The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.healthplanofnevada.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-777-1840 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	Not Applicable
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,500/Member and $5,000/Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for not obtaining any required prior authorization, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthplanofnevada.com/Member/Doctor-or-Provider or call 1-800-777-1840 for a list of Plan Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	None
	Specialist visit	$50 copay/visit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Preventive care/ screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $25 copay/service Lab: No charge	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Imaging (CT/PET scans, MRIs)	PET Scan: $100 copay/service MRI: $100 copay/service CT: $100 copay/service	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthplanofnevada.com	Tier 1	$7 copay/prescription (retail) $17.50 copay/prescription (mail)	Not Covered	You have a 3-Tier pharmacy plan. Covers up to a 30-day retail supply or up to a 90-day mail order supply. Member pays for cost of services if prior authorization or step therapy is not obtained.
	Tier 2	$30 copay/prescription (retail) $75 copay/prescription (mail)	Not Covered	
	Tier 3	$50 copay/prescription (retail) $125 copay/prescription (mail)	Not Covered	
	Tier 4	Not Covered	Not Covered	Not Applicable.

*For more information about limitations and exceptions, see plan or policy document at www.healthplanofnevada.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Physician/surgeon fees	No charge	Not Covered	
If you need immediate medical attention	Emergency room care	ER Physician: No charge ER Facility: $100 copay/visit	ER Physician: No charge ER Facility: $100 copay/visit	You may be balance billed from Non-Plan Providers.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$25 copay/visit	$25 copay/visit	You may be balance billed from Non-Plan Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Physician/surgeon fees	No charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Inpatient services	$400 copay/admit	Not Covered	
If you are pregnant	Office visits	No charge	Not Covered	Routine prenatal care obtained from a Plan Provider is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab).
	Childbirth/delivery professional services	Surgical: No charge Anesthesia: No charge	Not Covered	Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services; each service has a separate cost-share. Member pays for cost of services if prior authorization is not obtained.
	Childbirth/delivery facility services	$400 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.

*For more information about limitations and exceptions, see plan or policy document at www.healthplanofnevada.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$25 copay/visit	Not Covered	Does not include Specialty Prescription Drugs. Member pays for cost of services if prior authorization is not obtained.
	Rehabilitation services	$25 copay/visit	Not Covered	Coverage is limited to 60 days/visits per year. Member pays for cost of services if prior authorization is not obtained.
	Habilitation services	$25 copay/visit	Not Covered	Coverage is limited to 60 days/visits per year. Member pays for cost of services if prior authorization is not obtained.
	Skilled nursing care	$400 copay/admit	Not Covered	Coverage is limited to 100 days. Member pays for cost of services if prior authorization is not obtained.
	Durable medical equipment	$100 copay/device	Not Covered	For purchase or rental at HPN's option. Purchases are limited to a single type of DME, including repair and replacement, every 3 years. Member pays for cost of services if prior authorization is not obtained.
	Hospice services	$300 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Your plan may include certain vision and/or dental services. Please refer to your plan documents for more information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except for rape, incest, life at risk)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - One (1) per Lifetime
- Chiropractic care - 20 visits per calendar year
- Hearing aids - One (1) every three (3) years (including repair/replace)
- Limited infertility treatment
- Private-duty nursing

*For more information about limitations and exceptions, see plan or policy document at www.healthplanofnevada.com

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Nevada Department of Insurance at 888-872-3234or www.doi.nv.gov or call 1-800-777-1840

Does this plan provide Minimum Essential Coverage?

Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards?

Yes. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.

Tagalog (Tagalog): Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.

Chinese (中文): 若需要中文协助，请拨打本文件内的客户服务电话。

Navajo (Dine): Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section*----------

*For more information about limitations and exceptions, see plan or policy document at www.healthplanofnevada.com

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0.00
Specialist copayment	$50.00
Hospital (facility) copayment	$400.00
Other copayment	$0.00

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700.00
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0.00
Copayments	$1,000.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	$1,000.00

Managing Joe's type 2 diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0.00
Specialist copayment	$50.00
Hospital (facility) copayment	$200.00
Other copayment	$0.00

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$7,400.00
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0.00
Copayments	$1,100.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	$1,100.00

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0.00
Specialist copayment	$50.00
Hospital (facility) copayment	$200.00
Other copayment	$25.00

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$1,900.00
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0.00
Copayments	$400.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	$400.00

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

*For more information about limitations and exceptions, see plan or policy document at www.healthplanofnevada.com

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

English: You have the right to get help and information in your language at no cost. To request an interpreter, call the phone number listed within this Summary of Benefits and Coverage (SBC).

This letter is also available in other formats like large print. To request the document in another format, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

Español (Spanish): Usted tiene derecho a recibir ayuda e información en su idioma sin costo. Para pedir un intérprete, llame al número de teléfono que figura en este Resumen de Beneficios y Cobertura.

Tagalog (Tagalog): May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang libre. Upang humiling ng interpreter, tawagan ang numero ng telepono na nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

繁體中文 (Chinese):
您有權利以您的母語免費取得協助和資訊。若需申請口譯服務，請打本福利摘要 (SBC) 內含的電話號碼。

한국어(Korean): 귀하는 무료로 귀하의 언어를 통해 도움 및 정보를 받으실 권리가 있습니다. 통역사를 요청하시려면 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 전화번호로 전화하십시오.

