



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Distinct Advantage – POS Option 3 – HCR

Attachment A Benefit Schedule

This Plan includes a 12-month waiting period for maternity coverage.

Lifetime Maximum Benefit: Unlimited.

Tier I HMO Benefits apply when you obtain or arrange for Covered Services through an 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 less out-of-pocket expenses than the Tier II Plan Provider or Tier III Non-Plan Provider benefits.

Tier II Plan Provider Benefits apply when a Member obtains Covered Services from a Provider who is independently contracted by HPN to provide services to Members enrolled in Distinct Advantage – Point-of-Service (“POS”) Option 3. The Member’s out-of-pocket expenses will be higher than Tier I HMO benefits because the Member will be responsible for a Calendar Year Deductible (“CYD”), Coinsurance percentages and, in some instances, 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 Tier III Non-Plan Provider. All benefits are subject to a CYD and Coinsurance percentage, up to a Member’s Calendar Year Coinsurance Maximum. 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 pay benefits at the Tier I HMO benefit level. Benefits

for post-stabilization and follow-up care received at a Tier II Plan Provider or Tier III Non-Plan Provider Hospital facility are subject to the applicable benefit tier.

Calendar Year Deductible (CYD): Your CYD is \$500 per Member and \$1,500 of EME per family. The CYD is a combined total of EME for Tier II Plan Provider and Tier III Non-Plan Provider Covered Services.

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

Coinsurance Maximum: After satisfying your CYD, your Coinsurance 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 per family in any Calendar Year. Refer to the Distinct Advantage POS Rider for amounts that do not accumulate to the Calendar Year Coinsurance Maximum.

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 Calendar Year Coinsurance Maximum.

Benefit Schedule

Please read your HPN Agreement of Coverage ("AOC") 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	* P A R	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 <ul style="list-style-type: none"> • Office Visit/Consultation <table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Primary Care Physician</td> <td style="width: 10%;">No</td> <td style="width: 20%;">\$15 per visit</td> <td style="width: 20%;">\$30 per visit</td> <td rowspan="4" style="width: 20%; vertical-align: top;">After CYD, Member pays 40% of EME.</td> </tr> <tr> <td>Specialist</td> <td>Yes</td> <td>\$30 per visit</td> <td>\$45 per visit</td> </tr> <tr> <td colspan="4"><i>Prior Authorization is not required for Tier II and Tier III benefits.</i></td> </tr> <tr> <td colspan="4">• Inpatient Visit/Consultation</td> </tr> <tr> <td>Primary Care Physician</td> <td>Yes</td> <td>No charge</td> <td>No charge</td> <td rowspan="2"></td> </tr> <tr> <td>Specialist</td> <td>Yes</td> <td>No charge</td> <td>No charge</td> </tr> </table> 	Primary Care Physician	No	\$15 per visit	\$30 per visit	After CYD, Member pays 40% of EME.	Specialist	Yes	\$30 per visit	\$45 per visit	<i>Prior Authorization is not required for Tier II and Tier III benefits.</i>				• Inpatient Visit/Consultation				Primary Care Physician	Yes	No charge	No charge		Specialist	Yes	No charge	No charge				
Primary Care Physician	No	\$15 per visit	\$30 per visit	After CYD, Member pays 40% of EME.																										
Specialist	Yes	\$30 per visit	\$45 per visit																											
<i>Prior Authorization is not required for Tier II and Tier III benefits.</i>																														
• Inpatient Visit/Consultation																														
Primary Care Physician	Yes	No charge	No charge																											
Specialist	Yes	No charge	No charge																											
Preventive Healthcare Services	No	No charge	No charge	Not subject to CYD. Member pays 40% of EME.																										
Laboratory Services <i>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.</i>	Yes	\$15 per visit	\$15 per visit	After CYD, Member pays 40% of EME.																										
Routine Radiological and Non-Radiological Diagnostic Imaging Services <i>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.</i>	Yes	\$15 per visit	\$15 per visit	After CYD, Member pays 30% of EME.																										

