SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

SHL Solutions PPO 30/2000/20%

Attachment A Benefit Schedule

Lifetime Maximum Benefit for all Covered Services: Unlimited.

Calendar Year Deductible (CYD): Your CYD is $2,000 of EME per Insured and $4,000 of EME per Family for Plan Provider Services and $4,000 of EME per Insured and $8,000 of EME per Family for Non-Plan Provider Services. An Insured may not contribute any more than the Individual CYD amount toward the Family CYD amount. Further, the stated CYD maximum amounts are separate for each tier of benefits and do not accumulate to one another.

Coinsurance: After satisfying your CYD, your Coinsurance for most Plan Provider services is 20% of EME. Your Coinsurance for most Non-Plan Provider services is 50% of EME. Please reference the following pages for specific Coinsurance responsibilities.

Calendar Year Out of Pocket Maximum: Your Calendar Year Out of Pocket expenses are limited to a maximum of $6,000 of EME per Insured per Calendar Year and $12,000 of EME per Family when using Plan Providers and $12,000 of EME per Insured per Calendar Year and $24,000 of EME per Family when using Non-Plan Providers. The Calendar Year Out of Pocket Maximum amounts include the CYD, Copayments and Coinsurance.

The Calendar Year Out Of Pocket Maximum does not include; 1) amounts charged for non-Covered Services, 2) amounts exceeding applicable Plan benefit maximums or EME payments to Tier II Non-Plan Providers; or, 3) any penalties for not complying with SHL's Managed Care Program.

Once the Individual Out of Pocket Maximum is met, benefits for that Individual are payable at 100% of EME for the remainder of the Calendar Year. Once the Family Out of Pocket Maximum is met by two or more enrolled family members, benefits for the entire family are payable at 100% of EME for the remainder of the Calendar Year. Further, the stated Out of Pocket Maximum amounts are separate for each tier of benefits and do not accumulate to one another.

Please read your Certificate of Coverage (COC) to understand how EME payments to Providers are determined. Plan Providers have agreed to accept SHL's Reimbursement Schedule as payment in full for Covered Services, less any applicable Deductibles, Coinsurance and/or Copayments that are payable by you.

Important Note: When receiving Covered Services from Non-Plan Providers, you are responsible for all amounts exceeding the applicable benefit maximums, EME payments to Tier II Non-Plan Providers and any penalties for not complying with SHL's Managed Care Program. Further, such amounts do not accumulate to the Calendar Year Out of Pocket Maximum.

Please refer to Attachment B to the SHL Certificate, List of Services Requiring Prior Authorization, for the list of services and supplies requiring Prior Authorization.

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Medical Office Visits/Consultations and Visits in an Outpatient Setting		
Non-Specialist Services		
• Convenient Care Facility	Insured pays $20 per visit.	After CYD, Insured pays 50% of EME.
• Physician Extender or Assistant	Insured pays $20 per visit.	After CYD, Insured pays 50% of EME.
• Physician	Insured pays $30 per visit.	After CYD, Insured pays 50% of EME.
Specialist Services	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
Preventive Healthcare Services - For a complete list of Preventive Services, including all FDA approved contraceptives, go to http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/. If you question about whether or not a service is "Preventive", please contact the SHL Member Services Department (1-800-888-2264).	Insured pays $0 per visit.	After CYD, Insured pays 50% of EME.
Non-preventive Routine Lab and X-ray Services The Copayment/Cost-share is in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office or at an independent facility.		
• Lab	Insured pays $20 per visit	After CYD, Insured pays 50% of EME.
• X-Ray	Insured pays $40 per visit.	After CYD, Insured pays 50% of EME.
Virtual Visits (Available through select contracted Providers)	Insured pays $0 per visit.	After CYD, Insured pays 50% of EME.
Urgent Care Facility	Insured pays $30 per visit.	After CYD, Insured pays 50% of EME.
Emergency Services		
• Emergency Room Facility (includes Physician Services)	Insured pays $250 per visit plus 20% of EME; waived if admitted through a Hospital Emergency Room Facility.	Insured pays $250 per visit plus 20% of EME; waived if admitted through a Hospital Emergency Room Facility.
• Hospital Admission - Emergency Stabilization (includes Physician Services) Applies until patient is stabilized and safe for transfer as determined by the attending Physician.	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 20% of EME.
The maximum benefit for Medically Necessary but Non-Emergency Services received in an Emergency Room is 50% of EME. You are responsible for all amounts exceeding any applicable maximum benefit and amounts exceeding the Plan's EME payment to Non-Plan Providers. Such amounts do not accumulate to the Calendar Year Out of Pocket Maximum.		

