



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

***School Administrators' and Professional-technical
Employees' Welfare Trust ("Trust")
HMO Plan***

Attachment A Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
<p>Medical – Physician Services and Physician Consultations</p> <ul style="list-style-type: none"> • Office Visit/Consultation Primary Care Physician Specialist • Inpatient Visit/Consultation Primary Care Physician Specialist 	<p align="center">No</p> <p align="center">Yes</p> <p align="center">No</p> <p align="center">Yes</p>	<p align="center">\$10 per visit</p> <p align="center">\$10 per visit</p> <p align="center">No charge</p> <p align="center">No charge</p>
<p>Preventive Healthcare Services</p>	<p align="center">No</p>	<p align="center">No charge</p>
<p>Laboratory Services <i>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.</i></p>	<p align="center">Yes</p>	<p align="center">\$10 per visit</p>
<p>Routine Radiological and Non-Radiological Diagnostic Imaging Services <i>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.</i></p>	<p align="center">Yes</p>	<p align="center">\$10 per visit</p>

Legal Documents

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
<p>Emergency Medical/Surgical Services</p> <ul style="list-style-type: none"> • Urgent Care Facility • • Emergency Room Visit • Hospital Admission – Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i> • Office Visit to Non-Plan Physician 	<p>No</p> <p>No</p> <p>No</p> <p>No</p>	<p>\$15 per visit</p> <p>\$25 per visit</p> <p>\$100 per day not to exceed \$300 per admission</p> <p>\$15 per visit</p>
<p>Emergency Mental Health/Severe Mental Illness/ Substance Abuse Services</p> <ul style="list-style-type: none"> • Urgent Care Facility • Emergency Room Visit • Hospital Admission – Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i> • Office Visit 	<p>No</p> <p>No</p> <p>No</p> <p>No</p>	<p>\$15 per visit</p> <p>No charge</p> <p>No charge No charge</p> <p>No charge</p>
<p>Ambulance Services</p> <ul style="list-style-type: none"> • Emergency – Ground Transport • Emergency – Air Transport • Non-Emergency – HPN Arranged Transfers 	<p>No</p> <p>No</p> <p>Yes</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>
<p>Inpatient Hospital Facility Services <i>Elective and Emergency Post-Stabilization Admissions</i></p>	<p>Yes</p>	<p>\$100 per day not to exceed \$300 per admission</p>
<p>Outpatient Hospital Facility and Ambulatory Surgical Facility Services</p>	<p>Yes</p>	<p>\$50 per admission</p>

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Physician Surgical Services – Inpatient and Outpatient <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Hospital Facility • Physician’s Office Primary Care Physician (in addition to office visit Copayment) • Specialist (in addition to office visit Copayment) 	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>\$10 per visit</p>
Assistant Surgical Services	Yes	No charge
Anesthesia Services	Yes	No charge
Gastric Restrictive Surgical Services <i>The maximum lifetime benefit for all Gastric Restrictive Surgical Services is \$5,000 per Member.</i> <ul style="list-style-type: none"> • Physician Surgical Services • Complications <i>The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgical Services is \$5,000 per Member.</i> 	<p>Yes</p> <p>Yes</p>	<p>50% of EME. Subject to maximum benefit.</p> <p>50% of EME. Subject to maximum benefit.</p>
Mastectomy Reconstructive Surgical Services <ul style="list-style-type: none"> • Physician Surgical Services • Prosthetic Device for Mastectomy Reconstruction <i>Unlimited.</i> 	<p>Yes</p> <p>Yes</p>	<p>No charge</p> <p>\$750 per device</p>
Oral Physician Surgical Services <ul style="list-style-type: none"> • Office Visit • Physician Surgical and Diagnostic Services Inpatient Hospital Facility • Outpatient Hospital Facility 	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>

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<p>Organ and Tissue Transplant Surgical Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Physician Surgical Services – Inpatient Hospital Facility • Transportation, Lodging and Meals <i>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.</i> • Procurement <i>The maximum benefit per Member per Transplant Benefit Period for Procurement of the organ/ tissue is \$15,000 of EME.</i> • Retransplantation Services <i>The maximum benefit for Retransplantation Services is 50% of EME, which does not apply towards the Calendar Year Copayment Maximum.</i> 	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$100 per day not to exceed \$300 per admission</p> <p>No charge</p> <p>No charge. Subject to maximum benefit.</p> <p>No charge. Subject to maximum benefit.</p> <p>50% of EME. Subject to maximum benefit.</p>
<p>Post-Cataract Surgical Services</p> <ul style="list-style-type: none"> • Frames and Lenses <i>Maximum frame allowance of \$100.</i> • Contact Lenses <i>Maximum contact lenses allowance of \$100.</i> <p><i>Benefit limited to one (1) pair of glasses or set of contact lenses as applicable per Member per surgery.</i></p>	<p>Yes</p> <p>Yes</p>	<p>\$10 per pair of glasses. Subject to maximum benefit.</p> <p>\$10 per set of contact lenses. Subject to maximum benefit.</p>
<p>Home Healthcare Services (does not include Self-Injectable Prescription Drugs) <i>Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to outpatient Covered Drugs.</i></p> <ul style="list-style-type: none"> • Physician House Calls 	<p>Yes</p>	<p>No charge</p>

