HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

HPN Solutions POS Gold $25/0/500/80%

Attachment A Benefit Schedule

Unlimited Lifetime Benefit Maximum for all Covered Services

Tier I HMO Benefits apply when you obtain or arrange for Covered Services through a Health Plan of Nevada, Inc. ("HPN") contracted Primary Care Physician. No claim forms are required and the Tier I HMO benefits provide a higher level of coverage with lower Out of Pocket expenses than the Tier II or Tier III level of benefits.

Tier II Plan Provider Benefits apply when a Member obtains Covered Services from a Provider who is independently contracted with HPN to provide Covered Services to Members enrolled in HPN Point-of-Service ("POS") plans. The Member's out of pocket expenses will be higher than when accessing the Tier I HMO benefits because in most cases the Member will be responsible for a Calendar Year Deductible ("CYD"), higher Coinsurance percentages and/or higher Copayments for some services. Claim forms are not usually required when using contracted Tier II Plan Providers. Further, certain services are not covered under this Tier; please reference the following pages for detailed benefit information.

In no event will your total Out of Pocket amount paid for Eligible Medical Expenses for Tier I and Tier II Covered Services exceed your Tier II Out of Pocket maximum.

Tier III Non-Plan Provider Benefits apply when a Member obtains Covered Services from a Non-Plan Provider. Out of pocket expenses are the highest 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 Tier III Non-Plan Providers. Further, certain services are not covered under this Tier; please reference the following pages for detailed benefit information.

Emergency Services: The Tier I HMO level of benefits will apply to Emergency Services provided at any duly-licensed facility. Upon admission to a Tier III 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 Tier I HMO contracted facility in order to continue paying benefits at the Tier I HMO level. Benefits for Prior Authorized post-stabilization and follow-up care received at a Tier II or Tier III hospital facility are subject to the applicable benefit tier.

Calendar Year Deductible ("CYD"):

There is no Calendar Year Deductible when using Tier I HMO Providers. Your CYD is $500 of EME per Member and $1,000 of EME per Family for Tier II Plan Provider Services. Your Tier III CYD is $1,000 of EME per Member and $2,000 of EME per Family for Tier III Non-Plan Provider Services.

A Member may not contribute any more than the individual CYD amount toward the Family CYD amount.

Copayments: This Plan includes some fixed dollar copayment amounts (which are not subject to the CYD) for certain Covered Services. Please reference the following pages for detailed cost-share information.

Coinsurance: After meeting any applicable CYD, your Coinsurance, if applicable, for Tier I Covered Services is 20% of EME. Your Coinsurance for most Tier II Covered Services is 20% of EME. Your Coinsurance for most Tier III Covered Services is 50% EME.

Calendar Year Out of Pocket Maximum: Your Out of Pocket expenses are limited to a Calendar Year maximum of $3,500 of EME per Member and $7,000 of EME per Family when using Tier I HMO providers. Your Out of Pocket expenses are limited to a Calendar Year maximum of $6,250 of EME per Member and $12,500 of EME per Family when using Tier II Plan Providers. Your Out of Pocket expenses for Tier I HMO providers accumulate to both your Tier I and Tier II Out of Pocket maximums. Your Out of Pocket expenses for Tier II providers accumulate only to your Tier II Out of Pocket maximum. In no event will your Out of Pocket expenses for Tier I

and Tier II providers exceed your Tier II Calendar Year Out of Pocket maximum. Your Out of Pocket expenses are limited to a Calendar Year Maximum of $12,500 of EME per Member and $25,000 of EME per Family when using Tier III Non-Plan Providers. A Member may not contribute any more than the individual Calendar Year Out Of Pocket Maximum amount toward the applicable Family Calendar Year Out of Pocket Maximum amount.

The Tier I and Tier II Calendar Year Out Of Pocket Maximum amounts include the CYD, Copayments and Coinsurance. The Tier III Calendar Year Out of Pocket maximum amounts includes the CYD and applicable Coinsurance.

