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NEVADA HEALTH CO-OP
SOUTHERN SIMPLE/FÁCIL PLATINUM
34996NV005 - 0004

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 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"): Your CYD for Plan Provider Benefits is $0 per Member and $0 per family. Your CYD for Non-Plan Provider Benefits is $6,500 per Member and $13,000 per family.

Coinsurance: After meeting your CYD, your Coinsurance for most Plan Provider Covered Services is 10% of Allowable Expenses. Your Coinsurance for most Non-Plan Provider Covered Services is 50% of Allowable Expenses.

Out of Pocket Maximum: Your annual out-of-pocket maximum for Plan Provider Benefits is $2,500 per Member and $5,000 per family. Your annual out-of-pocket maximum for Non-Plan Provider Benefits is $20,000 per Member and $40,000 per family.

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
 	
  ○ Specialist
 	
• Inpatient Visit/Consultation
  ○ Primary Care Physician
 	
  ○ Specialist
 	
• Tele-Health Consultation
 	
  ○ Primary Care Physician
 	
  ○ Specialist
	
	$15 per visit.
	
	$40 per visit.
	
	Plan pays 100%.
	
	Plan pays 100%.
	
	Plan pays 100%.
	
	Plan pays 100%.
		After CYD, Member pays 50% of Allowable Expenses.

Laboratory Services	$0 per visit.	After CYD, Member pays 50% of Allowable Expenses.
Diagnostic Imaging Services • Radiology/Non-Radiology • CT/PET/MRI	 $25 per visit. $100 per procedure	After CYD, Member pays 50% of Allowable Expenses.
Urgent Care Facility	$50 per visit.	After CYD, Member pays 50% of Allowable Expenses.
Emergency Services • Emergency Room Visit • Hospital Admission – Emergency Stabilization	 In a calendar year, $100 for the first emergency room visit and $450 for subsequent visits; waived if admitted. After CYD, Member pays 10% of Allowable Expenses.	 In a calendar year, $100 for the first emergency room visit and $450 for subsequent visits; waived if admitted. After CYD, Member pays 10% of Allowable Expenses. Applies until patient is stabilized and safe for transfer to a Plan Provider hospital as determined by the attending Physician.

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
	In a calendar year, $100 first trip and $450 each additional use.
	
	Plan pays 100%.
		In a calendar year, $100 first trip and $450 each additional use.
		
		After CYD, Member pays 50% of Allowable Expenses.

Inpatient Hospital Facility Services *Elective and emergency post-stabilization admissions.*	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Outpatient Hospital Facility and Ambulatory Surgical Facility Services	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Physician Surgical Services – Inpatient • Assistant Surgical Services • Anesthesia Services	Plan pays 100%.	After CYD, Member pays 50% of Allowable Expenses.
Physician Surgical Services – Outpatient • Assistant Surgical Services • Anesthesia Services	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Gastric Restrictive Surgery Services • Physician Surgical Services • Complications *Requires Prior Authorization and may require a pre-surgery treatment plan.*	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Mastectomy Reconstructive Surgical Services • Physician Surgical Services • Prosthetic Device for Mastectomy Reconstruction	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Oral Physician Surgical Services • Office Visit • Physician Surgical Services • Inpatient Hospital Facility *(Benefit described above)* • Outpatient Hospital Facility	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
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 70% of Allowable Expenses.*	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Home Healthcare Services • Private Duty Nursing • Physical Therapy • Speech Therapy • Occupational Therapy • Rehabilitation Therapy • Infusion Drug Therapy *Subject to a maximum benefit of 30 visits per Member per Calendar Year.*	 $10 per visit. $10 per therapy. $10 per therapy. $10 per therapy. $10 per therapy. After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Hospice Care Services • Inpatient Hospice Facility • Outpatient Hospice Services • Inpatient Respite Services • Outpatient Respite Services • Bereavement Services	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Skilled Nursing Facility Services *Subject to a maximum benefit of 100 days per Member per Calendar Year.*	$50 per day.	After CYD, Member pays 50% of Allowable Expenses.
Chiropractic Services *Subject to a combined maximum benefit of 30 visits per Member per Calendar Year.*	$25 per visit.	After CYD, Member pays 50% of Allowable Expenses.
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.*	 After CYD, Member pays 10% of Allowable Expenses. $10 per visit.	After CYD, Member pays 50% of Allowable Expenses.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
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.*	After CYD, Member pays 10% of Allowable Expenses. $10 per visit.	After CYD, Member pays 50% of Allowable Expenses.
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.*	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Durable Medical Equipment *For purchase or rental as is recommended by your physician and determined to be medically necessary by the CO-OP*	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Genetic Disease Testing Services *Includes Inpatient, Outpatient and independent Laboratory Services.*	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Infertility Office Visit Evaluation	$25 per visit.	After CYD, Member pays 50% of Allowable Expenses.
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 ovulation cycles per Member per lifetime; Excludes IVF and complex procedures.* *Treatment and evaluation must be obtained by the plan preferred fertility benefit provider.*	After CYD, Member pays 10% of Allowable Expenses.	No coverage.
Medical Supplies	Plan pays 100%.	After CYD, Member pays 50% of Allowable Expenses.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
Other Diagnostic and Therapeutic Services *Coinsurance or copayment is in addition to the Physician office visit Copayment and applies to services rendered in a Physician's office or at an independent facility.* • Anti-Cancer Drug therapeutic services • Non-Cancer Intravenous therapeutic services • Other Medically Necessary intravenous therapeutic services • Dialysis • Therapeutic Radiology • Allergy Testing and Serum Injections • Vascular diagnostic and therapeutic services • Pulmonary diagnostic services • Complex neurological or psychiatric testing therapeutic services • Hearing Evaluations	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Prosthetic and Orthotic Devices	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Self-Management and Treatment of Diabetes • Education and Training • Supplies • Insulin Pump & Pump Supplies • Other Equipment	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Special Food Products and Enteral Formulas	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Temporomandibular Joint Treatment (TMJ)	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% Allowable Expenses.

