SINCE 1982

HEALTH PLAN OF NEVADA, INC.℠

a subsidiary of Sierra Health Services, Inc.®

Distinct Advantage – HMO Option 2

Attachment A Benefit Schedule

This Plan does not include maternity coverage.

Lifetime Maximum Benefit: $1,000,000

Copayment Maximum: $4,000 per Member per Calendar Year and $8,000 per Family per Calendar Year.

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Medical – Physician Services and Physician Consultations		
• Office Visit/Consultation Primary Care Physician	No	$25 per visit
Specialist	Yes	$50 per visit
• Inpatient Visit/Consultation Primary Care Physician	Yes	No charge
Specialist	Yes	No charge
Preventive Healthcare Services *Limited to a maximum benefit of $250 per Member per Calendar Year. Benefits for Pap smears and mammography will not be subject to the Calendar Year maximum benefit amount. Refer to your AOC for applicable age and frequency limitations.*	No	$10 per visit
Laboratory Services - Outpatient *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	$10 per visit
Routine Radiological and Non-Radiological Diagnostic Imaging Services - Outpatient *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	$10 per visit

Legal Documents

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Emergency Services Within the Service Area		
• Urgent Care Facility	No	
Southwest Medical Associates (SMA) Plan Provider		$45 per visit
Other Plan Provider		$50 per visit
Non-Plan Provider		$60 per visit
• Physician's Services in Emergency Room	No	
Plan Provider		$25 per visit
Non-Plan Provider		$75 per visit
• Emergency Room Facility	No	
Plan Provider		$75 per visit; waived if admitted.
Non-Plan Provider		$150 per visit; not waived if admitted.
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	No	$300 per day not to exceed $900 per admission.
• Lab and X-Ray	No	
Plan Provider		$10 per visit
Non-Plan Provider		$20 per visit
No benefits are payable for treatment received in a Hospital emergency room or other emergency facility for a condition other than an Emergency Service as defined in the AOC.		
Emergency Services Outside the Service Area		
• Urgent Care Facility	No	$60 per visit
• Physician's Services in Emergency Room	No	$75 per visit
• Emergency Room Facility	No	$150 per visit; not waived if admitted.
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	No	$300 per day not to exceed $900 per admission.
• Lab and X-Ray	No	$20 per visit
No benefits are payable for treatment received in a Hospital emergency room or other emergency facility for a condition other than an Emergency Service as defined in the AOC.		

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Ambulance Services		
• Emergency – Ground Transport	No	$150 per trip
• Emergency – Air Transport	No	50% of EME per trip
• Non-Emergency - HPN Arranged Transfers	Yes	No charge
Inpatient Hospital Facility Services *Elective and Emergency post-stabilization admissions.*	Yes	$300 per day not to exceed $900 per admission.
Outpatient Hospital Facility and Ambulatory Surgical Facility Services	Yes	$200 per admission
Physician Surgical Services - Inpatient and Outpatient		
• Inpatient Hospital Facility	Yes	$200 per surgery
• Outpatient Hospital Facility	Yes	$200 per surgery
• Physician's Office Primary Care Physician *(in addition to office visit Copayment)*	No	$25 per visit
Specialist *(in addition to office visit Copayment)*	Yes	$50 per visit
Assistant Surgical Services	Yes	$50 per surgery
Anesthesia Services	Yes	$100 per surgery
Gastric Restrictive Surgical Services *The maximum lifetime benefit for all Gastric Restrictive Surgical Services is $5,000 per Member.* • Physician Surgical Services • Complications *The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgical Services is $5,000 per Member.*	Yes	50% of EME. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Mastectomy Reconstructive Surgical Services		
• Physician Surgical Services	Yes	$200 per surgery
• Prosthetic Device for Mastectomy Reconstruction *Unlimited.*	Yes	$750 per device
Oral Physician Surgical Services		
• Office Visit	Yes	$50 per visit
• Physician Surgical and Diagnostic Services Inpatient Hospital Facility	Yes	$200 per surgery
Outpatient Hospital Facility	Yes	$200 per surgery
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	$300 per day not to exceed $900 per admission. Subject to maximum benefit.
• Physician Surgical Services – Inpatient Hospital Facility	Yes	$200 per surgery. Subject to maximum benefit.
• 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	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.*	Yes	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.*	Yes	50% of EME. Subject to maximum benefit.
The maximum lifetime benefit that will be paid for a Member for Covered Services received in connection with all Covered Transplant Procedures combined is ***$100,000****.*		

