CO-OP 226

detailed schedule of benefits

January 1, 2015

nevada health co-op

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Welcome to the Nevada Health CO-OP!

say hello to uncompli•care. uncomplicated healthcare.

Dear Nevada Health CO-OP 226 Member,

Thank you for being a part of the CO-OP! As a CO-OP, we exist for one purpose – to serve our members like you! We are member-owned and operated and focused on providing great care and affordable health insurance.

This document is your CO-OP 226 Health Plan Detailed Schedule of Benefits, also known as your Attachment A Benefit Schedule. Think of this document as the owner's manual for your health plan. It provides the coverage details of your specific plan – including what's covered, what's not, how much you're responsible for paying and more.

When you need information about your benefits, you should first look in this document. The benefit chart is located on page 2.

You can always view a copy of your CO-OP 226 Health Plan Detailed Schedule of Benefits online on our website at www.nevadahealthcoop.org.

We're Here To Help

If you have any questions, concerns or need help understanding your benefits, you can always call 702-823-2667, toll-free 1-855-606-2667 or visit us at 3900 Meadows Lane, Las Vegas, NV 89107. We are open Monday – Friday, from 8am – 6pm, and we have CO-OP Customer Care staff that can help you in both English and Spanish.

Nevada Health CO-OP
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NEVADA HEALTH CO-OP
Co-Op 226 Health Plan
Attachment A Benefit Schedule

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.

Lifetime Maximum: Unlimited.

Out of Pocket Maximum: Your annual out-of-pocket maximum for Plan Provider Benefits is **$6,350 per Member** and **$12,700 per Family**.

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 Copayments and any applicable Coinsurance percentages.

Non-Plan Providers are not covered except for:

- Emergency Room Services and Emergency Stabilization Hospital Admissions. The Plan Provider level of benefits will apply to Emergency Services provided at any duly-licensed facility. Balance billing may result if you go outside the network. 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.
- Inpatient Hospital Maternity Care. The Non-Plan Inpatient Maternity Care Benefit is subject to a $2,000 per admission copayment after which the patient is responsible for 40% of the Allowable Expenses.
- Hospital benefits at a Non-Plan hospitals may be paid at the Plan Provider rates provided the Member obtains Prior Authorization, the services are coordinated by the Plan, and the medical procedure is not available by a Plan Provider.

Referrals are required from your Primary Care Physician before you see a Specialist. You must choose a Primary Care Physician (PCP), or a pediatrician for children, from the list of CO-OP 226 Plan PCPs and pediatricians. Failure to obtain a referral will result in the denial of the Specialist's claim, and you will be responsible for the charges submitted by the Specialist.

Prior Authorization: Many Covered Services require Prior Authorization for coverage. Please see the Prior Authorization list set forth on pages 7-8.

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.

<table>
<thead>
<tr><th>Type of Care</th><th>Services</th><th>Copay per Visit</th><th>Coinsurance</th><th>Plan Pays</th><th>Maximum Benefit</th><th>Other Information</th></tr>
</thead>
<tbody>
<tr><td colspan="7">The Maximum yearly amount you have to pay out of your pocket for your co-pays and coinsurance is $6,350 per person or $12,700 per family.</td></tr>
<tr><td rowspan="8">Preventive Services</td><td>Immunizations for adults (Age appropriate) & children (Birth to 18 y/o)</td><td rowspan="8">No copay</td><td rowspan="8">No coinsurance</td><td rowspan="8">100% of allowable charges</td><td rowspan="8">No maximum benefit</td><td rowspan="8">Contact our CO-OP Customer Care Crew at 702-823-2667 for other services that may be covered, or visit http://doi.nv.gov/Healthcare-reform/Individuals-Families/Preventive-Care/</td></tr>
<tr><td>Well Baby Exams</td></tr>
<tr><td>Physical Exams</td></tr>
<tr><td>Nutritional Counseling</td></tr>
<tr><td>Osteoporosis Screening (Women 50 and older)</td></tr>
<tr><td>Mammography (Women 35 and older)</td></tr>
<tr><td>Women’s well check (Women 21 to 64 y/o)</td></tr>
<tr><td>Colonoscopy & Sigmoidoscopy (Adults ages 50-75)</td></tr>
<tr><td rowspan="14">Physician Office Services</td><td>Tele-Health Consultation</td><td>No copay</td><td rowspan="14">No coinsurance</td><td>100% of allowable charges</td><td rowspan="8">No maximum benefit</td><td rowspan="12">No other information.</td></tr>
<tr><td>Primary Care Physician (PCP)</td><td>$20</td><td rowspan="2">100% of allowable charges after copay</td></tr>
<tr><td>Specialist <u>– Requires referral from your PCP</u></td><td>$30</td></tr>
<tr><td>In-Patient Services</td><td rowspan="2">No copay</td><td rowspan="2">100% of allowable charges</td></tr>
<tr><td>Injection</td></tr>
<tr><td>IV Treatment</td><td>$7</td><td rowspan="9">100% of allowable charges after copay</td></tr>
<tr><td>Pulmonary Treatment</td><td>$5/procedure</td></tr>
<tr><td>Pulmonary Test</td><td>$7</td></tr>
<tr><td>Chiropractor</td><td>$25</td><td>Maximum of 30 visits per calendar year</td></tr>
<tr><td>Acupuncture</td><td>$20</td><td>Maximum of 20 visits per calendar year</td></tr>
<tr><td>Urgent Care</td><td>$40</td><td rowspan="4">No maximum benefit</td></tr>
<tr><td>X-Ray</td><td>$30</td></tr>
<tr><td>Radiology-PET/PET CT</td><td>$225/
Per visit</td><td rowspan="2">Copay applies only in select physician offices.</td></tr>
<tr><td>Radiology-CT/MRA/MRI</td><td>$125/
Per visit</td></tr>
</tbody>
</table>