Tiếng Việt (Vietnamese): Quý vị có quyền nhận hỗ trợ và thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu thông dịch viên, hãy gọi số điện thoại được liệt kê trong Tóm tắt quyền lợi và khoản đài thọ (Summary of Benefits and Coverage, SBC) này.

አማርኛ (Amharic):- የለምንም ወጪ እርዳታና መረጃ የማግኘት መብት አለዎት። አስተርጓሚ ለመጠየቅ፣ በዚህ Summary of Benefits and Coverage/የጥቅማጥቅሞችና የሽፋን ማጠቃለያ (SBC) ውስጥ የተዘረዘረውን የቴሌፎን ቁጥር ይደውሉ።

ภาษาไทย (Thai):
คุณมีสิทธิ์รับความช่วยเหลือและข้อมูลเป็นภาษาของคุณเองได้โดยไม่เสียค่าใช้จ่ายใด ๆ ถ้าต้องการล่ามแปล โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่ในเอกสาร "สาระสำคัญเกี่ยวกับผลประโยชน์และการคุ้มครอง (Summary of Benefits and Coverage หรือ SBC)" นี้

日本語 (Japanese):
ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、本「保障および給付の概要」（Summary of Benefits and Coverage、SBC）に記載されている電話番号にお電話ください。

العربية (Arabic): لديك الحق في الحصول على المساعدة بلغتك دون تكلفة. لطلب مترجم، اتصل برقم الهاتف المدرج في موجز المزايا والتغطية هذا (SBC).

Русский (Russian): Вы вправе получать помощь и информацию на родном языке без дополнительной оплаты. Чтобы заказать услуги переводчика, обращайтесь по номеру, указанному в данном Обзоре льгот и страхового покрытия (Summary of Benefits and Coverage, SBC)

Français (French): Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander l'aide d'un interprète, veuillez appeler le numéro de téléphone figurant dans ce Sommaire des prestations et de la couverture.

فارسی (Persian): شما حق دارید که راهنمایی و اطلاعات را به طور رایگان به زبان خودتان دریافت کنید. برای درخواست مترجم شفاهی، با شماره ای که در این خلاصه مزایا و پوشش (SBC) قید شده تماس بگیرید.

Gagana fa'a Sāmoa (Samoan): E iai lau aia tatau e maua ai le fesoasoani ma faamatalaga i lau gagana e aunoa ma se totogi. Ina ia talosaga mo se tagata faaliliu, telefoni i le numera o lisi atu i totonu o lenei Otootoga o Faamanuiaga ma le Kavaina (SBC).

Deutsch (German): Sie haben das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Zur Anforderung eines Dolmetschers wenden Sie sich bitte telefonisch an die in dieser Zusammenfassung der Leistungen und des Versicherungsschutzes aufgeführte Rufnummer.

Ilokano (Ilocano): Addaan ka ti karbengan nga makaala iti tulong ken impormasion ayan iti lenguahem nga awan bayad na. Tapno agkiddaw iti tagapataros, awagan ti numero ti telepono nga nakalista iti uneg iti Dagup dagiti Benipisyo ken Pannakasakup (SBC).

HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

HPN Solutions HMO 25 C

Attachment A Benefit Schedule

The Calendar Year Out of Pocket Maximum is $2,500 per Member and $5,000 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, 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).

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[(1)]	Tier I HMO Plan Provider Benefit*
Medical Office Visits and Consultations		
Primary Care Services		
• Convenient Care Facility	No	Member pays $15 per visit.
• Physician Extender or Assistant	No	Member pays $15 per visit.
• Physician	No	Member pays $25 per visit.
Specialist Services	Yes	Member pays $50 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 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		Member pays $0.
• X-Ray		Member pays $25 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 Plan Provider Benefit*
Telemedicine Services (Only available through select contracted Providers.)	No	Member pays $15 per visit.
Urgent Care Facility	No	Member pays $25 per visit.
Emergency Services		
• Emergency Room Facility (includes Physician Services)	No	Member pays $100 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	Member pays $400 per admission.
Ambulance Services		
• Emergency Transport	No	Member pays $0.
• Non-Emergency - HPN Arranged Transfers	Yes	Member pays $0.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)	Yes	Member pays $400 per admission.
Outpatient Hospital Facility Services	Yes	Member pays $200 per surgery.
Ambulatory Surgical Facility Services	Yes	Member pays $200 per surgery.
Anesthesia Services	Yes	Member pays $0.
Physician Surgical Services – Inpatient and Outpatient		
• Inpatient Hospital Facility	Yes	Member pays $0.
• Outpatient Hospital Facility	Yes	Member pays $0.
• Ambulatory Surgical Facility	Yes	Member pays $0.
• Physician's Office		
Primary Care Physician (Includes all physician services related to the surgical procedure)	No	Member pays $0.
Specialist (Includes all physician services related to the surgical procedure)	Yes	Member pays $0.

