HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

# *Health Plan of Nevada, Inc. ("HPN") Small Business Point-Of-Service ("POS") Rider to the Small Business Evidence of Coverage ("EOC")*

This Rider is a supplement to your EOC issued by HPN. Subject to the applicable terms, conditions, limitations and exclusions stated in the EOC and this Rider, the following benefits are included in your healthcare coverage. Nothing in this Rider will change the terms of the EOC except as otherwise stated herein. This Rider shall terminate upon termination of the Plan and under the same terms and conditions specified therein, and Members shall no longer be entitled to any of the benefits set forth in this Rider. Nothing contained in this Rider shall vary, waive, alter, or extend any of the terms, conditions or limitations of the EOC, except as specifically stated in this Rider.

All benefits for Emergency Services will be administered under the provisions of the HPN EOC. Benefits for services received in an emergency room which are Medically Necessary but not of an emergency nature are limited. Please refer to the Attachment A Benefit Schedule for further information.

## HPN SMALL BUSINESS POINT-OF-SERVICE PLAN

The HPN POS Plan "Point-Of-Service" Plans offers Members flexibility and freedom of choice to use either Health Maintenance Organization ("HMO") – Tier I Benefits, Expanded Plan Provider – Tier II Benefits, or Non-Plan Provider – Tier III Benefits when healthcare benefits are needed. Benefits for certain Covered Services may only be obtained from HPN HMO – Tier I Plan Providers. Certain benefit levels are subject to benefit maximums which limit the amount of benefit payments you may receive on a daily, Calendar Year or per Illness basis. Please refer to the Attachment A, Benefit Schedule for specific information.

Tier I HMO Benefit level offers the most comprehensive coverage and the lowest out-of-pocket costs to POS Members. Under Tier I: HMO, Covered Services are provided through a HPN contracted Primary Care Provider. No claim forms are required, a Deductible may apply and the Tier I HMO benefits provide a higher level of coverage with lower out-of-pocket expenses than Tier II or Tier III level of benefits. All Covered Services not provided by the Member's Primary Care Provider (PCP) require Prior Authorization from the PCP and HPN's Managed Care Program. The following Covered Services require Prior Authorization and review through HPN's Managed Care Program:

- Non-emergency Inpatient admissions and extensions of stay in a Hospital, Skilled Nursing Facility, Residential Treatment Center or Hospice;
- Outpatient surgery provided in any setting, including technical and professional services;
- Diagnostic and Therapeutic Services;
- Home Healthcare Services;
- All Inpatient and non-routine Outpatient non-Emergency Mental Health, Severe Mental Illness, and Substance Abuse Services, including:
    - Intensive outpatient program treatment;
    - Outpatient electro-convulsive treatment; and
    - Psychological testing
- All Specialist visits or consultations;
- Prosthetic Devices, Orthotic Devices and Durable Medical Equipment; and
- Allergy testing or treatment (e.g., skin, RAST); angioplasty; physiotherapy or Manual Manipulation; habilitative and rehabilitation therapy (physical, speech, occupational).

If Prior Authorization is not obtained for Tier I services for which it is required, or if any Tier I services received are determined by HPN not to be Medically Necessary as defined in this EOC, no benefits will payable under the Plan.

Please refer to the Attachment A, Benefit Schedule for specific information for Covered Services that require referral for Prior Authorization.

Tier II Expanded Plan Provider Benefit level offers a wider selection of Providers. Under Tier II, Covered Services are provided and/or arranged by a Tier II Provider selected from the HPN Expanded Plan Provider directory which includes PCPs, Specialists and various medical facilities that are not generally available under Tier I. Costs to the Member are higher than when accessing the Tier I HMO benefits

because in most cases the Member will be responsible for a higher copayments and/or Per Occurrence Deductibles for some services. Claim forms are not usually required when using contracted Tier II Plan Providers. When Covered Services are obtained through a Tier II Provider, coverage and benefits are subject to:

- No Referral requirement for access to Specialists or facilities;
- A Calendar Year Deductible (CYD);
- Coinsurance for most Covered Services up to the Calendar Year Out-of-Pocket Maximum;
- A Per Occurrence Deductible applies for some services;
- Claim forms are not required for most Covered Services;
- No balance bill from the Provider;
- Prior Authorization for certain Covered Services; and
- Not all services are covered under Tier II. Refer to the Attachment A, Benefit Schedule for a complete list of Tier II Covered Services.