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Physician Office Services (continued)	Lab	$0	No coinsurance	100% of allowable charges after copay	No maximum benefit	When labs performed & processed in physician's office.
	Vision Exam	$40				Lenses and frames are covered under the vision category.
	Chemotherapy	$7				No other information.
	Radiation Therapy					
	Hearing & Speech Exam	$40				
	Allergy Testing	$7/test type				
	Allergy Immunotherapy	$7/Injection				
	Surgery in the physician's office	$7/procedure				
	Nerve conduction studies	$7				
	All other physician office procedures	$7/procedure				
	Dialysis Management	No copay		100% of allowable charges		
Prescriptions	Culinary Pharmacy (Generic medications only)	No copay	No coinsurance	100% of allowable charges	No maximum benefit	Tip: you can save money by asking your doctor for a generic medication Contact the Culinary Free Pharmacy at 702-650-4417.
	Tier 1 Generic medications	$10		100% of allowable charges after copay		Tier 1, 2 & 3 medications available at retail pharmacies. For a complete list of retail pharmacies included in the Network, contact the Customer Care Crew at 702-823-2667
	Tier 2 Formulary	$30				
	Tier 3 Non-Formulary	$50				
	Specialty Drugs	No copay	25% of allowable charges	75% of allowable charges		
	Mail Order	$10,$20 or $35	No coinsurance	100% after copay		With one copay, you can get a 90-day supply.
Therapy Outpatient	Physical, Occupational and Speech Therapy	$20	No coinsurance	100% of allowable Charges after copay	30 visits per therapy	No other information.

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Free-Standing Facility Services (Not at a hospital) Cardiac/ Pulmonary Rehabilitation Ambulatory Surgery Center	Surgery	$150	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	Lab	No copay	No coinsurance	100% of allowable charges	No maximum benefit	
	X-Ray	$20		100% of allowable charges after copay		Tip: DesertRadiology is the only radiology office you can use.
	CT Scan, MRI, MRA	$125				
	PET	$175				
	Interventional Radiology Services	$150				
	Dialysis	No copay	No coinsurance	100% of allowable charges	No maximum benefit	Some services require prior authorization (approval).
	Sleep Center	$125		100% of allowable charges after copay		
	Cardiac/Pulmonary Rehabilitation	$30			30 visits annual limit	
Outpatient Services in a Hospital	Lab for Hospital Based preoperative or diagnostic services only	$15	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval). Tip: If your doctor refers you to a hospital to have these tests, ask your doctor to send you to Desert Radiology or a contracted laboratory.
	X-Ray	$45				
	MRI, MRA, C T Scan	$125				
	PET and combined PET/C T	$225				
	Interventional Radiology and Diagnostic Radiology Services only per formed in a hospital outpatient setting.	$250				
	Dialysis	No copay		100% of allowable charges		No other information
	Physical, Occupational & Speech Therapy (after discharge from inpatient hosp.)	$30	No coinsurance	100% of allowable charges after copay		
	Cardio/Pulmonary Rehab (after discharge from inpatient hospital)	$40			30 visits annual limit	