The Calendar Year Out Of Pocket Maximum does not include; 1) amounts charged for non-Covered Services, 2) amounts exceeding applicable Plan benefit maximums or EME payments to Non-Plan Providers; or, 3) penalties for not obtaining any required Prior Authorization or for the Member otherwise not complying with HPN's Managed Care Program.

Note: You are responsible for all amounts exceeding the applicable benefit maximums, EME payments to Tier III Non-Plan Providers and penalties for not complying with HPN's Managed Care Program. Further, such amounts do not accumulate to your applicable Calendar Year Out of Pocket Maximum.

Please read your HPN 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 EME payments to Providers are determined.

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Medical Office Visits and Consultations in a Medical Office Setting				After CYD, HPN pays 50% of EME.
• **Primary Care Services**	No			
Convenient Care Facility		Member pays $20 per visit.	Member pays $35 per visit.	
Physician Extender or Assistant		Member pays $20 per visit.	Member pays $35 per visit.	
Physician		Member pays $25 per visit.	Member pays $40 per visit.	
• **Specialist Services**	Yes	Member pays $45 per visit.	Member pays $60 per visit.	
Preventive Healthcare Services - *Services include various recommended exams, immunizations, diagnostic tests and screenings. Refer to the HPN Preventive Guidelines on the HPN website (www.healthplanofnevada.com) located under the "Members & Guests" tab or contact the Member Services Department (702-242-7300) for the complete list of covered Adult and Pediatric Preventive Services and Immunizations. These guidelines are updated in accordance with the Federal Government standards.*	No	Member pays $0 per visit.	Member pays $0 per visit	
Routine Lab and X-ray services provided and billed by the Physician's office. (*Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician's office.)*	Yes			
• Lab		Member pays $15 per visit.	Member pays $30 per visit.	
• X-Ray		Member pays $25 per visit.	Member pays $40 per visit.	
Telemedicine Services *(Only available through select Providers.)*	No	Member pays $20 per visit.	Telemedicine Services are covered under the Tier I HMO benefit.	
Laboratory Services - Outpatient *Performed at an independent facility.*	Yes	Member pays $15 per visit.	Member pays $30 per visit.	After CYD, HPN pays 50% of EME.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Routine Radiological and Non-Radiological Diagnostic Imaging Services *Performed at a Free-Standing Diagnostic Center.*	Yes	Member pays $25 per visit.	Member pays $40 per visit.	After CYD, HPN pays 50% of EME.
Emergency Services			Emergency Services are covered under the Tier I HMO benefit.	
• Urgent Care Facility	No	Member pays $50 per visit.		
• Emergency Room Visit	No	Member pays $150 per visit; waived if admitted.		
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	No	HPN pays 80% of EME.		
Ambulance Services			Emergency Ambulance Services are covered under the Tier I HMO benefit.	
• Emergency Transport	No	Member pays $250 per trip.		
• Non-Emergency – HPN Arranged Transfers	Yes	Member pays $0.		
Inpatient Hospital Facility Services *Elective and Emergency Post-Stabilization Admissions*	Yes	HPN pays 80% of EME.	After CYD, HPN pays 80% of EME.	After CYD, HPN pays 50% of EME.
Outpatient Surgery at a Hospital Facility	Yes	Member pays $350 per surgery.	After CYD, HPN pays 80% of EME.	After CYD, HPN pays 50% of EME.
Ambulatory Surgical Facility Services	Yes	Member pays $200 per surgery.	After CYD, HPN pays 80% of EME.	After CYD, HPN pays 50% of EME.
Anesthesia Services	Yes	Member pays $150 per surgery.	After CYD, HPN pays 80% of EME.	After CYD, HPN pays 50% of EME.