Legal Documents

Benefit Schedule

Covered Services and Limitations	* P A R	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		
<p>Emergency Services <i>Within The Service Area</i></p> <ul style="list-style-type: none"> Urgent Care Facility Southwest Medical Associates (SMA) Plan Provider Other Plan Provider Non-Plan Provider Physician's Services in Emergency Room Emergency Room Facility Hospital Admission – Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i> Lab and X-rays Plan Provider Non-Plan Provider <p><i>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.</i></p>	No	<p>\$45 per visit</p> <p>\$50 per visit</p> <p>\$60 per visit</p> <p>\$25 per visit</p> <p>\$75 per visit</p> <p>\$150 per day not to exceed \$400 per admission.</p> <p>\$15 per visit</p> <p>\$30 per visit</p>	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	* P A R	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	
<p>Emergency Services Outside the Service Area</p> <ul style="list-style-type: none"> • Urgent Care Facility • Physician's Services in Emergency Room • Emergency Room Facility • Hospital Admission - Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i> • Lab and X-rays <p><i>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.</i></p>	No	<p>\$60 per visit</p> <p>\$25 per visit</p> <p>\$75 per visit</p> <p>\$150 per day not to exceed \$400 per admission.</p> <p>\$30 per visit</p>	Emergency Services are covered under the Tier I HMO benefit.	Emergency Services are covered under the Tier I HMO benefit.
<p>Ambulance Services</p> <ul style="list-style-type: none"> • Emergency – Ground Transport • Emergency – Air Transport • Non-Emergency – HPN Arranged Transfers 	No No Yes	<p>\$150 per trip</p> <p>50% of EME per trip</p> <p>No charge</p>	Emergency Ambulance Services are covered under the Tier I HMO benefit.	Emergency Ambulance Services are covered under the Tier I HMO benefit.
<p>Inpatient Hospital Facility Services <i>Elective and emergency post-stabilization admissions.</i></p>	Yes	\$150 per day not to exceed \$400 per admission.	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.

Benefit Schedule

Covered Services and Limitations	* P A R	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	
Outpatient Hospital Facility and Ambulatory Surgical Facility Services	Yes	\$75 per admission	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Physician Surgical Services - Inpatient and Outpatient <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Hospital Facility • Physician's Office <p>Primary Care Physician (in addition to office visit Copayment)</p> <p>Specialist (in addition to office visit Copayment)</p>	Yes	\$100 per surgery \$75 per surgery \$15 per visit \$30 per visit	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Assistant Surgical Services	Yes	\$50 per surgery	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Anesthesia Services	Yes	\$100 per surgery	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Gastric Restrictive Surgical Services <i>The maximum lifetime benefit for all Gastric Restrictive Surgical Services is \$5,000 per Member.</i> <ul style="list-style-type: none"> • Physician Surgical Services • Complications 	Yes	50% of EME. Subject to maximum benefit.	Gastric Restrictive Surgical Services are covered under the Tier I HMO benefit.	Gastric Restrictive Surgical Services are covered under the Tier I HMO benefit.

Benefit Schedule

Covered Services and Limitations	* P A R	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 Surgical Services (continued) <i>The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgical Services is \$5,000 per Member.</i>				
Mastectomy Reconstructive Surgical Services <ul style="list-style-type: none"> • Physician Surgical Services • Prosthetic Device for Mastectomy Reconstruction <i>Unlimited.</i> 	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 is 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 is covered under the Tier I HMO benefit.
Oral Physician Surgical Services <ul style="list-style-type: none"> • Office Visit • Physician Surgical and Diagnostic Services Inpatient Hospital Facility Outpatient Hospital Facility	Yes	\$30 per visit \$100 per surgery \$75 per surgery	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
Organ and Tissue Transplant Surgical Services <ul style="list-style-type: none"> • Inpatient Hospital Facility Services 	Yes	\$150 per day not to exceed \$400 per admission.	Organ and Tissue Transplants and Retransplantation are covered under the Tier I HMO benefit.	Organ and Tissue Transplants and Retransplantation are covered under the Tier I HMO benefit.