**Refer to the Limitations Section of the COC for information regarding EME and benefit maximums.*

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Ambulance Services		
• Emergency Transport	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Non-Emergency - SHL Arranged Transfers	Insured pays $0.	Insured pays 0% of EME.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
Outpatient Hospital Facility Services	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
Ambulatory Surgical Facility Services	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
Anesthesia Services	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
Physician Surgical Services - Inpatient and Outpatient		
• Inpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Outpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Ambulatory Surgical Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Physician's Office		
Non-Specialist Physician (Includes all physician services related to the surgical procedure)	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
Specialist (Includes all physician services related to the surgical procedure)	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
Gastric Restrictive Surgery Services SHL provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Insured.		
• Physician Surgical Services	After CYD, Insured pays 50% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
• Physician's Office Visit	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.

**Refer to the Limitations Section of the COC for information regarding EME and benefit maximums.*

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Physician Surgical Services - Inpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Transportation, Lodging and Meals The maximum benefit per Insured per Transplant Benefit Period for transportation, lodging and meals is $10,000. The maximum daily limit for lodging and meals is $200.	Insured pays $0 per surgery. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
• Procurement The maximum benefit per Insured per Transplant Benefit Period for Procurement of the organ/tissue is $15,000 of EME.	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
Post-Cataract Surgical Services		
• Frames and Lenses	Insured pays $10 per pair of glasses. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
• Contact Lenses Benefit limited to one (1) pair of Medically Necessary glasses or set of contact lenses as applicable per Insured per surgery for Plan and Non-Plan Provider Services combined.	Insured pays $10 per set of contact lenses. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
Home Healthcare Services (does not include Specialty Prescription Drugs) The Tier II Non-Plan Provider maximum benefit for Home Healthcare Services is limited to thirty (30) visits per Insured per Calendar Year. A period of four (4) hours or less of Home Healthcare services equals one visit.	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.

**Refer to the Limitations Section of the COC for information regarding EME and benefit maximums.*

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Hospice Care Services		
• Inpatient Hospice Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Outpatient Hospice Services	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Inpatient and Outpatient Respite Services Limited to a combined Plan and Non-Plan Provider maximum benefit of five (5) Inpatient days or five (5) Outpatient visits per Insured per ninety (90) days of Home Hospice Care.		
◦ Inpatient	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
◦ Outpatient	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
• Bereavement Services Limited to a combined Plan and Non-Plan Provider maximum benefit of five (5) group therapy sessions. Treatment must be completed within six (6) months of the date of death of the Hospice patient.	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
Skilled Nursing Facility Limited to a combined Plan and Non-Plan Provider maximum benefit of one hundred (100) days per Insured per Calendar Year.	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
Residential Treatment Center Limited to a combined Plan and Non-Plan Provider maximum benefit of one hundred (100) days per Insured per Calendar Year.	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
Manual Manipulation Applies to Medical-Physician Services and Chiropractic office visit. Limited to a combined Plan and Non-Plan Provider maximum benefit of twenty (20) visits per Insured per Calendar Year.	Insured pays $45 per visit. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.

