

Distinct Advantage – HMO Option 4

Attachment A Benefit Schedule

This Plan does not include maternity coverage.

Lifetime Maximum Benefit: \$1,000,000

Copayment Maximum: \$5,000 per Member per Calendar Year and \$10,000 per Family per Calendar Year.

Covered Services and Limitations	Prior Auth. Required*	Copayment
Medical – Physician Services and Physician Consultations Office Visit/Consultation <ul style="list-style-type: none"> • Primary Care Physician • Specialist Inpatient Visit/Consultation <ul style="list-style-type: none"> • Primary Care Physician • Specialist 	No Yes Yes Yes	\$25 per visit \$50 per visit No charge per visit No charge per visit
Preventive Healthcare Services <i>Limited to 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 Agreement of Coverage for applicable age and frequency limitations.</i>	No	\$10 per visit
Laboratory Services <i>Copayment is in addition to the office visit Copayment and applies to services rendered in a Physician’s office or at an independent laboratory.</i>	Yes	\$15 per visit
Routine Radiological and Non-Radiological Diagnostic Imaging Services <i>Copayment is in addition to the office visit Copayment and applies to services rendered in a Physician’s office or at an independent radiological facility.</i>	Yes	\$15 per visit

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Covered Services and Limitations	Prior Auth. Required*	Copayment
<p>Emergency Services Within the Service Area</p> <p>Urgent Care Facility</p> <ul style="list-style-type: none"> • Southwest Medical Associates (SMA) Plan Provider • Other Plan Provider • Non-Plan Provider <p>Physician's Services in Emergency Room</p> <ul style="list-style-type: none"> • Plan Provider • Non-Plan Provider <p>Emergency Room Facility</p> <ul style="list-style-type: none"> • Plan Provider • Non-Plan Provider <p>Hospital Admission – Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i></p> <p>Lab and X-Ray</p> <ul style="list-style-type: none"> • Plan Provider • Non-Plan Provider <p><i>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.</i></p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p>	<p>\$45 per visit</p> <p>\$50 per visit \$60 per visit</p> <p>\$25 per visit \$75 per visit</p> <p>\$75 per visit; waived if admitted. \$150 per visit; not waived if admitted.</p> <p>\$300 per day not to exceed \$900 per admission.</p> <p>\$15 per visit \$30 per visit</p>
<p>Emergency Services Outside the Service Area</p> <p>Urgent Care Facility</p> <p>Physician's Services in Emergency Room</p> <p>Emergency Room</p> <p>Hospital Admission – Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i></p> <p>Lab and X-Ray</p> <p><i>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.</i></p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p>	<p>\$60 per visit</p> <p>\$75 per visit</p> <p>\$150 per visit; not waived if admitted.</p> <p>\$300 per day not to exceed \$900 per admission.</p> <p>\$30 per visit</p>

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Copayment
<p>Ambulance Services</p> <p>Emergency – Ground Transport</p> <p>Emergency – Air Transport</p> <p>HPN Arranged Transfers</p>	<p>No</p> <p>No</p> <p>Yes</p>	<p>\$150 per trip</p> <p>50% of EME per trip</p> <p>No charge per trip</p>
<p>Inpatient Hospital Facility Services <i>Elective and emergency post-stabilization admissions.</i></p>	Yes	\$300 per day not to exceed \$900 per admission.
<p>Outpatient Hospital Facility and Ambulatory Surgical Facility Services, includes Sterilization</p>	Yes	\$200 per admission
<p>Inpatient and Outpatient Physician Surgical Services</p> <p>Inpatient Hospital Facility</p> <p>Outpatient Hospital Facility</p> <p>Physician's Office</p> <ul style="list-style-type: none"> • Primary Care Physician (<i>in addition to office visit Copayment</i>) • Specialist (<i>in addition to office visit Copayment</i>) • Sterilizations performed in Physician's office (<i>in addition to office visit Copayment</i>) 	<p>Yes</p> <p>Yes</p> <p>No</p> <p>Yes</p> <p>Yes</p>	<p>\$200 per operative session</p> <p>\$200 per operative session</p> <p>\$25 per visit</p> <p>\$50 per visit</p> <p>\$25 per operative session</p>
<p>Assistant Surgical Services</p>	Yes	\$50 per operative session
<p>Anesthesia Services</p>	Yes	\$100 per operative session
<p>Gastric Restrictive Surgical Services</p> <p>Physician Surgical Services</p> <p><i>The maximum lifetime benefit for all Gastric Restrictive Surgical Services is \$5,000 per Member.</i></p> <p>Complications</p> <p><i>The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgical Services is \$5,000 per Member.</i></p>	<p>Yes</p> <p>Yes</p>	<p>50% of EME. Subject to maximum benefit.</p> <p>50% of EME. Subject to maximum benefit.</p>

