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NEVADA HEALTH CO-OP
FRONTIER SIMPLE/FÁCIL BRONZE 100%
34996NV002 – 0007

Attachment A Benefit Schedule

Lifetime Maximum: Unlimited.

Plan Provider Benefits apply when a Member obtains Covered Services from a Provider who is independently contracted by the CO-OP to provide Covered Services to Members. The Member will **not** be responsible for a Calendar Year Deductible ("CYD"), Coinsurance percentages and any applicable Copayments.

Non-Plan Provider Benefits apply when a Member obtains Covered Services from a Non-Plan Provider. Out-of pocket expenses are higher with this option because all benefits are subject to a higher CYD and higher Coinsurance percentage. Claim forms must be submitted for services received from Non-Plan Providers. **With respect to Non-Plan Provider Benefits, the Member pays the amounts listed in the schedule below for such Non-Plan Provider Benefits plus any amounts exceeding the Plan's Allowable Expenses and benefit maximums.**

Emergency Services: The Plan Provider level of benefits will apply to Emergency Services provided at any duly-licensed facility. Upon admission to a Non-Plan Provider hospital and stabilization of the emergency condition and safe for transfer status as determined by the attending physician, the Plan may require transfer to a Plan Provider contracted facility in order to continue paying benefits at the Plan Provider level. Benefits for Prior Authorized post-stabilization and follow-up care received at a Non-Plan Provider hospital facility are subject to the applicable benefit.

Calendar Year Deductible ("CYD"): Does not apply to this plan.

Coinsurance: No coinsurance is required for Plan Provider Coverage Services**.**

Out of Pocket Maximum: Does not apply to this plan.

Prior Authorization: Many Covered Services require Prior Authorization for coverage. Please see the Prior Authorization list set forth on pages 10-11.

Note: You are responsible for all amounts exceeding the applicable benefit maximums, Allowable Expenses payments to Non-Plan Providers and penalties for not complying with the CO-OP's Care Management Program.

This Benefit Schedule is a summary only. Please read your Evidence of Coverage and all other applicable Endorsements, Riders and Attachments, if any, to determine the governing contractual provisions for this Plan and to understand how Allowable Expenses payments to Providers are determined.

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BENEFIT SCHEDULE

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
Medical – Physician Services and Physician Consultants		
• Office Visit/Consultation		
○ Primary Care Physician	Plan pays 100%.	Plan pays 100%
○ Specialist		
• Inpatient Visit/Consultation		
○ Primary Care Physician	Plan pays 100%.	Plan pays 100%.
○ Specialist	Plan pays 100%.	Plan pays 100%.
• Tele-Health Consultation		
○ Primary Care Physician	Plan pays 100%.	Plan pays 100%.
○ Specialist	Plan pays 100%.	Plan pays 100%.
Laboratory Services	Plan pays 100%.	Plan pays 100%.
Routine Radiological and Non-Radiological Diagnostic Imaging Services	Plan pays 100%.	Plan pays 100%.
Urgent Care Facility	Plan pays 100%.	Plan pays 100%.
Emergency Services • Emergency Room Visit • Hospital Admission – Emergency Stabilization	Plan pays 100%.	Plan pays 100%.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*

Ambulance Services
 	
• Emergency
  ○ Ground Transport
  ○ Air Transport
 	
• Non-Emergency – CO-OP Arranged Transfers
	Plan pays 100%.
	
	Plan pays 100%.
		Plan pays 100%.
		
		Plan pays 100%.