**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 Plan Provider Benefit*
Gastric Restrictive Surgery Services HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.		
• Physician Surgical Services	Yes	Member pays $400 per admit. Subject to maximum benefit.
• Physician's Office Visit	Yes	Member pays $50 per visit.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	Member pays $400 per admission.
• Physician Surgical Services - Inpatient Hospital Facility	Yes	Member pays $150 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.
• Procurement The maximum benefit per Member per Transplant Benefit Period for Procurement of the organ/tissue is $15,000 of EME.	Yes	Member pays $0. 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 Benefit limited to one (1) pair of Medically Necessary glasses or set of contact lenses as applicable per Member per surgery.	Yes	Member pays $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.	Yes	Member pays $25 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 Plan Provider Benefit*
Hospice Care Services		
• Inpatient Hospice Facility	Yes	Member pays $300 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		Member pays $300 per admission. Subject to maximum benefit.
◦ Outpatient		Member pays $50 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 $25 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	Member pays $400 per admission; waived if admitted from an acute care facility. 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 $25 per visit. Subject to maximum benefit.
Short-Term Rehabilitation and Habilitation Services		
• Inpatient Hospital Facility	Yes	Member pays $400 per admission. Subject to maximum benefit.
• Outpatient	Yes	Member pays $25 per visit. Subject to maximum benefit.
All Inpatient and Outpatient Short Term Rehabilitation and Habilitative Services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.		
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 $100. 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 Plan Provider Benefit*
Genetic Disease Testing Services	Yes	
• Office Visit		Member pays $50 per visit.
• Lab Includes Inpatient, Outpatient and independent Laboratory Services.		Member pays $50 per visit.
Infertility Office Visit Evaluation Please refer to applicable surgical procedure Copayment/Cost-share amount herein for any surgical infertility procedures performed.	Yes	Member pays $50 per visit.
Medical Supplies (Obtained outside of a medical office visit)	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 $25 per day.
• Dialysis		Member pays $25 per day.
• Therapeutic Radiology		Member pays $25 per day.
• Complex Allergy Diagnostic Services (including RAST) and Serum Injections		Member pays $25 per visit.
• Otologic Evaluations		Member pays $25 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.		Member pays $100 per test or procedure.
• Positron Emission Tomography (PET) scans	Yes	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 $50 per device. Subject to maximum benefit.

**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 Plan Provider 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.
Self-Management and Treatment of Diabetes		
• Education and Training	No	Member pays $25 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	Member pays 50% of EME.
Mental Health and Severe Mental Illness Services		
• Inpatient Hospital Facility	Yes	Member pays $400 per admission.
• Outpatient Treatment	Yes	Member pays $25 per visit.
Substance Abuse Services		
• Inpatient Hospital Facility	Yes	Member pays $400 per admission.
• Outpatient Treatment	Yes	Member pays $25 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 $0. 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 Plan Provider 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 $25 per visit. Subject to maximum benefit.

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.

[(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 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 Evidence of Coverage for additional information.

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

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

3-Tier Outpatient Prescription Drug Rider to the HPN Group Evidence of Coverage

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

Plan Retail Prescription Drug Benefits

Tier I: Member pays
$7 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier II: Member pays
$30 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier III: Member pays
$50 Copayment per Designated Plan Pharmacy Therapeutic Supply

Plan Mail Order Prescription Drug Benefit

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

This Prescription Drug Benefit Rider is issued in consideration of: (a) Group's 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 Evidence of Coverage (EOC) 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 EOC and herein.

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

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.

prescribing Provider's "Dispense as written" requirements.

- Benefits for Specialty Covered Drugs as defined herein are payable subject to the applicable Tier I, II or III benefit level. 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 have 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 option for Covered Drugs.

(b). **Tier II –** is the midrange cost option for Covered Drugs.

(c). **Tier III –** is the high cost option for Covered Drugs.

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

- a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The Member will pay the Covered Copayment 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.

(e). When a Drug is dispensed through the Mail Order Plan Pharmacy, the applicable Tier I, Tier II, or Tier III Mail Order Plan Pharmacy benefit tier will apply per 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 EOC, the Member will pay to the Plan Pharmacy at the time the Covered Drug is dispensed, the Copayment amount subject to the applicable Tier I, Tier II or Tier III 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 EOC, 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 EOC and this Rider as follows:

1. When any Covered Drug is dispensed, the benefit payment will be subject to HPN's EME and the applicable Tier I, II or III Copayment amount. 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 Copayment.

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 Tier I, Tier II or Tier III 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 individual'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 individual.

2.4 Benefits are not payable if you are directed to a Designated Plan Pharmacy and you choose not to obtain your Covered Drug from that Designated Plan Pharmacy.

2.5 If HPN determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Plan Pharmacies may be limited. If this happens, HPN may require you to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if you use the assigned single Plan Pharmacy. If you do not make a selection within thirty-one (31) days of the date you are notified, then HPN will select a single Plan Pharmacy for you.

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 EOC.

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).

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 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 3.16 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" 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 I, Tier II and Tier III 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.

4.17 "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.

HPN may periodically change the placement of a Prescription Drug among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

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 (702) 242-7300 or 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.