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
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.
Home Healthcare Services (does not include Self-Injectable Prescription Drugs) *Refer to your Outpatient Prescription Drug Benefit Rider, if applicable, for your Outpatient Self-Injectable Covered Drug benefit.* • Physician House Calls • Home Care Services • Private Duty Nurse *Limited to a maximum benefit of thirty (30) visits per Member per Calendar Year.*	Yes	 $50 per visit $50 per visit $25 per visit
Hospice Care Services • Inpatient Hospice Facility *Limited to a maximum benefit of thirty (30) days per Member per Calendar Year.* • 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	 $300 per admission. Subject to maximum benefit. No charge $300 per admission. Subject to maximum benefit. $25 per visit. Subject to maximum benefit. $25 per visit. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Skilled Nursing Facility *Limited to a maximum benefit of thirty (30) days per Member per Calendar Year.*	Yes	$300 per admission. Subject to maximum benefit.
Manual Manipulation *Applies to Medical-Physician Services and Chiropractic office visit.*	Yes	$50 per visit
Short-Term Rehabilitation Services • Inpatient Hospital Facility • Outpatient *All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a maximum benefit of thirty (30) days/visits per Member per Calendar Year.*	Yes	 $300 per day not to exceed $900 per admission. Subject to maximum benefit. $25 per visit. Subject to maximum benefit.
Durable Medical Equipment *For purchase or rental at HPN's option. Limited to a maximum benefit of $1,000 per Member per Calendar Year.*	Yes	$100 or 50% of EME of purchase or rental price whichever is less. Subject to maximum benefit.
Genetic Disease Testing Services *Includes Inpatient, Outpatient and independent Laboratory Services.*	Yes	25% of EME per test.
Infertility Office Visit Evaluation *Please refer to applicable surgical procedure Copayment and/or Coinsurance amount herein for any surgical infertility procedures performed.*	Yes	$50 per visit
Medical Supplies	Yes	No charge
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.* • Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services. • Dialysis	Yes	 $25 per day $25 per day

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Other Diagnostic and Therapeutic Services (Continued)	Yes	
• Therapeutic Radiology		$25 per day
• Allergy Testing and Serum Injections		$25 per visit
• Otologic Evaluations		$25 per visit
• Other services such as complex diagnostic imaging (i.e., CAT scan, MRI); complex neurological or psychiatric testing or therapeutic services; pulmonary diagnostic services; vascular diagnostic and therapeutic services.		$25 per test or procedure
• Amniocentesis		$25 per visit
• Positron Emission Tomography (PET scan)		$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.
Self-Management and Treatment of Diabetes		
• Education and Training	No	$25 per visit
• Supplies (except for Insulin Pump Supplies) Insulin Pump Supplies	No Yes	$5 per therapeutic supply $25 per therapeutic supply
• Equipment (except for Insulin Pumps) Insulin Pumps	Yes Yes	$20 per device $100 per device
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.
Temporomandibular Joint Treatment *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.

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Mental Health Services • Inpatient Hospital Facility *Limited to a maximum benefit of thirty (30) days per Member per Calendar Year.* • Outpatient Treatment Group Therapy *Limited to a maximum benefit of twenty (20) visits per Member per Calendar Year.* Individual, Family and Partial Care Therapy** *Limited to a maximum benefit of twenty (20) visits per Member per Calendar Year.* *Benefit maximum does not apply to visits for medication management.* *** 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	 $300 per day not to exceed $900 per admission. Subject to maximum benefit. $25 per visit. Subject to maximum benefit. $25 per visit. Subject to maximum benefit.
Severe Mental Illness Services • Inpatient Hospital Facility *Limited to a maximum benefit of forty (40) days per Member per Calendar Year.* • Outpatient Treatment *Limited to a maximum benefit of forty (40) visits per Member per Calendar Year.* *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.* *Benefit maximum does not apply to visits for medication management.*	Yes	 $300 per day not to exceed $900 per admission. Subject to maximum benefit. $25 per visit. Subject to maximum benefit.
Substance Abuse Services • Inpatient Detoxification (treatment for withdrawal)	Yes	 $300 per day not to exceed $900 per admission.

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Substance Abuse Services (Continued)	Yes	
• Outpatient Detoxification *Limited to a maximum benefit of $1,500 per Member per Calendar Year.*		$25 per visit. Subject to maximum benefit.
• Inpatient Rehabilitation *Limited to a maximum benefit of $9,000 per Member per Calendar Year.*		$300 per day not to exceed $900 per admission. Subject to maximum benefit.
• Outpatient Rehabilitation Counseling* Group Therapy		$25 per visit. Subject to maximum benefit.
Individual, Family and Partial Care Therapy**		$25 per visit. Subject to maximum benefit.
** Rehabilitation counseling services for all group, individual, family and partial care therapy is limited to a maximum benefit of $2,500 per Member per Calendar Year.* *** 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.*		

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 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.

Any and all amounts exceeding any stated maximum benefit amounts under this Plan do not accumulate to the calculation of the Calendar Year Coinsurance Maximum.

*PAR (Prior Authorization Required) – Except as otherwise noted, 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.