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Physician Surgical Services – Inpatient and Outpatient			After CYD, HPN pays 80% of EME.	After CYD, HPN pays 50% of EME.
• Inpatient Facility	Yes	Member pays $200 per surgery.		
• Ambulatory Surgical or Outpatient Hospital Facility	Yes	Member pays $150 per surgery.		
• Physician's Office Primary Care Physician (Includes all physician services related to the surgical procedure)	No	Member pays $25 per visit.	Member pays $40 per visit.	
• Specialist (Includes all physician services related to the surgical procedure)	Yes	Member pays $45 per visit.	Member pays $60 per visit.	
Gastric Restrictive Surgery Services *HPN provides a lifetime benefit maximum of one Medically Necessary surgery per Member.*			Gastric Restrictive Surgery Services are covered under the Tier I HMO benefit.	
• Physician Surgical Services	Yes	Member pays $2,500 per surgery. Subject to maximum benefit.		
• Physician Office Visit	Yes	Member pays $45 per visit.		
Organ and Tissue Transplant Surgical Services			Organ and Tissue Transplants and Retransplantations are covered under the Tier I HMO benefit.	
• Inpatient Hospital Facility	Yes	HPN pays 80% of EME.		
• Physician Surgical Services – Inpatient Hospital Facility	Yes	Member pays $200 per surgery.		
• 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.*	Yes	Member pays $0. Subject to maximum benefit.		

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Organ and Tissue Transplant Surgical Services (continued)			Organ and Tissue Transplants and Retransplantations are covered under the Tier I HMO benefit.	
• Procurement *Benefits for procurement procedures and/or services are limited to those deemed by HPN to be Medically Necessary and appropriate for an approved Organ Transplant in a single Transplant Benefit Period.*	Yes	HPN pays 80% of EME.		
• Retransplantation Services *Benefits are limited to one (1) Medically Necessary Retranplantation per Member per type of transplant.*	Yes	HPN pays 50% of EME. Subject to maximum benefit.		
Post-Cataract Surgical Services			Post-Cataract Surgical Services are covered under the Tier I HMO benefit.	
• Frames and Lenses	Yes	$10 per pair of glasses. Subject to maximum benefit.		
• Contact Lenses *Benefit limited to one (1) Medically Necessary pair of glasses or set of contact lenses as applicable per Member per surgery.*	Yes	$10 per set of contact lenses. Subject to maximum benefit.		
Home Healthcare Services (*does not include Specialty Prescription Drugs)* *Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drugs.* *Subject to a combined Tier II and Tier III maximum benefit of sixty (60) visits per Member per Calendar Year.*	Yes	Member pays $25 per visit.	After CYD, HPN pays 80% of EME. Subject to maximum benefit.	After CYD, HPN pays 50% of EME. Subject to maximum benefit.
Hospice Care Services			Hospice Care Services are covered under the Tier I HMO benefit.	
• Inpatient Hospice Facility	Yes	HPN pays 80% of EME.		
• Outpatient Hospice Services	Yes	Member pays $25 per visit.		

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Hospice Care Services (continued)			Hospice Care Services are covered under the Tier I HMO benefit.	
• 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.*	Yes			
• Inpatient		HPN pays 80% of EME. Subject to maximum benefit.		
• Outpatient		Member pays $25 per visit. Subject to maximum benefit.		
• 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.*	Yes	Member pays $25 per visit. Subject to maximum benefit.		
Skilled Nursing Facility *Subject to a combined Tier I, II and III maximum benefit of one hundred (100) days per Member per Calendar Year.*	Yes	HPN pays 80% of EME. Subject to maximum benefit.	After CYD, HPN pays 80% of EME. Subject to maximum benefit.	After CYD, HPN pays 50% of EME. Subject to maximum benefit.
Manual Manipulation (*Applies to Medical-Physician Services and Chiropractic office visit.) Subject to a combined Tier I, II and III maximum benefit of twenty (20) visits per Member per Calendar Year.*	Yes	Member pays $25 per visit. Subject to maximum benefit.	After CYD, HPN pays 80% of EME. Subject to maximum benefit.	After CYD, HPN pays 50% of EME. Subject to maximum benefit.
Short-Term Rehabilitation and Habilitative Services			After CYD, HPN pays 80% of EME. Subject to maximum benefit.	After CYD, HPN pays 50% of EME. Subject to maximum benefit.
• Inpatient Hospital Facility	Yes	HPN pays 80% of EME. Subject to maximum benefit.		
• Outpatient *All Inpatient and Outpatient Short-Term Rehabilitation and Habilitative Services are subject to a combined Tier I, Tier II and Tier III maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.*	Yes	Member pays $25 per visit. Subject to maximum benefit.		

