective and Emergency Post-Stabilization Admissions*	Yes	No charge
Outpatient Hospital Facility and Ambulatory Surgical Facility Services	Yes	No charge

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Physician Surgical Services – Inpatient and Outpatient		
• Inpatient Hospital Facility	Yes	No charge
• Outpatient Hospital Facility	Yes	No charge
• Physician's Office Primary Care Physician (in addition to office visit Copayment)	No	$3 per visit
Specialist (in addition to office visit Copayment)	Yes	$3 per visit
Assistant Surgical Services	Yes	No charge
Anesthesia Services	Yes	$100 per surgery
Gastric Restrictive Surgery Services *The maximum lifetime benefit for all Gastric Restrictive Surgery Services is $5,000 per Member.*		
• Physician Surgical Services	Yes	50% of EME. Subject to maximum benefit.
• Complications *The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgery Services is $5,000 per Member.*	Yes	50% of EME. Subject to maximum benefit.
Mastectomy Reconstructive Surgical Services		
• Physician Surgical Services	Yes	No charge
• Prosthetic Device for Mastectomy Reconstruction *Unlimited.*	Yes	$200 per device
Oral Physician Surgical Services		
• Office Visit	Yes	$3 per visit
• Physician Surgical and Diagnostic Services Inpatient Hospital Facility	Yes	No charge
Outpatient Hospital Facility	Yes	No charge

Benefit Schedule

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Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	No charge
• Physician Surgical Services – Inpatient Hospital Facility	Yes	No charge
• 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	No charge. 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	No charge. Subject to maximum benefit.
• Retransplantation Services *The maximum benefit for Retransplantation Services is 50% of EME, which does not apply towards the Calendar Year Copayment Maximum.*	Yes	50% of EME. Subject to maximum benefit.
Post-Cataract Surgical Services		
• Frames and Lenses *Maximum frame allowance of $100.*	Yes	$10 per pair of glasses. Subject to maximum benefit.
• Contact Lenses *Maximum contact lenses allowance of $100.*	Yes	$10 per set of contact lenses. Subject to maximum benefit.
Benefit limited to one (1) pair of glasses or set of contact lenses as applicable per Member per surgery.		
Home Healthcare Services (*does not include Self-Injectable Prescription Drugs)* *Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to outpatient Covered Drugs.*		
• Physician House Calls	Yes	$20 per visit

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Home Healthcare Services (continued)		
• Home Care Services	Yes	No charge
• Private Duty Nurse	Yes	No charge
Hospice Care Services		
• Inpatient Hospice Facility	Yes	No charge
• Outpatient Hospice Services	Yes	No charge
• Inpatient Respite Services *Limited to a maximum benefit of $1,500 per Member per Calendar Year.*	Yes	No charge. Subject to maximum benefit.
• Outpatient Respite Services *Limited to a maximum benefit of $1,000 per Member per Calendar Year.*	Yes	No charge. Subject to maximum benefit.
• Bereavement Services *Limited to a maximum benefit of five (5) group therapy sessions or $500, whichever is less. Treatment must be completed within six (6) months of the date of death.*	Yes	$20 per visit. Subject to maximum benefit.
Skilled Nursing Facility *Limited to a maximum benefit of one hundred (100) days per Member per Calendar Year.*	Yes	No charge. Subject to maximum benefit.
Manual Manipulation *Applies to Medical-Physician Services and Chiropractic office visit.*	Yes	$3 per visit
Short-Term Rehabilitation Services		
• Inpatient Hospital Facility	Yes	No charge. Subject to maximum benefit.
• Outpatient	Yes	$3 per visit. Subject to maximum benefit.
All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a maximum benefit of sixty (60) days/visits per Member per Calendar Year.		