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Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
<p>Home Healthcare Services (continued)</p> <ul style="list-style-type: none"> • Home Care Services • Private Duty Nurse 	<p>Yes</p> <p>Yes</p>	<p>No charge</p> <p>No charge</p>
<p>Hospice Care Services</p> <ul style="list-style-type: none"> • Inpatient Hospice Facility • Outpatient Hospice Services • Inpatient Respite Services <i>Limited to a maximum benefit of \$1,500 per Member per Calendar Year.</i> • Outpatient Respite Services <i>Limited to a maximum benefit of \$1,000 per Member per Calendar Year.</i> • Bereavement Services <i>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.</i> 	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$100 per day not to exceed \$300 per admission</p> <p>No charge</p> <p>\$100 per day not to exceed \$300 per admission. Subject to maximum benefit.</p> <p>\$10 per visit. Subject to maximum benefit.</p> <p>\$10 per visit. Subject to maximum benefit.</p>
<p>Skilled Nursing Facility <i>Limited to a maximum benefit of one hundred (100) days per Member per Calendar Year.</i></p>	<p>Yes</p>	<p>\$100 per day not to exceed \$300 per admission. Subject to maximum benefit.</p>
<p>Manual Manipulation <i>Applies to Medical-Physician Services and Chiropractic office visit.</i></p>	<p>Yes</p>	<p>\$10 per visit</p>
<p>Short-Term Rehabilitation Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient <p><i>All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a maximum benefit of sixty (60) days/visits per Member per Calendar Year.</i></p>	<p>Yes</p> <p>Yes</p>	<p>\$100 per day not to exceed \$300 per admission. Subject to maximum benefit.</p> <p>\$10 per visit. Subject to maximum benefit.</p>

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Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
<p>Durable Medical Equipment <i>For purchase or rental at HPN's option.</i></p>	Yes	\$100 or 50% of EME of purchase or rental price, whichever is less.
<p>Genetic Disease Testing Services <i>Includes Inpatient, Outpatient and independent Laboratory Services.</i></p>	Yes	25% of EME per test
<p>Infertility Office Visit Evaluation <i>Please refer to applicable surgical procedure Copayment and/or Coinsurance amount herein for any surgical infertility procedures performed.</i></p>	Yes	\$10 per visit
<p>Medical Supplies</p>	Yes	No charge
<p>Other Diagnostic and Therapeutic Services <i>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.</i></p> <ul style="list-style-type: none"> • Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services. • Dialysis • Therapeutic Radiology • Allergy Testing and Serum Injections • Otologic Evaluations • Other services such as complex diagnostic imaging; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services. • Positron Emission Tomography (PET Scan) 	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$10 per day</p> <p>\$10 per day</p> <p>\$10 per day</p> <p>\$10 per visit</p> <p>\$10 per visit</p> <p>\$10 per test or procedure</p> <p>\$10 per test</p>

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
<p>Prosthetic and Orthotic Devices <i>Limited to a maximum lifetime benefit of \$10,000 per Member including:</i></p> <ul style="list-style-type: none"> • repairs; and • post-mastectomy external prosthetic device. 	Yes	\$750 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><i>Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.</i></p>	No No Yes Yes Yes	\$10 per visit \$5 per therapeutic supply \$10 per therapeutic supply \$20 per device \$100 per device
<p>Special Food Products and Enteral Formulas <i>Limited to a maximum benefit of \$2,500 per Member per Calendar Year for Special Food Products only.</i></p>	Yes	No charge. See maximum benefit.
<p>Temporomandibular Joint Treatment <i>Dental-related treatment is limited to \$2,500 per Member per Calendar Year and \$4,000 maximum lifetime benefit per Member.</i></p>	Yes	\$10 per visit. Subject to maximum benefit.
<p>Mental Health Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Treatment <ul style="list-style-type: none"> Group Therapy Individual, Family and Partial Care Therapy** 	Yes Yes Yes	\$100 per day not to exceed \$300 per admission \$10 per visit \$10 per visit

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Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
<p>Mental Health Services (continued)</p> <p><i>** 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.</i></p>		
<p>Severe Mental Illness Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Treatment 	<p>Yes</p> <p>Yes</p>	<p>\$100 per day not to exceed \$300 per admission</p> <p>\$10 per visit</p>
<p>Substance Abuse Services</p> <ul style="list-style-type: none"> • Inpatient Detoxification (treatment for withdrawal) • Outpatient Detoxification • Inpatient Rehabilitation • Outpatient Rehabilitation Counseling Group Therapy Individual, Family and Partial Care Therapy** <p><i>** 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.</i></p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$100 per day not to exceed \$300 per admission</p> <p>\$10 per visit</p> <p>\$100 per day not to exceed \$300 per admission</p> <p>\$10 per visit</p> <p>\$10 per visit</p>
<p>Hearing Aids</p> <p><i>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.</i></p>	<p>Yes</p>	<p>\$100 or 50% of EME, whichever is less. Subject to maximum benefit.</p>

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Applied Behavioral Analysis (ABA) for the treatment of Autism <i>Limited to a maximum benefit of \$36,000 per Member per Calendar Year.</i>	Yes	\$10 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) 562-8077 or 1-800-279-4863, 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.