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Covered Services and Limitations	Prior Auth. Required*	Copayment
<p>Mastectomy Reconstructive Surgical Services</p> <p>Physician Surgical Services</p> <p>Prosthetic Device for Mastectomy Reconstruction <i>Unlimited.</i></p>	<p>Yes</p> <p>Yes</p>	<p>\$200 per operative session</p> <p>\$750 per device</p>
<p>Oral Surgical Services</p> <p>Office Visit</p> <p>Physician Surgical Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Hospital Facility 	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$50 per visit</p> <p>\$200 per operative session</p> <p>\$200 per operative session</p>
<p>Organ and Tissue Transplant Surgical Services</p> <p>Inpatient Hospital Facility Services</p> <p>Physician Surgical Services – Inpatient Hospital Facility</p> <p>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></p> <p>Procurement <i>The maximum benefit per Member per Transplant Benefit Period for Procurement of the organ/tissue is \$15,000 of EME.</i></p> <p>Retransplantation Services <i>The 50% of EME for Retransplantation Services does not apply towards the Calendar Year Copayment maximum.</i></p> <p><i>The maximum lifetime benefit that will be paid for a Member for all Covered Transplant Procedures combined is \$100,000.</i></p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$300 per day not to exceed \$900 per admission. Subject to maximum benefit.</p> <p>\$200 per operative session. Subject to maximum benefit.</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>

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Copayment
<p>Home Healthcare Services <i>Refer to your outpatient Prescription Drug Benefit Rider, if applicable, for your outpatient self-injectable covered drug benefit.</i></p> <p>Physician House Calls</p> <p>Home Care Services</p> <p>Private Duty Nurse</p> <p><i>Limited to thirty (30) visits per Member per Calendar Year.</i></p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$50 per visit</p> <p>\$50 per visit</p> <p>\$25 per visit</p>
<p>Hospice Care Services</p> <p>Inpatient Hospice Services <i>Limited to thirty (30) days of care per Member per Calendar Year.</i></p> <p>Outpatient Hospice Services</p> <p>Inpatient Respite Services <i>Limited to \$1,500 per Member per Calendar Year.</i></p> <p>Outpatient Respite Services <i>Limited to \$1,000 per Member per Calendar Year.</i></p> <p>Bereavement Services <i>Limited to five (5) group therapy sessions or a maximum of \$500, whichever is less. Treatment must be completed within six (6) months.</i></p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$300 per admission. Subject to maximum benefit.</p> <p>No charge</p> <p>\$300 per admission. Subject to maximum benefit.</p> <p>\$25 per visit. Subject to maximum benefit.</p> <p>\$25 per visit. Subject to maximum benefit.</p>
<p>Skilled Nursing Facility <i>Limited to thirty (30) days per Member per Calendar Year.</i></p>	<p>Yes</p>	<p>\$300 per admission. Subject to maximum benefit.</p>
<p>Manual Manipulation (except for reduction of fractures or dislocation)</p>	<p>Yes</p>	<p>\$50 per visit</p>
<p>Short-Term Rehabilitation Services</p> <p>Inpatient Hospital Facility</p> <p>Outpatient Hospital Facility</p> <p><i>All Inpatient and outpatient Short-Term Rehabilitation Services are subject to a combined maximum benefit of thirty (30) days per Member per Calendar Year.</i></p>	<p>Yes</p> <p>Yes</p>	<p>\$300 per day not to exceed \$900 per admission. Subject to maximum benefit.</p> <p>\$25 per visit. Subject to maximum benefit.</p>