Legal Documents

Benefit Schedule

Covered Services and Limitations	* P A R	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		
<p>Organ and Tissue Transplant Surgical Services (continued)</p> <ul style="list-style-type: none"> Physician Surgical Services – Inpatient Hospital Facility Transportation, Lodging, and Meals <i>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.</i> Procurement <i>The maximum benefit per Member per Transplant Benefit Period for Procurement of the organ/tissue is \$15,000 of EME.</i> Retransplantation Services <i>The maximum benefit for Retransplantation Services is 50% of EME which does not apply towards the Calendar Year Copayment Maximum.</i> 	Yes	<p>\$100 per surgery</p> <p>No charge. Subject to maximum benefit.</p> <p>No charge. Subject to maximum benefit.</p> <p>50% of EME. Subject to maximum benefit.</p>	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.

Benefit Schedule

Covered Services and Limitations	* P A R	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	
<p>Post-Cataract Surgical Services</p> <ul style="list-style-type: none"> • Frames and Lenses <i>Maximum frame allowance of \$100.</i> • Contact Lenses <i>Maximum contact lenses allowance of \$100.</i> <p><i>Benefit limited to one (1) pair of glasses or set of contact lenses as applicable per Member per surgery.</i></p>	Yes	<p>\$10 per pair of glasses. Subject to maximum benefit.</p> <p>\$10 per set of contact lenses. Subject to maximum benefit.</p>	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
<p>Home Healthcare Services (does not include Self-Injectable Prescription Drugs) <i>Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to outpatient Covered Drugs.</i></p> <ul style="list-style-type: none"> • Physician House Calls • Home Care Services • Private Duty Nursing <p><i>Subject to a combined Tier II and Tier III maximum benefit of thirty (30) visits per Calendar Year.</i></p>	Yes	<p>\$30 per visit</p> <p>\$30 per visit</p> <p>\$15 per visit</p>	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
<p>Hospice Care Services</p> <ul style="list-style-type: none"> • Inpatient Hospice Facility 	Yes	\$150 per day not to exceed \$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.

Legal Documents

Benefit Schedule

Covered Services and Limitations	* P A R	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) <ul style="list-style-type: none"> Outpatient Hospice Services Inpatient Respite Services <i>Limited to a maximum benefit of \$1,500 per Member per Calendar Year.</i> Outpatient Respite Services <i>Limited to a maximum benefit of \$1,000 per Member per Calendar Year.</i> Bereavement Services <i>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.</i> 	Yes	No charge \$150 per day not to exceed \$400 per admission. Subject to maximum benefit. \$15 per visit. Subject to maximum benefit. \$15 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 <i>Subject to a combined Tier I, Tier II, and Tier III maximum benefit of one hundred (100) days per Member per Calendar Year.</i>	Yes	\$150 per day not to exceed \$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 <i>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.</i>	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	* P A R	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	
<p>Short-Term Rehabilitation Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient <p><i>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.</i></p>	Yes	<p>\$150 per day not to exceed \$400 per admission.</p> <p>\$15 per visit</p>	After CYD, Member pays 20% of EME. Subject to maximum benefit.	After CYD, Member pays 40% of EME. Subject to maximum benefit.
<p>Durable Medical Equipment <i>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.</i></p>	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.
<p>Genetic Disease Testing Services <i>Includes Inpatient, Outpatient and independent Laboratory Services.</i></p>	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.
<p>Infertility Office Visit Evaluation <i>Please refer to the applicable surgical procedure Copayment and/or Coinsurance amount herein for any surgical infertility procedures performed.</i></p>	Yes	\$30 per visit	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
<p>Medical Supplies</p>	Yes	No charge	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.

