



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

HMO 20-1A

Attachment A Benefit Schedule

The Calendar Year Out of Pocket Maximum is \$6,850 per Member and \$13,700 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*
<p>Medical Office Visits and Consultations</p> <p>Primary Care Services</p> <ul style="list-style-type: none"> • Convenient Care Facility • Physician Extender or Assistant • Physician <p>Specialist Services</p> <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>No</p> <p>Yes</p> <p>No</p>	<p>Member pays \$10 per visit.</p> <p>Member pays \$10 per visit.</p> <p>Member pays \$20 per visit.</p> <p>Member pays \$40 per visit.</p> <p>Member pays \$0 per visit.</p>
<p>Non-preventive Routine Lab and X-ray Services</p> <p>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 \$10 per visit.</p> <p>Member pays \$20 per visit.</p>

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

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Covered Services and Limitations	Referral or Prior Auth. Required ⁽¹⁾	Tier I HMO Plan Provider Benefit*
Telemedicine Services (Available through select contracted Providers)	No	Member pays \$10 per visit.
Urgent Care Facility	No	Member pays \$35 per visit.
Emergency Services		
<ul style="list-style-type: none"> • Emergency Room Facility (includes Physician Services) 	No	Member pays \$500 per visit; waived if admitted.
<ul style="list-style-type: none"> • 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 \$500 per admission.
Ambulance Services		
<ul style="list-style-type: none"> • Emergency Transport 	No	Member pays \$500 per trip.
<ul style="list-style-type: none"> • Non-Emergency - HPN Arranged Transfers 	Yes	Member pays \$0.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)	Yes	Member pays \$500 per admission.
Outpatient Surgery at a Hospital Facility	Yes	Member pays \$500 per surgery.
Ambulatory Surgical Facility Services	Yes	Member pays \$100 per surgery.
Anesthesia Services	Yes	Member pays \$150 per surgery.
Physician Surgical Services - Inpatient and Outpatient		
<ul style="list-style-type: none"> • Inpatient Hospital Facility 	Yes	Member pays \$100 per surgery.
<ul style="list-style-type: none"> • Outpatient Hospital Facility 	Yes	Member pays \$100 per surgery.
<ul style="list-style-type: none"> • Ambulatory Surgical Facility 	Yes	Member pays \$50 per surgery.
<ul style="list-style-type: none"> • Physician's Office 		
<ul style="list-style-type: none"> • Primary Care Physician (Includes all physician services related to the surgical procedure) 	No	Member pays \$20 per visit.
<ul style="list-style-type: none"> • Specialist (Includes all physician services related to the surgical procedure) 	Yes	Member pays \$40 per visit.

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Covered Services and Limitations	Referral or Prior Auth. Required ⁽¹⁾	Tier I HMO Plan Provider Benefit*
<p>Gastric Restrictive Surgery Services HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.</p> <ul style="list-style-type: none"> Physician Surgical Services Physician's Office Visit 	<p>Yes</p> <p>Yes</p>	<p>Member pays \$2,500 per surgery. Subject to maximum benefit.</p> <p>Member pays \$40 per visit.</p>
<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 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. Procurement The maximum benefit per Member per Transplant Benefit Period for Procurement of the organ/tissue is \$15,000 of EME. Retransplantation Services Benefits are limited to one (1) Medically Necessary Retransplantation per Member per type of transplant. 	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$500 per admission.</p> <p>Member pays \$100 per surgery.</p> <p>Member pays \$0 per surgery. Subject to maximum benefit.</p> <p>Member pays \$0. Subject to maximum benefit.</p> <p>Member pays 50% of EME. Subject to maximum benefit.</p>
<p>Post-Cataract Surgical Services</p> <ul style="list-style-type: none"> Frames and Lenses Contact Lenses <p>Benefit 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) Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drug.</p>	<p>Yes</p>	<p>Member pays \$20 per visit.</p>

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

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Covered Services and Limitations	Referral or Prior Auth. Required ⁽¹⁾	Tier I HMO Plan Provider Benefit*
<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. <ul style="list-style-type: none"> ◦ Inpatient ◦ 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. 	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$500 per admission.</p> <p>Member pays \$0 per visit.</p> <p>Member pays \$500 per admission. Subject to maximum benefit.</p> <p>Member pays \$40 per visit. Subject to maximum benefit.</p> <p>Member pays \$20 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>	<p>Yes</p>	<p>Member pays \$500 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.</p>
<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>	<p>Yes</p>	<p>Member pays \$20 per visit. Subject to maximum benefit.</p>
<p>Short-Term Rehabilitation and 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 Rehabilitation and Habilitative Services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.</p>	<p>Yes</p> <p>Yes</p>	<p>Member pays \$500 per admission. Subject to maximum benefit.</p> <p>Member pays \$20 per visit. Subject to maximum benefit.</p>
<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>	<p>Yes</p>	<p>Member pays \$0. Subject to maximum benefit.</p>

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

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Covered Services and Limitations	Referral or Prior Auth. Required ⁽¹⁾	Tier I HMO Plan Provider Benefit*
<p>Genetic Disease Testing Services</p> <ul style="list-style-type: none"> • Office Visit • Lab Includes Inpatient, Outpatient and independent Laboratory Services. 	Yes	<p>Member pays \$40 per visit.</p> <p>Member pays \$40 per visit.</p>
<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>	Yes	Member pays \$40 per visit.
<p>Medical Supplies (Obtained outside of a medical office visit)</p>	Yes	Member pays \$0.
<p>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.</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 • Complex Allergy Diagnostic Services (including RAST) and Serum Injections • 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>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$20 per day.</p> <p>Member pays \$20 per day.</p> <p>Member pays \$20 per day.</p> <p>Member pays \$20 per visit.</p> <p>Member pays \$20 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 \$150 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.

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

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Covered Services and Limitations	Referral or Prior Auth. Required ⁽¹⁾	Tier I HMO Plan Provider 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>Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.</p>	<p>No</p> <p>No</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$20 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 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.</p>	Yes	Member pays \$0. Subject to maximum benefit.
<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 	<p>Yes</p> <p>Yes</p>	<p>Member pays \$500 per admission.</p> <p>Member pays \$20 per visit.</p>
<p>Substance Abuse Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Treatment 	<p>Yes</p> <p>Yes</p>	<p>Member pays \$500 per admission.</p> <p>Member pays \$20 per visit.</p>
<p>Hearing Aids Purchases are limited to a single purchase of a type of Hearing Aid, 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 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.</p>	Yes	Member pays \$20 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

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

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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 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
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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

\$15 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier II: Member pays

\$40 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier III: Member pays

\$60 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.

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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.

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- 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.

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- 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.

- 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

SECTION 4. Glossary

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- 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

PRESCRIPTION DRUG RIDER

HPN's 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.healthplanofnevada.com.