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Covered Services and Limitations	Prior Auth. Required*	Copayment
<p>Self-Management and Treatment of Diabetes</p> <p>Education and Training</p> <p>Supplies (except for Insulin Pump Supplies)</p> <ul style="list-style-type: none"> • Insulin Pump Supplies <p>Equipment (except for Insulin Pumps)</p> <ul style="list-style-type: none"> • Insulin Pumps 	<p>No</p> <p>No</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$25 per visit</p> <p>\$5 per therapeutic supply \$25 per therapeutic supply</p> <p>\$20 per device \$100 per device</p>
<p>Special Food Products and Enteral Formulas <i>Special food products are limited to a maximum benefit of \$2,500 per Member per Calendar Year.</i></p>	<p>Yes</p>	<p>No charge. See maximum benefit.</p>
<p>Temporomandibular Joint Treatment <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>Mental Health Services</p> <p>Inpatient Hospital Facility <i>Limited to thirty (30) days per Member per Calendar Year.</i></p> <p>Outpatient Treatment</p> <ul style="list-style-type: none"> • Group Therapy <i>Limited to twenty (20) visits per Member per Calendar Year.</i> • Individual, Family and Partial Care Therapy** <i>Limited to twenty (20) visits per Member per Calendar Year.</i> <p><i>Benefit maximum does not apply to visits for medication management.</i></p> <p><i>** Partial care 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>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$300 per day not to exceed \$900 per admission. Subject to maximum benefit.</p> <p>\$25 per visit. Subject to maximum benefit.</p> <p>\$25 per visit. Subject to maximum benefit.</p>
<p>Severe Mental Illness Services</p> <p>Inpatient Hospital Facility <i>Limited to forty (40) days per Member per Calendar Year.</i></p>	<p>Yes</p>	<p>\$300 per day not to exceed \$900 per admission. Subject to maximum benefit.</p>

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Covered Services and Limitations	Prior Auth. Required*	Copayment
<p>Severe Mental Illness Services (continued)</p> <p>Outpatient Treatment <i>All outpatient therapy is limited to forty (40) visits per Member per Calendar Year.</i></p> <p><i>Two (2) visits for partial or respite care, or a combination thereof, may be substituted for each (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>	<p>Yes</p>	<p>\$25 per visit. Subject to maximum benefit.</p>
<p>Substance Abuse Services</p> <p>Inpatient Rehabilitation <i>Limited to a maximum benefit of \$9,000 per Member per Calendar Year.</i></p> <p>Outpatient Rehabilitation*</p> <ul style="list-style-type: none"> • Group Therapy • Individual, Family and Partial Care Therapy** <p><i>*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.</i></p> <p>Inpatient Detoxification (<i>treatment for withdrawal</i>)</p> <p>Outpatient Detoxification <i>Limited to a maximum benefit of \$1,500 per Member per Calendar Year.</i></p> <p><i>**Partial care 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>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$300 per day not to exceed \$900 per admission. Subject to maximum benefit.</p> <p>\$25 per visit. Subject to maximum benefit.</p> <p>\$25 per visit. Subject to maximum benefit.</p> <p>\$300 per day not to exceed \$900 per admission.</p> <p>\$25 per visit. Subject to maximum benefit.</p>

Please note in addition to specified surgical Copayment amounts, Member is also responsible for all other applicable facility and professional Copayments as outlined in the Attachment A Benefit Schedule.

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

Benefit Schedule

The Calendar Year Copayment Maximum for basic health services is 200% of the total annual premium rate the Member would pay if he were enrolled under an HPN Plan with no Copayments. Contact HPN's Member Services Department at (702) 242-7300 or 1-800-777-1840 for the appropriate Calendar Year out-of-pocket maximum applicable to the Plan.

***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 Agreement of Coverage for additional information.**



HEALTH PLAN OF NEVADA, INC.SM
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***Disclosure Summary for Individual
Distinct Advantage – HMO Option 2 and Option 4***

This Plan does not include maternity coverage.

This Disclosure Summary outlines certain provisions of the Health Plan of Nevada, Inc. ("HPN") Agreement of Coverage ("AOC"). **Please read your AOC in its entirety for governing contractual provisions and refer to your Attachment A, Benefit Schedule for additional information on benefits.**

Carefully read the information contained in this Disclosure Summary to understand:

- 1) How some expenses are considered;
- 2) The meaning of certain words; and
- 3) Some specific requirements which will maximize your benefits.

To understand exactly what coverage you have and what your responsibilities are, please read your HPN AOC, applicable Riders and Attachments.

Important Information

All Covered Services not provided by the Member's Primary Care Physician ("PCP") require Prior Authorization from the PCP and HPN's Managed Care Program. Covered Services which require Prior Authorization and review through HPN's Managed Care Program include, but are not limited to:

- (a) Non-emergency Inpatient admissions and extensions of stay beyond the original certified length of stay in a Hospital, Skilled Nursing Facility or Hospice.
- (b) All Outpatient surgery provided in any setting, including technical and professional services.
- (c) Diagnostic and Therapeutic Services.
- (d) Home Health Care Services.
- (e) All Specialist visits or Consultations.
- (f) Prosthetic or Orthotic Devices.
- (g) Courses of treatment, including but not limited to allergy testing or treatment (e.g., skin, RAST); anti-cancer drug therapy; dialysis; angioplasty; physiotherapy; and rehabilitation therapy (physical, speech, occupational).