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Benefit Schedule

Covered Services and Limitations	* P A R	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		
<p>Other Diagnostic and Therapeutic Services <i>Copayment is in addition to the Physician office visit</i> <i>Copayment and applies to services rendered in a Physician's office or at an independent facility.</i></p> <ul style="list-style-type: none"> • 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 • Other services such as complex diagnostic imaging; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services. • Amniocentesis • Positron Emission Tomography (PET Scan) 	Yes	<p>\$30 per day</p> <p>\$30 per day</p> <p>\$30 per day</p> <p>\$30 per visit</p> <p>\$30 per visit</p> <p>\$30 per test or procedure</p> <p>\$30 per visit</p> <p>\$750 per test</p>	After CYD, Member pays 20% of EME.	After CYD, Member pays 40% of EME.
<p>Prosthetic and Orthotic Devices <i>Limited to a maximum lifetime benefit of \$10,000 per Member including:</i></p> <ul style="list-style-type: none"> • <i>repairs; and</i> • <i>post-mastectomy external prosthetic device.</i> 	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	* P A R	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 <ul style="list-style-type: none"> • Education and Training • Supplies (except for Insulin Pump Supplies) <ul style="list-style-type: none"> Insulin Pump Supplies • Equipment (except for Insulin Pumps) <ul style="list-style-type: none"> Insulin Pump <p><i>Refer to the Outpatient Prescription Drug Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.</i></p>	<p>No</p> <p>No</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$15 per visit</p> <p>\$5 per therapeutic supply</p> <p>\$15 per therapeutic supply</p> <p>\$20 per device</p> <p>\$100 per device</p>	<p>\$30 per visit</p> <p>\$5 per therapeutic supply</p> <p>\$15 per therapeutic supply</p> <p>\$20 per device</p> <p>\$100 per device</p>	<p>After CYD, Member pays 40% of EME.</p>
Special Food Products and Enteral Formulas <i>Limited to a maximum benefit of \$2,500 per Member per Calendar Year for Special Food Products only.</i>	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) <i>Dental-related treatment is limited to \$2,500 per Member per Calendar Year and \$4,000 maximum lifetime benefit per Member.</i>	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 <ul style="list-style-type: none"> • Inpatient Hospital Facility <i>Limited to a maximum benefit of thirty (30) days per Member per Calendar Year.</i> • Outpatient Treatment <ul style="list-style-type: none"> Group Therapy <i>Unlimited visits.</i> 	Yes	<p>\$150 per day not to exceed \$400 per admission. Subject to maximum benefit.</p> <p>\$15 per visit</p>	<p>After CYD, Member pays 20% of EME. Subject to maximum benefit.</p> <p>After CYD, Member pays 20% of EME.</p>	<p>After CYD, Member pays 40% of EME. Subject to maximum benefit.</p> <p>After CYD, Member pays 40% of EME.</p>

Legal Documents

Benefit Schedule

Covered Services and Limitations	* P A R	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		
<p>Mental Health Services (continued) Individual, Family and Partial Care Therapy** <i>Limited to a maximum benefit of twenty (20) visits per Member per Calendar Year.</i></p> <p><i>Benefit maximum does not apply to visits for medication management.</i></p> <p><i>**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.</i></p>	Yes	\$20 per visit. 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.
<p>Severe Mental Illness Services</p> <ul style="list-style-type: none"> Inpatient Hospital Facility <i>Limited to a maximum benefit of forty (40) days per Member per Calendar Year.</i> Outpatient Treatment <i>Limited to a maximum benefit of forty (40) visits per Member per Calendar Year.</i> <p><i>Two (2) visits for partial or respite care or a combination thereof, may be substituted for each one (1) day of Inpatient hospitalization not used by the Member.</i></p> <p><i>Benefit maximum does not apply to visits for medication management.</i></p>	Yes	<p>\$150 per day not to exceed \$400 per admission. Subject to maximum benefit.</p> <p>\$15 per visit. Subject to maximum benefit.</p>	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	* P A R	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		
<p>Substance Abuse Services</p> <ul style="list-style-type: none"> • Inpatient Detoxification (treatment for withdrawal) • Outpatient Detoxification <i>Unlimited visits.</i> • Inpatient Rehabilitation • Outpatient Rehabilitation Counseling <li style="padding-left: 20px;">Group Therapy <li style="padding-left: 20px;">Individual, Family and Partial Care Therapy** <i>**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.</i> 	Yes	<p>\$150 per day not to exceed \$400 per admission.</p> <p>\$15 per visit</p> <p>\$150 per day not to exceed \$400 per admission. Subject to maximum benefit.</p> <p>\$15 per visit. Subject to maximum benefit.</p> <p>\$20 per visit. Subject to maximum benefit.</p>	After CYD, Member pays 20% of EME. Subject to applicable maximum benefit.	After CYD, Member pays 40% of EME. Subject to applicable maximum benefit.

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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.

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.