HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Group 1 POS C-XV-500 – HCR

Attachment A Benefit Schedule

Lifetime Maximum: Unlimited.

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, no Deductible applies, 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 by 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"), Coinsurance percentages and, in some plans, higher Copayments. Claim forms are not usually required when using contracted Tier II Plan Providers.

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.

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"): Your CYD is $500 per Member and $1,500 per family. The CYD is a combined total of EME for Tier II and Tier III Covered Services.

Coinsurance: After meeting your CYD, your Coinsurance for most Tier II Covered Services is 20% of EME. Your Coinsurance for most Tier III Covered Services is 40% of EME.

Coinsurance Maximum: After satisfying your CYD, your Coinsurance (including office visit Copayments) is limited to a maximum of $2,000 of EME per Member per Calendar Year ($6,000 per family) if you use Tier II Plan Providers and $4,000 of EME per Member per Calendar Year ($12,000 per family) if you use Tier III Non-Plan Providers. In no event will the total Coinsurance amount you pay exceed $4,000 of EME per Member or $12,000 of EME per family in any Calendar Year.

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 Coinsurance 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.

Benefit Schedule

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Medical - Physician Services and Physician Consultations				After CYD, Member pays 40% of EME.
• Office Visit/Consultation				
Primary Care Physician	No	$15 per visit	$30 per visit	
Specialist *Prior Authorization is not required for Tier II and Tier III benefits.*	Yes	$30 per visit	$45 per visit	
• Inpatient Visit/Consultation				
Primary Care Physician	Yes	No charge	No charge	
Specialist	Yes	No charge	No charge	
Laboratory Services *Copayment is in addition to the Physician office visit Copayment and applies to services rendered in a Physician's office or at an independent laboratory.*	Yes	$15 per visit	$15 per visit	After CYD, Member pays 40% of EME.
Routine Radiological and Non-Radiological Diagnostic Imaging Services *Copayment is in addition to the Physician office visit Copayment and applies to services rendered in a Physician's office or at an independent radiological facility.*	Yes	$15 per visit	$15 per visit	After CYD, Member pays 30% of EME.

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Emergency Services *Within* The Service Area • Urgent Care Facility • Emergency Room Visit • Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.* • Office Visit to Non-Plan Physician *The maximum benefit for Medically Necessary but non-Emergency Services received in an Emergency Room is 50% of EME. You are responsible for all amounts exceeding the Plan's applicable maximum benefit and amounts exceeding the Plan's EME payment to Tier III Non-Plan Providers. Such amounts do not accumulate to the Coinsurance Maximum.*	No	 $20 per visit $75 per visit; waived if admitted. $400 per admission Not applicable	Emergency Services are covered under the Tier I HMO benefit.	Emergency Services are covered under the Tier I HMO benefit except for an Office Visit to a Non-Plan Physician. After CYD, Member pays 40% of EME.
Emergency Services *Outside* the Service Area • Urgent Care Facility	No	 $40 per visit	Emergency Services are covered under the Tier I HMO benefit.	Emergency Services are covered under the Tier I HMO benefit.

Benefit Schedule

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Emergency Services *Outside* the Service Area (continued)	No		Emergency Services are Covered under the Tier I HMO benefit.	Emergency Services are covered under the Tier I HMO benefit except for an Office Visit to a Non-Plan Physician.
• Emergency Room Visit		$75 per visit; waived if admitted.		
• Hospital Admission - Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*		$400 per admission		
• Office Visit to Non-Plan Physician		Not applicable		After CYD, Member pays 40% of EME.
The maximum benefit for Medically Necessary but Non-Emergency Services received in an emergency room is 50% of EME. You are responsible for all amounts exceeding the Plan's applicable maximum benefit and amounts exceeding the Plan's EME payment to Tier III Non-Plan Providers. Such amounts do not accumulate to the Coinsurance Maximum.				
Ambulance Services			Emergency Ambulance Services are covered under the Tier I HMO benefit.	Emergency Ambulance Services are covered under the Tier I HMO benefit.
• Emergency – Ground Transport	No	$50 per trip		
• Emergency – Air Transport	No	50% of EME per trip		
• Non-Emergency – HPN Arranged Transfers	Yes	No charge		