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
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, every three (3) years.*	Yes	Member pays $150 or 50% of EME of purchase or monthly rental price, whichever is less.	Durable Medical Equipment is covered under the Tier I HMO benefit.	
Genetic Disease Testing Services • Office Visit • Lab *Includes Inpatient, Outpatient and independent Laboratory Services.*	Yes	Member pays $45 per visit. Member pays $45 per test.	Genetic Disease Testing Services are covered under the Tier I HMO benefit.	
Infertility Office Visit Evaluation *Please refer to applicable surgical procedure Copayment/Cost-share herein for any surgical infertility procedures performed.*	Yes	Member pays $45 per visit.	Infertility Office Visit Evaluations are covered under the Tier I HMO benefit.	
Medical Supplies	Yes	Member pays $0.	After CYD, HPN pays 80% of EME.	After CYD, HPN pays 50% of EME.
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.* • 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	Yes	Member pays $25 per visit. Member pays $25 per visit. Member pays $25 per visit. Member pays $25 per day. Member pays $25 per day.	After CYD, HPN pays 80% of EME.	After CYD, HPN pays 50% of EME.

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Other Diagnostic and Therapeutic Services (continued) • Other complex diagnostic imaging services such as Positron Emission Tomography (PET) scans, CT Scan and MRI); vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.	Yes	Member pays $100 per test or procedure.	After CYD, HPN pays 80% of EME.	After CYD, HPN pays 50% of EME.
Prosthetic Devices *Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.*	Yes	Member pays $750 per device. Subject to maximum benefit.	Prosthetic Devices are covered under the Tier I HMO benefit.	
Orthotic Devices *Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.*	Yes	Member pays $50 per device. Subject to maximum benefit.	Orthotic Devices are covered under the Tier I HMO benefit.	
Self-Management and Treatment of Diabetes			Self-Management and Treatment of Diabetes are covered under the Tier I HMO benefit.	
• Education and Training	No	Member pays $25 per visit.		
• Supplies (except for Insulin Pump Supplies)	No	Member pays $5 per therapeutic supply.		
Insulin Pump Supplies	Yes	Member pays $10 per therapeutic supply.		
• Equipment (except for Insulin Pump)	Yes	Member pays $20 per device.		
Insulin Pump *Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.*	Yes	Member pays $100 per device.		

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
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.*	Yes	Member pays $0. Subject to maximum benefit.	Special Food Products and Enteral Formulas are covered under the Tier I benefit only.	
Temporomandibular Joint Treatment	Yes	HPN pays 50% of EME.	TMJ Treatment is covered under the Tier I HMO benefit only.	
Mental Health and Severe Mental Illness				After CYD, HPN pays 50% of EME.
• Inpatient Hospital Facility	Yes	HPN pays 80% of EME.	After CYD, HPN pays 80% of EME.	
• Outpatient Treatment	Yes	Member pays $25 per visit.	Member pays $40 per visit.	
Substance Abuse Services				After CYD, HPN pays 50% of EME.
• Inpatient Hospital Facility	Yes	HPN pays 80% of EME.	After CYD, HPN pays 80% of EME.	
• Outpatient Treatment	Yes	Member pays $25 per visit.	Member pays $40 per visit.	
Hearing Aids *Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.*	Yes	Member pays $150 or 50% of EME, whichever is less.	Hearing Aids are covered under the Tier I HMO benefit.	
Applied Behavioral Analysis (ABA) for the treatment of Autism *Limited to maximum benefit of two hundred fifty (250) visits per Member not to exceed seven hundred fifty (750) total hours per Member per Calendar Year.*	Yes	Member pays $25 per visit. Subject to maximum benefit.	ABA Services are covered under the Tier I HMO benefit.	
Pediatric Vision Services for Members up to age 19			Pediatric Vision Services are covered under the Tier I HMO benefit.	
Vision Examination *One (1) vision examination by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be covered once every calendar year.*	No	Member pays $0 per visit. Subject to maximum benefit.		

