



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

*School Administrators' and Professional-technical
Employees' Welfare Trust ("Trust")
POS Plan 2*

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 \$250 per Member and \$750 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 10% of EME. Your Coinsurance for most Tier III Covered Services is 30% of EME.

Coinsurance Maximum: After satisfying your CYD, your Coinsurance (including office visit Copayments) is limited to a maximum of \$1,000 of EME per Member per Calendar Year (\$3,000 per family) if you use Tier II Plan Providers and \$2,000 of EME per Member per Calendar Year (\$6,000 per family) if you use Tier III Non-Plan Providers. In no event will the total Coinsurance amount you pay exceed \$2,000 of EME per Member or \$6,000 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.

Benefit Schedule

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 | * 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-collapse: collapse;"> <tr> <td style="width: 30%;">Primary Care Physician</td> <td style="width: 10%;">No</td> <td style="width: 20%;">\$10 per visit</td> <td style="width: 20%;">\$20 per visit</td> <td rowspan="4" style="width: 20%; vertical-align: top;">After CYD, Member pays 30% of EME.</td> </tr> <tr> <td>Specialist</td> <td>Yes</td> <td>\$10 per visit</td> <td>\$20 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 | \$10 per visit | \$20 per visit | After CYD, Member pays 30% of EME. | Specialist | Yes | \$10 per visit | \$20 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 | \$10 per visit | \$20 per visit | After CYD, Member pays 30% of EME. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Specialist | Yes | \$10 per visit | \$20 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | No charge | \$5 per visit | After CYD, Member pays 30% 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 | \$10 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</i> The Service Area</p> <ul style="list-style-type: none"> Urgent Care Facility Emergency Room Visit Hospital Admission – Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i> Office Visit to Non-Plan Physician <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>\$15 per visit</p> <p>\$65 per visit; waived if admitted.</p> <p>\$100 per day not to exceed \$400 per admission</p> <p>Not applicable</p> | Emergency Services are covered under the Tier I HMO benefit except for an Office Visit to a Non-Plan Physician. | <p>Emergency Services are covered under the Tier I HMO benefit except for an Office Visit to a Non-Plan Physician.</p> <p>After CYD, Member pays 30% of EME.</p> |
| <p>Emergency Services <i>Outside</i> the Service Area</p> <ul style="list-style-type: none"> Urgent Care Facility | No | \$15 per visit | Emergency Services are covered under the Tier I HMO benefit except for an Office Visit to a Non-Plan Physician. | Emergency Services are covered under the Tier I HMO benefit except for an Office Visit to a Non-Plan Physician. |