If Prior Authorization is not obtained for Medically Necessary Tier II services for which it is required, benefits will be reduced to 50% of the amount that would have otherwise been payable. If Tier II services are received which are determined by HPN not to be Medically Necessary, or are not Covered Services under Tier II, no benefits are payable under the Plan.

Tier III Non-Plan Provider Benefit level offers the greatest selection of Providers, allowing Member's to obtain Covered Services from any duly-licensed Provider within the United States. Costs to the Member are highest under this benefit option. When Covered Services are obtained through a Tier III Provider, coverage and benefits are subject to:

- No Referral requirement for access to Specialists or facilities;
- Tier III Non-Plan Providers may require full payment of Covered Services at time services are provided;
- Claim forms and itemized bills are required;
- Balance billing from the Provider, so Members pay any portion of the bill that exceeds HPN's Eligible Medical Expense (EME) payment;
- A Calendar Year Deductible (CYD) and, if applicable, inpatient Deductibles;
- Higher Coinsurance for Covered Services up to the plan's stated Calendar Year Out of Pocket Maximum;
- Prior Authorization for certain Covered Services; and
- Not all services are covered under Tier III Refer to the Attachment A, Benefit Schedule for a complete list of Tier III Covered Services.

If Prior Authorization is not obtained for Medically Necessary Tier III services for which it is required, benefits will be reduced to 50% of the amount that would have otherwise been payable. If Tier III services are received which are determined by HPN not to be Medically Necessary, or are not Covered Services under Tier III, no benefits are payable under the Plan.

Please refer to the Attachment A, Benefit Schedule for specific information for Covered Services that require referral for Prior Authorization.

## EMERGENCY SERVICES

Emergency Services: Benefits for Emergency Services and Urgently Needed Services are subject to any limit shown in the Attachment A Benefit Schedule and as set forth in the HPN EOC.

The HMO – Tier I level of benefits will apply to Emergency Services provided at any duly licensed facility. Upon admission to a Non-Plan – Tier III Hospital and stabilization of the emergency condition and safe for transfer as determined by the attending Physician, the Plan may require transfer to an HMO – Tier I contracted facility in order to pay benefits at the HMO – Tier I level. Benefits for post-stabilization and follow-up care received at a Non-Plan – Tier III Hospital facility are subject to the applicable benefit tier.

NOTE: You are responsible for expenses which exceed the Eligible Medical Expense ("EME") payments to Non-Plan Providers – Tier III, amounts that exceed applicable maximum benefit payments, and penalties for not complying with the Managed Care Program. Claim forms must be submitted for services received from Non-Plan Providers – Tier III.

## IMPORTANT INFORMATION

Only those services and supplies, listed herein and which meet HPN's definition of Medically Necessary will be considered to be Covered Services. The Attachment A, Benefit Schedule shows applicable Copayments, Deductibles, Coinsurance and benefit limitations for Covered Services as well as the Plan's Tier I: HMO Plan Provider Calendar Year Out of Pocket Maximum and the Tier II: Expanded Plan Provider and Tier III: Non-Plan Provider Calendar Year Out of Pocket Maximum amounts. All Covered Services are subject to HPN's Managed Care Program.

Under the Small Business POS Plans, the following are only available under the Tier I: HMO Plan Provider level of benefits, some are subject to Prior Authorization by HPNs Managed Care Program:

- Telemedicine;
- Urgent Care Services;
- Ambulance Services;
- Gastric Restrictive Surgery Services;
- Mastectomy Reconstructive Services;
- Organ and Tissue Transplant Surgical Services;
- Post-Cataract Surgical Services;
- Hospice Care Services;
- Durable Medical Equipment;
- Genetic Disease Testing Services;
- Infertility Office Visit Evaluation;
- Prosthetic Devices;
- Orthotic Devices;
- Self-Management and Treatment of Diabetes;
- Special Food Products and Enteral Formulas;
- Temporomandibular Joint Treatment;
- Hearing Aids;
- Applied Behavioral Analysis Services for the treatment of Autism;
- Pediatric Vision Services;
- Pediatric Dental Services; and
- Gender Dysphoria Services.

Please refer to the Attachment A, Benefit Schedule for the applicable Tier I: HMO Plan Provider Copayment requirements, benefit limitations and Prior Authorization for each of these services.

## SECTION 1. Obtaining Covered Services under the Tier II Plan Provider and Tier III Non-Plan Provider benefit levels

This section tells you under what conditions benefits for Covered Services are available under the Tier II and Tier III benefit levels and your obligations as a Member. You should also carefully review the Exclusions and Limitations described in the HPN EOC prior to obtaining healthcare services.