- (h) Mental Health, Severe Mental Illness, and Substance Abuse Services.

Failure to comply with this Prior Authorization requirement will result in the Member being responsible for the costs incurred for these medical services. Please read the HPN AOC and Attachment A, Benefit Schedule to determine what Covered Services require Prior Authorization.

Emergency Services: Benefits and Copayments for Emergency Services received from Plan and Non-Plan Providers are subject to varying Copayment amounts and limitations shown in the Attachment A Benefit Schedule and as set forth in the HPN AOC.

The Plan Provider level of benefits will apply to Emergency Services provided at any duly licensed Plan facility. When a Member is admitted to a Non-Plan Provider Hospital, upon stabilization of the emergency condition and establishment that Member is safe for transfer as determined by the attending Physician, the Plan may require transfer to a contracted Plan facility in order to pay benefits at the Plan level as specifically set forth in the Attachment A Benefit Schedule.

Exclusions and Limitations

This section tells you what services are excluded from coverage under this Agreement.

- Services or supplies for which coverage is not specifically provided, complications resulting from non-Covered Services, or services which are not Medically Necessary, whether or not recommended or provided by a Provider.
- Services not provided, arranged, and/or Prior Authorized by a Member's Primary Care Physician and the Managed Care Program, except for ; 1) Emergency Services; or 2) Urgently Needed Services received outside the Service Area.
- Personal comfort, hygiene, or convenience items such as a Hospital television, telephone,

or private room when not Medically Necessary. Housekeeping or meal services as part of Home Health Care. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.

- Services for a private room in excess of the average semi-private room and board rate.
- Dental or orthodontic splints or dental prostheses, or any treatment on or to teeth, gums, or jaws and other services customarily provided by a dentist. Charges for dental services in connection with temporomandibular joint dysfunction are also not covered unless they are determined to be Medically Necessary. Such dental-related services are subject to the limitations shown in the Benefit Schedule.
- Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function.
- Third-party physical exams for employment, licensing, insurance, school, camp, sports, or adoption purposes. Immunizations related to foreign travel. Expenses for medical reports, including presentation and preparation. Exams or treatment ordered by a court, or in connection with legal proceedings if not Medically Necessary or a Covered Service.
- The following infertility services and supplies are excluded, in addition to any other infertility services or supplies determined by HPN not to be Medically Necessary or not Prior Authorized by the Managed Care Program;
 1. Advanced reproductive techniques such as embryo transplants, in vitro fertilization, GIFT and ZIFT procedures, assisted hatching, intracytoplasmic sperm injection, egg retrieval via laparoscope or needle aspiration, sperm preparation, specialized sperm retrieval techniques, sperm washing except prior to artificial insemination if required;
 2. Home pregnancy or ovulation tests;
 3. Sonohysterography;
 4. Monitoring of ovarian response to stimulants;
 5. CT or MRI of sella turcica unless elevated prolactin level;
 6. Evaluation for sterilization reversal;
 7. Laparoscopy;
 8. Ovarian wedge resection;
 9. Removal of fibroids, uterine septae and polyps;
 10. Open or laparoscopic resection, fulguration, or removal of endometrial implants;
 11. Surgical lysis of adhesions;
 12. Surgical tube reconstruction.
- Services for the treatment of sexual dysfunction or inadequacies, including, but not

limited to, impotence and implantation of a penile prosthesis. Reversal of surgically performed sterilization or subsequent reesterilization.