Inpatient Hospital Facility Services *Elective and emergency post-stabilization admissions.*	Plan pays 100%.	Plan pays 100%.
Outpatient Hospital Facility and Ambulatory Surgical Facility Services	Plan pays 100%.	Plan pays 100%.
Physician Surgical Services – Inpatient • Assistant Surgical Services • Anesthesia Services	Plan pays 100%.	Plan pays 100%.
Physician Surgical Services – Outpatient • Assistant Surgical Services • Anesthesia Services	Plan pays 100%.	Plan pays 100%.
Gastric Restrictive Surgery Services • Physician Surgical Services • Complications *Requires Prior Authorization and may require a pre-surgery treatment plan.*	Plan pays 100%.	Plan pays 100%.
Mastectomy Reconstructive Surgical Services • Physician Surgical Services • Prosthetic Device for Mastectomy Reconstruction	Plan pays 100%.	Plan pays 100%.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
Oral Physician Surgical Services • Office Visit • Physician Surgical Services Inpatient Hospital Facility *(Benefit described above)* Outpatient Hospital Facility	Plan pays 100%.	Plan pays 100%.
Organ and Tissue Transplant Surgical Services • Inpatient Hospital Facility *(Benefit described above)* • Physician Surgical Services – Inpatient Hospital Facility *The maximum benefit for Retransplantation Services is 100% of Allowable Expenses.*	Plan pays 100%.	Plan pays 100%.
Home Healthcare Services • Skilled Nursing/Private Duty Nursing • Physical Therapy • Speech Therapy • Occupational Therapy • Infusion Drug Therapy • Rehabilitation Therapies *Subject to a maximum benefit of 30 visits per Member per Calendar Year.*	Plan pays 100%.	Plan pays 100%.
Hospice Care Services • Inpatient Hospice Facility • Outpatient Hospice Services • Inpatient Respite Services • Outpatient Respite Services • Bereavement Services	Plan pays 100%.	Plan pays 100%.
Skilled Nursing Facility Services *Subject to a maximum benefit of 100 days per Member per Calendar Year.*	Plan pays 100%.	Plan pays 100%.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
Manual Manipulation *Subject to a combined maximum benefit of 30 visits per Member per Calendar Year.*	Plan pays 100%.	Plan pays 100%.
Short Term Habilitation Services • Inpatient Hospital Facility *(Benefit described above)* • Outpatient *All Inpatient and Outpatient Short-Term Habilitation Services are subject to a maximum benefit of 60 days/visits per Calendar Year.*	Plan pays 100%.	Plan pays 100%.
Short Term Rehabilitation Services • Inpatient Hospital Facility *(Benefit described above)* • Outpatient *All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a maximum benefit of 60 days/visits per Calendar Year.*	Plan pays 100%.	Plan pays 100%.
Applied Behavioral Analysis (ABA) for the treatment of Autism *Subject to a combined limit of the greater of (i) 200 visits or (ii) 700 hours, per Member per Calendar Year.*	Plan pays 100%.	Plan pays 100%.
Durable Medical Equipment *For purchase or rental as is recommended by your physician and determined to be medically necessary by the CO-OP*	Plan pays 100%.	Plan pays 100%.
Genetic Disease Testing Services *Includes Inpatient, Outpatient and independent Laboratory Services.*	Plan pays 100%.	Plan pays 100%.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
Infertility Office Visit Evaluation	Plan pays 100%.	Plan pays 100%.
Infertility Treatment *Please refer to the applicable surgical procedure Copayment and/or Coinsurance amount for any surgical infertility procedures performed.* *Subject to a maximum benefit of 6 cycles per Member per lifetime.*	Plan pays 100%.	Plan pays 100%.
Medical Supplies	Plan pays 100%.	Plan pays 100%.
Other Diagnostic and Therapeutic Services *Coinsurance is in addition to the Physician office visit Copayment and applies to services rendered in a Physician's office or at an independent facility.* • Anti-Cancer Drug Therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services. • Dialysis • Therapeutic Radiology • Allergy Testing and Serum Injections • Otologic Evaluations • Other services such as vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services. • Imaging: CT/ PET/ MRI	Plan pays 100%.	Plan pays 100%.
Prosthetic and Orthotic Devices	Plan pays 100%.	Plan pays 100%.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
Self-Management and Treatment of Diabetes • Education and Training • Supplies • Insulin Pump & Pump Supplies • Other Equipment	Plan pays 100%.	Plan pays 100%.
Special Food Products and Enteral Formulas	Plan pays 100%.	Plan pays 100%.
Temporomandibular Joint Treatment (TMJ)	Plan pays 100%.	Plan pays 100%.
Preventative Healthcare Services	Plan pays 100%.	Plan pays 100%.
Hearing Aids *Subject to a combined limit of 1 unit per Member per Calendar Year.* *Repairs and replacement limited to once every 3 years.*	Plan pays 100%.	Plan pays 100%.
Pediatric Vision • Routine Eye Exam • Eye glasses, lens treatment, contact lenses • Pediatric preventive care/low vision screening *Subject to limit of one visit per year and one of each item per year.*	Plan pays 100%.	Plan pays 100%.
Acupuncture *Subject to a combined limit of 20 visits per Member per Calendar Year.*	Plan pays 100%.	Plan pays 100%.
Clinical Trials	Plan pays 100%.	Plan pays 100%.
Delivery and Inpatient Hospital Maternity Care	Plan pays 100%.	Plan pays 100%.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
Prenatal and Postnatal Care	Plan pays 100%.	Plan pays 100%.
Mental Health & Substance Abuse Services • Inpatient Hospital Admissions • Outpatient Therapy	Plan pays 100%.	Plan pays 100%.
Prescription Drug Benefits • Generic Prescriptions • Formulary Prescriptions • Nonformulary Prescriptions • Specialty drugs • Preventive care drugs *Copayments shown are for up to a 30-day supply.*	Plan pays 100%.	Plan pays 100%.
• Mail-Order – maximum 90 day supply o Generic o Formulary o Non Formulary o Specialty drugs o Preventive care drugs *The CYD for Prescription Drug benefits is integrated with the Plan's CYD for all other medical benefits.*	Plan pays 100%.	Plan pays 100%.
Post-Cataract Surgical Services • Frames and Lenses • Contact Lenses *Benefit limited to one pair of glasses or set of contact lenses per Member per surgery.*	Plan pays 100%.	Plan pays 100%.