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Inpatient Hospital Facility Services *Elective and emergency post-stabilization admissions.*	Yes	$400 per admission	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Outpatient Hospital Facility and Ambulatory Surgical Facility Services	Yes	$50 per admission	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Physician Surgical Services - Inpatient and Outpatient			After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
• Inpatient Hospital Facility	Yes	$100 per surgery		
• Outpatient Hospital Facility	Yes	$50 per surgery		
• Physician's Office				
Primary Care Physician (in addition to office visit Copayment)	No	$15 per visit		
Specialist (in addition to office visit Copayment)	Yes	$30 per visit		
Assistant Surgical Services	Yes	No charge	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Anesthesia Services	Yes	$150 per surgery	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Gastric Restrictive Surgery Services *The maximum lifetime benefit for all Gastric Restrictive Surgery Services is $5,000 per Member.*	Yes	50% of EME. Subject to maximum benefit.	Gastric Restrictive Surgery Services are covered under the Tier I HMO benefit.	Gastric Restrictive Surgery Services are covered under the Tier I HMO benefit.

Benefit Schedule

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Gastric Restrictive Surgery Services (continued) • Physician Surgical Services • Complications *The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgery Services is $5,000 per Member.*	Yes	50% of EME. Subject to maximum benefit.	Gastric Restrictive Surgery Services are covered under the Tier I HMO benefit.	Gastric Restrictive Surgery Services are covered under the Tier I HMO benefit.
Mastectomy Reconstructive Surgical Services • Physician Surgical Services • Prosthetic Device for Mastectomy Reconstruction *Unlimited.*	Yes	$100 per surgery $750 per device	Mastectomy Reconstructive Surgical Services is covered under the Tier I HMO benefit. Prosthetic Devices For Mastectomy Reconstructive Surgical Services are covered under the Tier I HMO Benefit.	Mastectomy Reconstructive Surgical Services is covered under the Tier I HMO benefit. Prosthetic Devices For Mastectomy Reconstructive Surgical Services are covered under the Tier I HMO Benefit.
Oral Physician Surgical Services • Office Visit • Physician Surgical Services Inpatient Hospital Facility Outpatient Hospital Facility	Yes	$30 per visit $100 per surgery $50 per surgery	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Organ and Tissue Transplant Surgical Services	Yes		Organ and Tissue Transplants and Retransplantations are covered under the Tier I HMO benefit.	Organ and Tissue Transplants and Retransplantations are covered under the Tier I HMO benefit.
• Inpatient Hospital Facility		$400 per admission		
• Physician Surgical Services - Inpatient Hospital Facility		$100 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.*		No charge. Subject to maximum benefit.		
• Procurement *The maximum benefit per Member per Transplant Benefit Period for Procurement of the organ/tissue is $15,000 of EME.*		No charge. Subject to maximum benefit.		
• Retransplantation Services *The maximum benefit for Retransplantation Services is 50% of EME which does not apply towards the Calendar Year Copayment Maximum.*		50% of EME. Subject to maximum benefit.		

Benefit Schedule

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Post-Cataract Surgical Services • Frames and Lenses *Maximum frame allowance of $100.* • Contact Lenses *Maximum contact lenses allowance of $100.* *Benefit limited to one (1) pair of glasses or set of contact lenses as applicable per Member per surgery.*	Yes	$10 per pair of glasses. Subject to maximum benefit. $10 per set of contact lenses. Subject to maximum benefit.	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
Home Healthcare Services *(does not include Self-Injectable Prescription Drugs)* *Refer to the HPN group prescription drug rider for benefits applicable to outpatient Covered Drugs.* • Physician House Calls • Home Care Services • Private Duty Nursing *Subject to a combined Tier II and Tier III maximum benefit of thirty (30) visits per Member per Calendar Year.*	Yes	$20 per visit No charge No charge	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
Hospice Care Services • Inpatient Hospice Facility	Yes	$400 per admission	Hospice Care Services are covered under the Tier I HMO benefit.	Hospice Care Services are covered under the Tier I HMO benefit.