- Elective abortions.
- Except as provided in the Covered Services Gastric Restrictive Surgery section, weight reduction procedures are excluded. Also excluded are any weight loss programs, whether or not recommended, provided or prescribed by a Physician or other medical Practitioner.
- Treatment of marital or family problems; occupational, religious, or other social maladjustments; chronic behavior disorders, codependency; impulse control disorders; organic disorders, learning disabilities or mental retardation or any Severe Mental Illness as defined in the AOC and otherwise covered under the Severe Mental Illness Covered Services section. For purposes of this exclusion, "chronic" means any condition existing for more than six (6) months.
- Institutional care which is determined to be for the primary purpose of controlling Member's environmental and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures.
- Vision exams to determine refractive errors of vision and eyeglasses or contacts. Coverage is provided for vision exams only when required to diagnose an Illness or Injury.
- Hearing exams to determine the need for or the appropriate type of hearing aid or similar. Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.
- Ecological or environmental medicine. Use of chelation, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for treatment; electrodiagnosis; Hahnemannian dilution and succession; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile, gerovital.
- Services for chronic, intractable pain by a pain control center or under a pain control program.
- Acupuncture or hypnosis.
- Treatment of an Illness or Injury caused by or arising out of a riot, declared or undeclared war or act of war, insurrection; rebellion; armed invasion or aggression.
- Treatment of an occupational Injury or Illness which is any Injury or Illness arising out of or in the course of employment for pay or profit.
- Travel and accommodations, whether or not recommended by prescribed by a Provider.
- Vitamins, herbal medicines, appetite suppressants, and other over-the-counter drugs. Drugs and medicines approved by the FDA for experimental or investigational use.
- Any services provided before the Effective Date or after the termination of coverage.
- Care for conditions that federal, state or local

law requires to be treated in a public facility for which a charge is not normally made.

- Any equipment or supplies that condition the air, arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace, heating pads, hot water bottles, wigs and their care and other primarily non-medical equipment.
- Special formulas, food supplements other than as specifically covered or special diets on an outpatient basis. (Except for the treatment of inherited metabolic disease)
- Services, supplies or accommodations provided without cost to the Member or which the Member is not legally required to pay.
- Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolffing, residential treatment, vocational rehabilitation and wilderness programs.
- Experimental or investigational treatment or devices.
- Sports medicine treatment plans intended to primarily improve athletic ability.
- Radial keratotomy or any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses.
- Any services given by a Provider to himself or to members of his family.
- Ambulance services when a Member could be safely transported by other means. Air ambulance services when a Member could be safely transported by ground Ambulance or other means.
- Late discharge billing and charges resulting from a canceled appointment or procedure.
- If you are eligible for Medicare, any services covered by Medicare under Parts A and B are excluded to the extent actually paid for by Medicare.
- HPN will not be liable for any delay or failure to provide or arrange for Covered Services if the delay or failure is caused by:
 - Natural disaster.
 - War.
 - Riot.
 - Civil insurrection.
 - Epidemic.
 - Or any other emergency beyond HPN's control.
- In the event of one of these types of emergencies, HPN and its Plan Providers will provide the Covered Services shown in the AOC to the extent practical according to their best judgment.
- Any services or supplies provided in connection with pregnancy or childbirth except when provided in connection with Complications of Pregnancy.
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- Autologous blood donations.
- During the first twelve (12) consecutive

months of coverage under the Agreement, no benefits will be payable for a Preexisting Condition or any complications thereof, with exception to Complications of Pregnancy.

- Durable Medical Equipment including administration, maintenance and operating costs of such equipment, if the equipment is not Medically Necessary or Prior Authorized. Durable Medical Equipment includes but is not limited to; outpatient oxygen, wheelchairs, crutches, walkers, hospital beds and traction equipment.
- Any services or supplies rendered in connection with Member acting as or utilizing the services of a surrogate mother.
- An attempt to commit or committing a felony by the Member.
- Covered Services received in connection with a clinical trial or study which includes the following:
 1. Drugs and medicines approved by the FDA for experimental or investigational use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan.
 2. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;
 3. Healthcare services that are specifically excluded from coverage under this Plan regardless of whether such services are provided under the clinical trial or study;
 4. Healthcare services that are customarily provided by the sponsors of the clinical trial or study free of charge to the Member in the clinical trial or study;
 5. Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing and other expenses that a Member may incur;
 6. Any expenses incurred by a person who accompanies the Member during the clinical trial or study;
 7. Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the Member; and
 8. Any cost for the management of research relating to the clinical trial or study.

Please read your HPN AOC and Attachment A, Benefit Schedule for governing provisions, limitations and exclusions.

Premiums

HPN reserves the right to establish a revised schedule of premium payments provided it gives the Subscriber sixty (60) days prior written notice.

The following factors may be considered in the premium rate determination: the age and gender of each individual, family composition, the geographical area, industry of the employer and employer contribution to the cost of coverage. The selection of variable Copayments will also affect the respective rates. Upon renewal, HPN will consider changes in case characteristics, including each individual's attained age, change in base premium rates and an adjustment factor for claims experience, health status and duration of coverage.