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit	Tier II Plan Provider Benefit	Tier III Non-Plan Provider Benefit
Pediatric Vision Services for Members up to age 19 (continued)			Pediatric Vision Services are covered under the Tier I HMO benefit.	
Lenses *One (1) pair of lenses will be covered once every calendar year when a prescription change is determined Medically Necessary. Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal and lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglasses.*	No	Member pays $0 per visit. Subject to maximum benefit.		
Frames *One (1) pair of frames, from the approved Formulary frame series, will be covered every calendar year. Charges for frames selected outside of the approved Formulary frame series are the responsibility of the Member. Discounts for non- Formulary frames may be available through the Plan Provider.*	No	Member pays $0 per visit. Subject to maximum benefit.		
Contact Lenses *Contact lenses are covered once every calendar year in lieu of eye glasses. Charges for contact lenses considered to be cosmetic in purposes shall be the responsibility of the Member..*	No	Member pays $0 per visit. Subject to maximum benefit.		
Low Vision Exam *One comprehensive evaluation every five (5) years.*	Yes	Member pays $0 per visit. Subject to maximum benefit.		
Optional Lenses and Treatments • Standard Anti-Reflective (AR) Coating • UV Treatment • Tint (Fashion & Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Photocromatic/Transitions Plastic *(Other optional lenses and treatment services may be available to the Member at a discount. Please consult with your Provider.)*	No	Member pays $0.		

Benefit Schedule

<table>
<tr><th>Covered Services and Limitations</th><th>Referral or Prior Auth. Required*</th><th>Tier I HMO Plan Provider Benefit</th><th>Tier II Plan Provider Benefit</th><th>Tier III Non-Plan Provider Benefit</th></tr>
<tr><td colspan="5">Pediatric Dental Services for Members up to age 19</td></tr>
<tr><td>Diagnostic and Preventive
• Oral exam every six (6) months
• Periodic X-rays
• Diagnostic procedures
• Prophylaxis every six (6) months
• Topical fluoride treatment every six (6) months
• Sealants once per permanent molar
• Space maintenance therapy</td><td>No</td><td>HPN pays 100% of EME.</td><td colspan="2" rowspan="9">Pediatric Dental Services are covered under the Tier I HMO benefit.</td></tr>
<tr><td>Restorative
• Amalgam or composite fillings as needed
• Crowns as needed
• Sedative fillings</td><td>Yes</td><td>HPN pays 80% of EME.</td></tr>
<tr><td>Endodontics
• Root canal therapy
• Pulpal therapy</td><td>Yes</td><td>HPN pays 50% of EME.</td></tr>
<tr><td>Periodontics
Usually limited to Members at least fourteen (14) years of age.</td><td>Yes</td><td>HPN pays 50% of EME.</td></tr>
<tr><td>Prosthodontics
• Partial and complete dentures
Limited to one unit once every sixty (60) months.</td><td>Yes</td><td>HPN pays 50% of EME.</td></tr>
<tr><td>Orthodontics
Coverage provided for Medically Necessary Services only.</td><td>Yes</td><td>HPN pays 50% of EME.</td></tr>
<tr><td>Oral Surgery (includes Anesthesia)
• Extractions</td><td>Yes</td><td>HPN pays 50% of EME.</td></tr>
<tr><td>Emergency Dental Services
• Services or procedures necessary to control bleeding, relieve significant pain and/or eliminate acute infection.
• Services or procedures required to prevent pulpal death and/or imminent loss of teeth.</td><td>No</td><td>HPN pays 50% of EME.</td></tr>
</table>

A Tier I 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.

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

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 Copayment and Coinsurance Maximums.

*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.

Tier I HMO benefits are provided by Health Plan of Nevada, Inc. (HPN), a Health Maintenance Organization (HMO). No benefits will be paid if Medically Necessary Covered Services are provided without Prior Authorization for those services covered which require Prior Authorization and are available only under the Tier I HMO benefit.

Tier II and Tier III benefits are underwritten by HPN. If Medically Necessary Covered Services are provided without the required Prior Authorization, benefits are reduced to 50% of what the Member would have received with Prior Authorization.