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>Outside</i> the Service Area (continued)</p> <ul style="list-style-type: none"> Emergency Room Visit Hospital Admission - Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i> Office Visit to Non-Plan Physician <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>\$65 per visit; waived if admitted.</p> <p>\$100 per day not to exceed \$400 per admission</p> <p>Not applicable</p> | Emergency Services are Covered under the Tier I HMO benefit except for an Office Visit to a Non-Plan Physician. | Emergency Services are covered under the Tier I HMO benefit except for an Office Visit to a Non-Plan Physician. After CYD, Member pays 30% of EME. |
| <p>Ambulance Services</p> <ul style="list-style-type: none"> Emergency – Ground Transport Emergency – Air Transport Non-Emergency – HPN Arranged Transfers | <p>No</p> <p>No</p> <p>Yes</p> | <p>\$75 per trip</p> <p>50% of EME per trip</p> <p>No charge</p> | Ambulance Services are covered under the Tier I HMO benefit. | Ambulance 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 | |
| Inpatient Hospital Facility Services <i>Elective and emergency post-stabilization admissions.</i> | Yes | \$100 per day not to exceed \$400 per admission | After CYD, Member pays 10% of EME. | After CYD, Member pays 30% of EME. |
| Outpatient Hospital Facility and Ambulatory Surgical Facility Services | Yes | \$100 per admission | After CYD, Member pays 10% of EME. | After CYD, Member pays 30% of EME. |
| Physician Surgical Services - Inpatient and Outpatient | | | After CYD, Member pays 10% of EME. | After CYD, Member pays 30% of EME. |
| <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Hospital Facility • Physician's Office | Yes | \$100 per surgery | | |
| | Yes | \$50 per surgery | | |
| Primary Care Physician (in addition to office visit Copayment) | No | \$10 per visit | | |
| Specialist (in addition to office visit Copayment) | Yes | \$10 per visit | | |
| Assistant Surgical Services | Yes | \$50 per surgery | After CYD, Member pays 10% of EME. | After CYD, Member pays 30% of EME. |
| Anesthesia Services | Yes | \$100 per surgery | After CYD, Member pays 10% of EME. | After CYD, Member pays 30% of EME. |
| Gastric Restrictive Surgical Services <i>The maximum lifetime benefit for all Gastric Restrictive Surgical Services is \$5,000 per Member.</i> | 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) <ul style="list-style-type: none"> • Physician Surgical Services • Complications <i>The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgical Services is \$5,000 per Member.</i> | 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. |
| 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 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 <ul style="list-style-type: none"> • Office Visit • Physician Surgical and Diagnostic Services Inpatient Hospital Facility Outpatient Hospital Facility | Yes | \$10 per visit \$100 per surgery \$50 per surgery | After CYD, Member pays 10% of EME. | 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>Organ and Tissue Transplant Surgical Services</p> <ul style="list-style-type: none"> Inpatient Hospital Facility 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 day not to exceed \$400 per admission.</p> <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 10% of EME. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. |
| <p>Home Healthcare Services (does not include Self-Injectable Prescription Drugs) <i>Refer to your 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>\$10 per visit</p> <p>\$10 per visit</p> <p>No charge</p> | After CYD, Member pays 10% of EME. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. |
| <p>Hospice Care Services</p> <ul style="list-style-type: none"> • Inpatient Hospice Facility | Yes | \$100 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 \$100 per day not to exceed \$400 per admission. Subject to maximum benefit. \$10 per visit. Subject to maximum benefit. \$10 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>Limited to a maximum benefit of one hundred (100) days per Member per Calendar Year.</i> | Yes | \$100 per day not to exceed \$400 per admission. Subject to maximum benefit. | After CYD, Member pays 10% of EME. Subject to maximum benefit. | After CYD, Member pays 30% 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 | \$10 per visit | \$20 per visit. Subject to maximum benefit. | After CYD, Member pays 30% 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 Member per Calendar Year.</i></p> | Yes | <p>\$100 per day not to exceed \$400 per admission</p> <p>\$10 per visit</p> | After CYD, Member pays 10% of EME. Subject to maximum benefit. | After CYD, Member pays 30% 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 | No charge | After CYD, Member pays 10% of EME. Subject to maximum benefit. | After CYD, Member pays 30% 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 | \$15 per visit | After CYD, Member pays 10% of EME. | After CYD, Member pays 30% of EME. |
| <p>Medical Supplies</p> | Yes | No charge | After CYD, Member pays 10% of EME. | 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>Other Diagnostic and Therapeutic 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 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. • Positron Emission Tomography (PET) Scans | Yes | <p>\$10 per day</p> <p>\$10 per day</p> <p>\$10 per day</p> <p>\$10 per visit</p> <p>\$10 per visit</p> <p>\$30 per test or procedure</p> <p>\$750 per test</p> | After CYD, Member pays 10% of EME. | After CYD, Member pays 30% 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 10% of EME. Subject to maximum benefit. | After CYD, Member pays 30% 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>Self-Management and Treatment of Diabetes</p> <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 Benefit 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>\$10 per visit</p> <p>\$5 per therapeutic supply</p> <p>\$10 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>\$10 per therapeutic supply</p> <p>\$20 per device</p> <p>\$100 per device</p> | <p>After CYD, Member pays 30% of EME.</p> |
| <p>Special Food Products and Enteral Formulas</p> <p><i>Limited to a maximum benefit of \$2,500 per Member per Calendar Year for Special Food Products only.</i></p> | <p>Yes</p> | <p>No charge. Subject to maximum benefit.</p> | <p>After CYD, Member pays 10% of EME. Subject to maximum benefit.</p> | <p>After CYD, Member pays 30% of EME. Subject to maximum benefit.</p> |
| <p>Temporomandibular Joint Treatment (TMJ)</p> <p><i>Dental-related treatment is limited to \$2,500 per Member per Calendar Year and \$4,000 maximum lifetime benefit per Member.</i></p> | <p>Yes</p> | <p>50% of EME. Subject to maximum benefit.</p> | <p>TMJ Treatment is covered under the Tier I HMO benefit.</p> | <p>TMJ Treatment is covered under the Tier I HMO benefit.</p> |
| <p>Mental Health Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Treatment Group Therapy | <p>Yes</p> | <p>\$100 per day not to exceed \$400 per admission</p> <p>\$10 per visit</p> | <p>After CYD, Member pays 10% of EME.</p> <p>\$10 per visit</p> | <p>After CYD, Member pays 30% 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 | | |
| Mental Health Services (continued) Individual, Marital, 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 | \$10 per visit after 1 st visit which has no Copayment. | \$10 per visit | After CYD, Member pays 30% of EME. |
| Severe Mental Illness Services <ul style="list-style-type: none"> Inpatient Hospital Facility Outpatient Treatment | Yes | \$100 per day not to exceed \$400 per admission \$10 per visit | After CYD, Member pays 10% of EME. \$10 per visit | After CYD, Member pays 30% of EME. |
| Substance Abuse Services <ul style="list-style-type: none"> Inpatient Detoxification (treatment for withdrawal) Outpatient Detoxification Inpatient Rehabilitation Outpatient Rehabilitation Counseling Group Therapy Individual, Marital, Family and Partial Care Therapy** | Yes | \$100 per day not to exceed \$400 per admission \$10 per visit \$100 per day not to exceed \$400 per admission \$10 per visit \$10 per visit after 1 st visit which has no Copayment. | After CYD, Member pays 10% of EME. \$10 per visit After CYD, Member pays 10% of EME. \$10 per visit \$10 per visit | After CYD, Member pays 30% 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 | |
| Substance Abuse Services (continued) <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> | | | | |
| Hearing Aids <i>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.</i> | Yes | No charge. Subject to maximum benefit. | After CYD, Member pays 10% of EME. Subject to maximum benefit. | After CYD, Member pays 30% of EME. Subject to maximum benefit. |
| Preventive Healthcare Services | No | No charge | No charge | Not subject to CYD. Member pays 30% of EME. |
| Applied Behavioral Analysis (ABA) for the Treatment of Autism <i>Limited to a maximum benefit of \$36,000 per Member per Calendar Year.</i> | Yes | \$10 per visit | ABA Services are covered under the Tier I HMO benefit. | ABA Services are covered under the Tier I HMO benefit. |

Legal Documents

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) 562-8077 or 1-800-279-4863, Monday through Friday from 8:00 AM to 5:00 PM for the appropriate Calendar Year Copayment Maximum applicable to this Plan.

Benefit Schedule

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 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, and 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.