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Hospice Care Services (continued) • Outpatient Hospice Services • Inpatient Respite Services *Limited to a maximum benefit of $1,500 per Member per Calendar Year.* • Outpatient Respite Services *Limited to a maximum benefit of $1,000 per Member per Calendar Year.* • Bereavement Services *Limited to a maximum benefit of five (5) therapy sessions or $500, whichever is less. Treatment must be completed within six (6) months of the date of death.*	Yes	No charge $400 per admission. Subject to maximum benefit. $15 per visit. Subject to maximum benefit. $20 per visit. Subject to maximum benefit.	Hospice Care Services are covered under the Tier I HMO benefit.	Hospice Care Services are covered under the Tier I HMO benefit.
Skilled Nursing Facility Services *Subject to a combined Tier I, Tier II and Tier III maximum benefit of 100 days per Member per Calendar Year.*	Yes	$400 per admission. Subject to maximum benefit.	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
Manual Manipulation *Applies to Medical-Physician Services and Chiropractic office visit. Subject to a combined Tier II and Tier III maximum benefit of $1,000 per Member per Calendar Year and $5,000 maximum lifetime benefit.*	Yes	$30 per visit	$45 per visit. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Short-Term Rehabilitation Services • Inpatient Hospital Facility • Outpatient *All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a combined Tier II and Tier III maximum benefit of sixty (60) days/visits per Calendar Year.*	Yes	 $400 per admission $15 per visit	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
Durable Medical Equipment *For purchase or rental at HPN's option. Subject to a combined Tier II and Tier III maximum lifetime benefit of $4,000 per Member.*	Yes	$100 or 50% of EME of purchase or rental price, whichever is less.	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
Genetic Disease Testing Services *Includes Inpatient, Outpatient and independent Laboratory Services.*	Yes	25% of EME per test	Genetic Disease Testing Services are covered under the Tier I HMO benefit.	Genetic Disease Testing Services are covered under the Tier I HMO benefit.
Infertility Office Visit Evaluation *Please refer to the applicable surgical procedure Copayment and/or Coinsurance amount herein for any surgical infertility procedures performed.*	Yes	$30 per visit	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Medical Supplies	Yes	No charge	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Other Diagnostic and Therapeutic Services *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.*	Yes		After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
• Anti-Cancer Drug Therapy, non-cancer related intra-venous injection therapy or other Medically Necessary intravenous therapeutic services.		$30 per day		
• Dialysis		$30 per day		
• Therapeutic Radiology		$30 per day		
• Allergy Testing and Serum Injections		$30 per visit		
• Otologic Evaluations		$30 per visit		
• Other services such as complex diagnostic imaging; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.		$30 per test or procedure		
• Positron Emission Tomography (PET) Scans		$750 per test		
Prosthetic and Orthotic Devices *Limited to a maximum lifetime benefit of $10,000 per Member including:* • *repairs; and* • *post-mastectomy external prosthetic device.*	Yes	$750 per device. Subject to maximum benefit.	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Self-Management and Treatment of Diabetes				After CYD, Member pays 40% of EME.
• Education and Training	No	$15 per visit	$30 per visit	
• Supplies (except for Insulin Pump Supplies)	No	$5 per therapeutic supply	$5 per therapeutic supply	
Insulin Pump Supplies	Yes	$10 per therapeutic supply	$10 per therapeutic supply	
• Equipment (except for Insulin Pumps)	Yes	$20 per device	$20 per device	
Insulin Pump	Yes	$100 per device	$100 per device	
Refer to the Outpatient Prescription Drug Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.				
Special Food Products and Enteral Formulas *Limited to a maximum benefit of $2,500 per Member per Calendar Year for Special Food Products only.*	Yes	No charge. Subject to maximum benefit.	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
Temporomandibular Joint Treatment (TMJ) *Dental-related treatment is limited to $2,500 per Member per Calendar Year and $4,000 maximum lifetime benefit per Member.*	Yes	50% of EME. Subject to maximum benefit.	TMJ Treatment is covered under the Tier I HMO benefit.	TMJ Treatment is covered under the Tier I HMO benefit.
Mental Health Services	Yes		After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
• Inpatient Hospital Facility		$400 per admission		
• Outpatient Treatment				
Group Therapy		$15 per visit	$30 per visit	