Wellness Program

In addition to the Mental Health and Substance Abuse benefits outlined above, a Member may have access to five (5) free in-office consultations with a mental health provider under the Nevada Health CO-OP's Wellness Program. For additional information on this program, contact the CO-OP's Member Services Department at (702) 823-2667 or (855) 606-2667.

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

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 Cost-Sharing Maximum.

Cost-Sharing Maximum

After satisfying your CYD, your cost-sharing for any single service or item is limited to a maximum of 50% of the usual and customary charges and 50% of the Allowable Expenses for such service or item as required by Nevada regulations.

Additional Limitations and Exclusions

The CO-OP will not be liable for any delay or failure to provide or arrange for Covered Services if the delay or failure is caused by (i) natural disaster, (ii) war, (iii) riot, (iv) civil insurrection, (v) epidemic, or (vi) any other emergency beyond the CO-OP's control.

Reimbursement for Covered Services approved by the CO-OP and provided by a Non-Plan Provider outside the CO-OP's Service Area shall be limited to the average payment which the CO-OP makes to Plan Providers in the CO-OP's Service Area.

Certain services and treatments are specifically excluded from coverage, including, without limitation, services or supplies for which coverage is not specifically provided in the Evidence of Coverage, complications resulting from non-covered services, or services which are not medically necessary, whether or not recommended or provided by a provider, experimental or investigational treatment or devices as determined by the CO-OP, late discharge billing and charges resulting from a canceled appointment or procedure. Please review the full description of these specific exclusions at Section 6 of the Plan's Evidence of Coverage.

Prior Authorization Required

Some Covered Services will require Prior Authorization from the CO-OP and benefits may be reduced for such Covered Services if the Member receives them without Prior Authorization. Please refer to your CO-OP Evidence of Coverage for additional information.

The CO-OP may, from time to time, review the Prior Authorization requirements and may, at its sole discretion, make changes to these requirements. These changes may include requiring Prior Authorization for care, services and supplies not currently listed in this Benefits Schedule or the Evidence of Coverage as requiring Prior Authorization. You will receive at least thirty (30) days advance notice of any additional Prior Authorization requirements.

The list of Covered Services that require Prior Authorization currently includes:

High Tech Diagnostic Service Review	
OB Ultrasounds	Fetal biophysical profiles
All MRI/MRA's	All PET scans
All CT/CTA scans	Discography
Sleep Studies (must be ordered by a Neurologist, Pulmonologist or ENT)	
Medical/Radiation Oncology Treatments	
Chemotherapy	Intensity-modulated radiation therapy (IMRT)
Hormone Therapy	Brachytherapy
Biologics	Stereotactic radiation therapy & proton-beam procedures
Supportive care medications related to cancer diagnosis	Two-dimensional (2D)/three-dimensional (3D) conformal radiation
Ambulatory Surgery Review	
Blepharoplasty	Septoplasty
Varicose vein stripping/ligation	Breast reduction & breast surgery (except those with an accepted medical diagnosis)
Orthotripsy for plantar fasciitis	Ventral hernia repair>18 years
Surgical treatment of sleep apnea	Orthoses/orthotics
Additional Services Requiring Prior Authorization	
Gastric Restrictive Evaluation and Surgical Services	Infertility Treatment
All hospital admissions (including elective admissions and those resulting from ER or observation stay)	Durable medical equipment items for which the purchase price is over $500 (whether it is rental or purchase)
All TMJ procedures	Dialysis
Skilled nursing facility	Home health and infusion therapy
Inpatient rehabilitation	Orthoses/orthotics
Long term acute care	Prosthetic appliances

Insulin pumps/pump supplies	Outpatient Chemotherapy or Radiation Therapy
All hysterectomies (Inpatient or Outpatient)	Back surgeries (inpatient or outpatient services)
Custom compression stockings	Genetic testing
Cochlear implants	Implantable hormone replacement therapy (i.e. Testopel)
Orallmandibular/orthognathic surgery	Stereotactic radiosurgery (Gamma/Cyber Knife)
Gastric neurostimulator	EECP
Skin substitutes/Grafts	All Inpatient and all Non-Routine Mental Health and Substance Abuse and Severe Mental Illness Services
Hip and Knee Surgeries	