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Outpatient Hospital Services (continued)	Outpatient Surgery	$250	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval).
	Diabetes Education	No copay		100% of allowable charges		
	All other outpatient hospital services (Examples: Chemotherapy, Sleep Studies)	No copay	25%	75% of allowable charges	No maximum benefit	No other information.
Ambulance	Ground or Air	No copay	25%	75% of allowable charges	No maximum benefit	No other information.
Emergency Room vs. Urgent Care	Emergency Room	$350 per visit	No coinsurance	100% of allowable charges after copay, including all other covered ER services, as well as lab and X-ray	No maximum benefit	Tip: please go to the Urgent Care for non-life threatening issues. Take a look at the Provider Directory for 24/7 Urgent Care locations.
	Urgent Care	$40 per visit		100% of allowable charges after copay		No other information.
In-Network Hospital (in-patient)	Inpatient Stay	$250	No coinsurance	100% of allowable charges after copay	No maximum benefit	Tip: Call the Customer Care Crew at 702-823-2667 to make sure your hospital is in our Network.
	Obstetrics	$250				
	Skilled Nursing Facility	$250			60 day maximum	
	Inpatient Rehabilitation	$250			60 day maximum	
	23hr observation	$250			No maximum benefit	
	Surgery/Anesthesia	No copay		100% of allowable charges		
Mental Health and Addictions	Outpatient Therapy	No copay for the first 5 visits per issue/$20 copay after.	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services may require prior approval. Call the Customer Care Crew at 702-823-2667 for additional information.
	Inpatient	$250				
	Partial Hospital Admission	$250				
	Intensive Outpatient Program	$250				

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Applied Behavioral Analysis (ABA) for the treatment of Autism	Outpatient treatment	$20	No coinsurance	100% of allowable charges after copay	Subject to a combined limit of the greater of (i) 200 visits or (ii) 700 hours, per Member per Calendar Year	No other information
Other Services	Home Healthcare	$15 per day	No coinsurance	100% of allowable charges after copay	Maximum benefit of 60 days per calendar year	No other information
	Home Infusion Therapy	No copay		100% of allowable charges	No maximum benefit	
	Hospice					
	Diabetic Shoes	$55 per pair		100% of allowable charges after copay	2 pair per calendar year	
	Mastectomy Bras	$12 per item			$350 per calendar year	
	Diabetic Supplies	No copay		100% of allowable charges	No maximum benefit	
	Hearing Aids	No copay	No coinsurance	100% of allowable charges	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 a plan preferred provider. Repairs or replacement limited to once every 3 years	
	Compression Stockings	$22 per pair	No coinsurance	100% of allowable charges after copay	3 pair per calendar year	Custom-made compression stockings require prior authorization (approval).
	Orthotic Shoe Inserts	$10 per pair			1 pair or 2 inserts every 5 years	They must be prescribed by a PPO Physician, Podiatrist, Orthopedic Physician or an Orthotic Provider.
	Durable Medical Equipment & Medical Supplies	No copay	25% of allowable charges	75% of allowable charges	No maximum benefit	Prior Authorization (approval) is required for items over $500.
	Prosthetic & Orthotic Appliances				No maximum benefit	Prior Authorization (approval) is required.

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Other Services (continued)	Vision: Glasses and Contact Lenses	No copay	No coinsurance	$150 every two years	$150 every two years	Your eye exam is covered under your Physician Office Services Benefit.

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.

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.

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.

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 in Section 7 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 denied for such Covered Services if the Member receives them without Prior Authorization. Please refer to your CO-OP 226 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 are subject to change and include, but are not limited to:

High Tech Diagnostic Service Review	
OB Ultrasounds	Fetal biophysical profiles
All MRI/MRA's	All PET scans
All CT/CTA scans	Sleep Studies
Discography	

Medical/Radiation Oncology Treatments	
Chemotherapy	Biologics
Hormone Therapy	Brachytherapy
Intensity-modulated radiation therapy (IMRT)	Two-dimensional (2D)/three-dimensional (3D) conformal radiation
Supportive care medications related to cancer diagnosis	Stereotactic radiation therapy & proton-beam procedures

Ambulatory Surgery Review	
Blepharoplasty	Septoplasty
Varicose vein stripping/ligation	Ventral hernia repair>18 years
Orthotripsy for plantar fasciitis	Breast reduction & breast surgery (except those with an accepted medical diagnosis)
Surgical treatment of sleep apnea	

Additional Services Requiring Prior Authorization	
Dialysis	Physical, occupational and speech therapy after the 12th visit
EECP	Durable medical equipment items for which the purchase price is over $500 (whether it is rental or purchase)
All TMJ procedures	Specialty medications given in office (Authorized and supplied through Catamaran/Briova)
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
Genetic testing	Spinal surgery or invasive procedures for pain relief or control (inpatient or outpatient services)
Custom compression stockings	All hospital admissions (including elective admissions and those resulting from ER or observation stay)
Cochlear implants	Implantable hormone replacement therapy (i.e. Testopel)
Oralmandibular/orthognathic surgery	Stereotactic radiosurgery (Gamma/Cyber Knife)
Gastric neurostimulator	All hysterectomies (Inpatient or Outpatient)
Skin substitutes/Grafts	Hip and Knee Surgeries
All Inpatient and all Non-Routine Mental Health and Substance Abuse and Severe Mental Illness Services	