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Mental Health Services (continued) Individual, Family and Partial Care Therapy** ***Partial Care Therapy refers to a coordinated Outpatient program of treatment that provides structured daytime, evening and/or weekend services for a minimum of four (4) hours per session as an alternative to Inpatient care.*	Yes	$30 per visit	$30 per visit	After CYD, Member pays 40% of EME.
Severe Mental Illness Services • Inpatient Hospital Facility • Outpatient Treatment	Yes	$400 per admission $15 per visit	After CYD, Member pays 20% of EME. $30 per visit	After CYD, Member pays 40% of EME.
Substance Abuse Services • Inpatient Detoxification (treatment for withdrawal) • Outpatient Detoxification • Inpatient Rehabilitation • Outpatient Rehabilitation Counseling Group Therapy Individual, Family and Partial Care Therapy**	Yes	$400 per admission $15 per visit $400 per admission $15 per visit $30 per visit	After CYD, Member pays 20% of EME. $30 per visit After CYD, Member pays 20% of EME. $30 per visit $30 per visit	After CYD, Member pays 40% of EME.

Legal Documents

Benefit Schedule

Covered Services and Limitations	* PAR	Tier I HMO Provider (Copayments)	Tier II Plan Provider	Tier III Non-Plan Provider
			Member pays amounts listed below plus any amounts exceeding the Plan's EME and benefit maximums	
Substance Abuse Services (continued) ***Partial Care Therapy refers to a coordinated Outpatient program of treatment that provides structured daytime, evening and/or weekend services for a minimum of four (4) hours per session as an alternative to Inpatient care.*				
Preventive Healthcare Services	No	No charge	No charge	Member pays 40% of EME. Not subject to CYD.
Hearing Aids *Limited to a combined maximum benefit of $5,000 per Member per Calendar Year and further limited to a single purchase. Repairs and Replacement are limited to once every three (3) years.*	Yes	$100 or 50% of EME, whichever is less. Subject to maximum benefit.	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
Applied Behavioral Analysis (ABA) for the treatment of Autism *Limited to a maximum benefit of $36,000 per Member per Calendar Year.*	Yes	$15 per visit. Subject to maximum benefit.	ABA Services are covered under the Tier I HMO benefit.	ABA Services are covered under the Tier I HMO benefit.

The Calendar Year Copayment Maximum for Tier I HMO basic health services is 200% of the total premium rate the Member would pay if he were enrolled under a Health Benefit Plan Certificate without Copayments. A Copayment will not exceed more than 50% of the total cost of providing any single service to a Member, or, in the aggregate, not more than 20% of the total cost of providing all of the basic healthcare services as required by Nevada regulations. Tier I HMO benefits have a Calendar Year Copayment Maximum.

Contact HPN's Member Services Department at (702) 242-7300 or 1-800-777-1840, Monday through Friday from 8:00 AM to 5:00 PM for the appropriate Calendar Year Copayment Maximum applicable to this Plan.

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 Maximum.

*PAR (Prior Authorization Required) – Except as otherwise noted, and with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness, Substance Abuse Services, all Covered Services not provided by the Member's Primary Care Physician require 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.