Renewability

Coverage under the Agreement is guaranteed renewable at the option of the Subscriber, except for the following reasons for which coverage may be terminated:

- 1) Nonpayment of required premiums;
- 2) Misrepresentation by the Subscriber of any information regarding the Subscriber or Dependent covered under the Plan or other information regarding eligibility for coverage under the Plan;
- 3) Failure to comply with any underwriting requirements; or
- 4) If HPN discontinues transacting healthcare in the geographic area of the state where the Subscriber lives or works, provided HPN notifies the commissioner and all affected Subscribers at least 180 days in advance.

Glossary

"Eligible Medical Expenses" or "EME" means charges up to the HPN Reimbursement Schedule amount, incurred by a Member while he/she is covered under the AOC for Covered Services. Plan Providers have agreed to accept HPN's Reimbursement Schedule amount as payment in full for Covered Services, plus the Member's payment of any applicable Copayment. Non-Plan Providers have not. Members who use the services of Non-Plan Providers will receive no benefit payments or reimbursement for charges for the service, except in the case of Emergency Services, Urgently Needed Services, as defined in the AOC, or other Covered Services provided by a Non-Plan Provider that are Prior Authorized by HPN's Managed Care Program. In no event will HPN pay more than the applicable HPN Reimbursement Schedule amount for such services.

"Emergency Services" means Covered Services provided after the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious:

- jeopardy to his health;
- jeopardy to the health of an unborn child;
- impairment of a bodily function; or
- dysfunction of any bodily organ or part.

See definition of Urgently Needed Services.

"HPN Reimbursement Schedule" means the schedule showing the amount HPN will pay for Eligible Medical Expenses. It is based on:

- the amount usually paid to the Provider; or
- the amount paid to other Providers with the same or similar qualifications; or
- the relative value and worth of the service compared to other services which HPN determines to be similar in complexity and nature with reference to other industry and governmental sources.

"Medically Necessary" means a service or supply needed to improve a specific health condition or to preserve the Member's health and which, as determined by HPN is:

- consistent with the diagnosis and treatment of the Member's Illness or Injury;
- the most appropriate level of service which can be safely provided to the Member; and
- not solely for the convenience of the Member, the Provider(s) or Hospital.

In determining whether a service or supply is Medically Necessary, HPN may give consideration to any or all of the following:

- the likelihood of a certain service or supply producing a significant positive outcome;
- reports in peer-review literature;
- evidence based reports and guidelines published by nationally recognized professional organizations that include supporting scientific data;
- professional standards of safety and effectiveness that are generally recognized in the United States for diagnosis, care or treatment;
- the opinions of independent expert Physicians in the health specialty involved when such opinions are based on broad professional consensus; or
- other relevant information obtained by HPN.

When applied to Inpatient services, "Medically Necessary" further means that the Member's condition requires treatment in a Hospital rather than in any other setting. **Services and**

accommodations will not automatically be considered Medically Necessary simply because they were prescribed by a Physician.

“Managed Care Program” means the process that determines medical necessity and directs care to the most appropriate setting to provide quality care in a cost-effective manner, including Prior Authorization of certain services.

“Preexisting Condition” means any illness, injury or any related condition to an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of coverage under this Agreement. This term does not include genetic information in the absence of a diagnosis of the condition related to such information nor does it include Complications of Pregnancy, newborns, newly adopted children and coverage for enteral formulas and special food products.

“Primary Care Physician” or **“PCP”** means a Plan Provider who has an independent contractor agreement with HPN to assume responsibility for arranging and coordinating the delivery of Covered Services to Members. A Primary Care Physician’s agreement with HPN may terminate. In the event that a Member’s Primary Care Physician’s agreement terminates, the Member will be required to select another Primary Care Physician.

“Prior Authorization” means a system that requires a Provider to get approval from HPN before providing non-emergency healthcare services to a Member for those services to be considered Covered Services.

“Service Area” means the geographical area where HPN is licensed to operate. It is shown in Attachment B. Subscribers must live or work in the Service Area to be covered under this Plan. Dependent children that are covered under this Plan, due to a court order, do not have to reside within the Service Area.

“Urgently Needed Services” means Covered Services needed to prevent a serious deterioration in a Member’s health. While not as immediate as Emergency Services, these services cannot be delayed until the Member can see a Plan Provider.

If you have any questions about your benefits or provider information, call the Member Services Department at (702) 242-7300 or 1-800-777-1840.