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
Preventive Healthcare Services For a complete list of Preventive Services including contraceptives, go to: http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/	Plan pays 100%.	After CYD, Member pays 50% of Allowable Expenses.
Hearing Aids *Subject to a combined limit of 1 unit per Member per Calendar Year. One purchase of a plan approved list of formulary approved devices; supplied by plan preferred provider. Repairs or replacement limited to once every 3 years.*	After CYD, Member pays 10% of Allowable Expenses.	No coverage.
Pediatric Vision • Routine Eye Exam • Eye glasses, lens treatment, contact lenses • Pediatric preventive care/low vision screening between the ages of 3 and 5 years *Subject to limit of one visit per year and one of each item per year.* *Frames from select list of approved frames; Purchased from a plan approved provider; excludes designer frames.*	$15 per visit. After CYD, Member pays 10% of Allowable Expenses. Plan pays 100%.	After CYD, Member pays 50% of Allowable Expenses.
Acupuncture *Subject to a combined limit of 20 visits per Member per Calendar Year.*	$10 per visit.	After CYD, Member pays 50% of Allowable Expenses.
Clinical Trials	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.
Delivery and Inpatient Hospital Maternity Care	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.

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%.	After CYD, Member pays 50% of Allowable Expenses.
Mental/Behavioral Health & Substance Use Disorder • Inpatient Hospital Admissions • Outpatient Therapy	After CYD, Member pays 10% of Allowable Expenses. $10 per visit.	After CYD, Member pays 50% of Allowable Expenses.
Prescription Drug Benefits Retail – maximum 30 day supply • Generic drugs • Preferred drugs • Non Preferred drugs • Preventive care drugs • Specialty drugs Mail-Order – maximum 90 day supply • Generic drugs • Preferred drugs • Non Preferred drugs • Preventive care drugs • Specialty drugs *The CYD for Prescription Drug benefits is integrated with the Plan's CYD for all other medical benefits.* *The maximum copayment for oral chemotherapy drugs shall not exceed $100 per prescription.*	 $10 $20 $75 Plan pays 100%. After CYD, Member pays 10% of Allowable Expenses. $20 $40 $150 Plan pays 100%. After CYD, Member pays 10% of Allowable Expenses.	No coverage.
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.*	After CYD, Member pays 10% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.

Wellness Program
In addition to the Mental Health and Substance Use Disorder 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 provided by Non-Plan Provider 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.

Covered Services that require Prior Authorization may include but are not limited to:

High Tech Diagnostic Service Review	
OB Ultrasounds	Fetal biophysical profiles
MRI/MRA's	PET scans
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	Conformal Radiation - Two-dimensional (2D) / three-dimensional (3D)
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	
Additional Services Requiring Prior Authorization	
Gastric Restrictive Evaluation and Surgical Services	Infertility Treatment (Authorization requires documentation of 12 months under medical surveillance and routine care without conception prior to evaluation and treatment.)
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)

TMJ procedures	Dialysis
Skilled nursing facility	Home health and infusion therapy
Inpatient rehabilitation	Orthoses/orthotics (purchase price over $500)
Long term acute care	Prosthetic appliances (purchase price over $500)
Insulin pumps/pump supplies	Outpatient Chemotherapy or Radiation Therapy
Hysterectomies (Inpatient or Outpatient)	Spinal surgery or invasive procedures for pain relief or control (inpatient or outpatient services)
Custom compression stockings	Genetic testing
Cochlear implants	Implantable hormone replacement therapy (i.e. Testopel)
Oralmandibular/orthognathic surgery	Stereotactic radiosurgery (Gamma/Cyber Knife)
Gastric neurostimulator	EECP
Skin substitutes/Grafts	Inpatient and Non-Routine Mental Health and Substance Use Disorder and Severe Mental Illness Services
Hip and Knee Surgeries	Specialty medications given in office (Authorized and supplied through Catamaran/Briova)