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Durable Medical Equipment *For purchase or rental at HPN's option.*	Yes	$100 or 50% of EME of purchase or rental price, whichever is less.
Genetic Disease Testing Services *Includes Inpatient, Outpatient and independent Laboratory Services.*	Yes	25% of EME per test
Infertility Office Visit Evaluation *Please refer to applicable surgical procedure Copayment and/or Coinsurance amount herein for any surgical infertility procedures performed.*	Yes	$3 per visit
Medical Supplies	Yes	No charge
Other Diagnostic and Therapeutic Services *Copayment is in addition to the Physician office visit Copayment 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	$20 per day
• Dialysis	Yes	$20 per day
• Therapeutic Radiology	Yes	$20 per day
• Allergy Testing and Serum Injections	Yes	$3 per visit
• Otologic Evaluations	Yes	$3 per visit
• Other services such as complex diagnostic imaging; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.	Yes	$20 per test or procedure
• Positron Emission Tomography (PET Scan)	Yes	$750 per test

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Prosthetic and Orthotic Devices *Limited to a maximum lifetime benefit of $10,000 per Member including:* • *repairs; and* • *post-mastectomy external prosthetic device.*	Yes	$200 per device. Subject to maximum benefit.
Self-Management and Treatment of Diabetes		
• Education and Training	No	$3 per visit
• Supplies (except for Insulin Pump Supplies)	No	$5 per therapeutic supply
Insulin Pump Supplies	Yes	$10 per therapeutic supply
• Equipment (except for Insulin Pump)	Yes	$20 per device
Insulin Pump	Yes	$100 per device
Refer to the Outpatient Prescription Drug Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail pharmacy.		
Special Food Products and Enteral Formulas *Limited to a maximum benefit of $2,500 per Member per Calendar Year for Special Food Products only.*	Yes	No charge. Subject to maximum benefit.
Temporomandibular Joint Treatment *Dental-related treatment is limited to $2,500 per Member per Calendar Year and $4,000 maximum lifetime benefit per Member.*	Yes	50% of EME. Subject to maximum benefit.
Mental Health Services		
• Inpatient Hospital Facility	Yes	No charge. Subject to maximum benefit.
• Outpatient Treatment		
Group Therapy	Yes	$3 per visit
Individual, Family and Partial Care Therapy**	Yes	$3 per visit

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Mental Health Services (continued) *** Partial Care Therapy refers to a coordinated Outpatient program of treatment that provides structured daytime, evening and/or weekend services for a minimum of four (4) hours per session as an alternative to Inpatient care.*		
Severe Mental Illness Services		
• Inpatient Hospital Facility	Yes	No charge
• Outpatient Treatment	Yes	$3 per visit
Substance Abuse Services		
• Inpatient Detoxification (treatment for withdrawal)	Yes	No charge
• Outpatient Detoxification	Yes	$3 per visit
• Inpatient Rehabilitation	Yes	No charge
• Outpatient Rehabilitation Counseling		
Group Therapy	Yes	$3 per visit
Individual, Family and Partial Care Therapy** *** Partial Care Therapy refers to a coordinated Outpatient program of treatment that provides structured daytime, evening and/or weekend services for a minimum of four (4) hours per session as an alternative to Inpatient care.*	Yes	$3 per visit
Preventive Healthcare Services	No	No charge
Hearing Aids *Limited to a maximum benefit of $5,000 per Member per Calendar Year and further limited to a single purchase. Repairs and Replacement are limited to once every three (3) years.*	Yes	$100 or 50% of EME, whichever is less. Subject to maximum benefit.

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Applied Behavioral Analysis (ABA) for the treatment of Autism *Limited to a maximum benefit of $36,000 per Member per Calendar Year.*	Yes	$3 per visit. Subject to maximum benefit.

The Calendar Year Copayment Maximum for Tier I HMO basic health services is 200% of the total premium rate the Member would pay if he were enrolled under a Health Benefit Plan without Copayments. A Copayment will not exceed more than 50% of the total cost of providing any single service to a Member, or, in the aggregate, not more than 20% of the total cost of providing all of the basic healthcare services as required by Nevada regulations. Tier I HMO benefits have a Calendar Year Copayment Maximum.

Contact HPN's Member Services Department at (702) 242-7300 or 1-800-777-1840, Monday through Friday from 8:00 AM to 5:00 PM, for the appropriate Calendar Year Copayment Maximum applicable to this Plan.

Please note: For Inpatient and Outpatient admissions, in addition to specified surgical Copayments and/or Coinsurance amounts, Member is also responsible for all other applicable facility and professional Copayments and/or Coinsurance amounts 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 Copayment Maximum.

*PAR (Prior Authorization Required) – Except as otherwise noted and with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness, Substance Abuse Services, Covered Services not provided by the Member's Primary Care Physician require Prior Authorization in the form of a written referral authorization from HPN. Please refer to your HPN Evidence of Coverage for additional information.