### 1.1 Provider Selection

Subject to all conditions, Exclusions, and Limitations of the HPN EOC and this Rider, if the Member uses the services of a Provider who is a licensed Practitioner in the state in which he is practicing and who is operating within the scope of his license, then such services shall be treated as though they had been performed by a Physician.

### 1.2 Tier II and Tier III Services Requiring Prior Authorization

Covered Services requiring Prior Authorization and review through HPN's Managed Care Program include, but are not limited to:

a) All elective Inpatient admissions and extensions of stay beyond the original certified length of stay to a Hospital or Skilled Nursing Facility;
b) All outpatient surgery provided in any setting, including technical and professional services;
c) All outpatient tests, including technical and professional services, including, for example, but not limited to the following: angiograms; echocardiograms; EEGs; EMGs; and nerve conduction studies; Holter monitors (heart monitor-24 hours); myelograms; non-invasive vascular studies; psychological testing; pulmonary function tests; CAT scans, MRI scans, nuclear scans; sleep apnea studies; and treadmill stress tests (cardiac exercise tests); Positron Emission Tomography (PET Scan); and
d) All outpatient courses of treatment, including, for example, but not limited to, the following: allergy testing/treatment (e.g. skin, RAST); angioplasty; anti-cancer drug therapy; dialysis; Home Health Care; physiotherapy or Manual Manipulation; radiation therapy; and habilitative and rehabilitation (physical, speech, occupational) services.

### 1.3 Failure to Comply

Failure of the Member to comply with the requirements of HPN's Managed Care Program will result in a reduction of benefits. Benefits for Covered Services obtained under the Tier II or Tier III benefit levels which are not certified by HPN's Managed Care Program will be reduced to 50% of the benefits which would have been payable if the services had been certified.

### 1.4 Appeals Rights

All decisions of HPN's Managed Care Program may be appealed by the Member through the Appeals Procedures. Please refer to the HPN EOC for additional information on the Appeals Procedure.

## SECTION 2. Claims Provisions

This section tells you how and when to file a claim for benefits under this Plan when you receive services from a Tier III Non-Plan Provider.

### 2.1 Notice and Proof of Claim

Written notice of each claim for benefits should be given to the Plan within thirty (30) days of the date any healthcare services are received. Failure to furnish notice within thirty (30) days will not invalidate or reduce any claim if it is shown that notice was provided to the Plan within twelve (12) months of the date of service. The Plan, upon receipt of such notice, will furnish to the Member forms for filing the proof of claim. The Plan agrees to:

a) provide claim forms to the Group for submitting claims to the Plan;
b) receive claims and claims documentation;
c) correspond with the Members and Providers of services if additional information is deemed by the Plan to be necessary to complete the processing of claims;
d) coordinate benefits payable under the Plan with other benefit plans, if any;
e) determine the amount of benefits payable under the Plan; and
f) pay the amount of benefits determined to be payable under the Plan and pay all claims that are clearly for eligible Members for Covered Services that were appropriately authorized within thirty (30) days. Claims may be pended and appropriately delayed if there are issues regarding proper authorization, eligibility or Coordination of Benefits.

### 2.2 Late Claims Exclusion

No payment shall be made under the Plan with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by the Plan within twelve (12) months after the date Covered Services are provided.

## SECTION 3. Glossary

❖ **"Expanded Plan Provider - Tier II Benefits"** means those benefits for services received from an HPN Plan Provider from HPN's expanded list of Providers, after satisfaction of a Calendar Year Deductible and subject to the Member's Coinsurance percentages, and/or Copayments, in some instances. Certain Covered Services require Prior Authorization from the Managed Care Program in order for the Member to receive maximum benefits.

❖ **"Non-Plan Provider - Tier III Benefits"** means those benefits for services received from a Non-Plan Provider after satisfaction of the Calendar Year Deductible and subject to the Member's Coinsurance percentage. Certain Covered Services require Prior Authorization from HPN's Managed Care Program in order for the Member to receive maximum benefits. Member will be required to submit claim forms and itemized bills for services rendered.

❖ **"Per Occurrence Deductible"** means the amount of Eligible Medical Expenses stated as a set dollar amount that you must pay for Certain Covered Health Services (prior to and addition to any Annual Deductible) before HPN begins paying for Benefits for those Covered Health Services.