**Refer to the Limitations Section of the COC for information regarding EME and benefit maximums.*

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Short-Term Habilitation Services (including but not limited to Physical, Speech and Occupational Therapy)		
• Inpatient Hospital Facility	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
• Outpatient	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
All Inpatient and Outpatient Short-Term Habilitation Services are subject to a to a combined Plan and Non-Plan Provider maximum benefit of sixty (60) days/visits per Insured per Calendar Year.		
Short-Term Rehabilitation Services (including but not limited to Physical, Speech and Occupational Therapy)		
• Inpatient Hospital Facility	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
• Outpatient	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a to a combined Plan and Non-Plan Provider maximum benefit of sixty (60) days/visits per Insured per Calendar Year.		
Durable Medical Equipment Monthly rental or purchase at SHL's option. Purchases are limited to a single purchase of a type of DME, including repair and replacement, once every three (3) years.	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
Genetic Disease Testing Services		
• Office Visit	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Lab Includes Inpatient, Outpatient and independent Laboratory Services.	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
Infertility Office Visit Evaluation Please refer to applicable surgical procedure Copayment/Cost-share and/or Coinsurance amount herein for any surgical infertility procedures performed.	Insured pays $30 per visit.	After CYD, Insured pays 50% of EME.
Medical Supplies (Obtained outside of a medical office visit)	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.

**Refer to the Limitations Section of the COC for information regarding EME and benefit maximums.*

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Other Diagnostic and Therapeutic Services The Copayment/Cost-share amounts are in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office or at an independent facility.		
• Anti-cancer drug therapy, non-cancer related drug therapy or other Medically Necessary therapeutic drug services.	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Dialysis	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Therapeutic Radiology	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Complex Allergy Diagnostic Services (including RAST) and Serum Injections	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Otologic Evaluations	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Other complex diagnostic imaging services including: CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; and complex neurological or psychiatric testing or therapeutic services.	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Positron Emission Tomography (PET) scans	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
Prosthetic Devices Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
Orthotic Devices Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.

**Refer to the Limitations Section of the COC for information regarding EME and benefit maximums.*

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Self-Management and Treatment of Diabetes		
• Education and Training	Insured pays $30 per visit.	After CYD, Insured pays 50% of EME.
• Supplies (except for Insulin Pump Supplies)	Insured pays $5 per therapeutic supply.	After CYD, Insured pays 50% of EME.
Insulin Pump Supplies	Insured pays $10 per therapeutic supply.	After CYD, Insured pays 50% of EME.
• Equipment (except for Insulin Pump)	Insured pays $20 per device.	After CYD, Insured pays 50% of EME.
Insulin Pump	Insured pays $100 per device.	After CYD, Insured pays 50% of EME.
Special Food Products and Enteral Formulas Special Food Products only are limited to a combined Plan and Non-Plan Provider maximum benefit of a one (1) thirty (30) day therapeutic supply per Insured four (4) times per Calendar Year.	Insured pays $0. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
Temporomandibular Joint Treatment	After CYD, Insured pays 50% of EME.	After CYD, Insured pays 50% of EME.
Mental Health and Severe Mental Illness Services		
• Inpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Outpatient Treatment	Insured pays $30 per visit.	After CYD, Insured pays 50% of EME.
Substance-Related and Addictive Disorder Services		
• Inpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 50% of EME.
• Outpatient Treatment	Insured pays $30 per visit.	After CYD, Insured pays 50% of EME.
Hearing Aids Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.
Applied Behavioral Analysis (ABA) for the treatment of Autism for Insureds up to age 22 Limited to a combined Plan and Non-Plan Provider maximum benefit of one thousand five hundred (1,500) total hours of therapy per Insured per Calendar Year.	Insured pays $30 per visit. Subject to maximum benefit.	After CYD, Insured pays 50% of EME. Subject to maximum benefit.

**Refer to the Limitations Section of the COC for information regarding EME and benefit maximums.*

Please read the SHL Certificate of Coverage to determine the governing contractual provisions, exclusions and limitations.

Please note: For Inpatient and Outpatient admissions, in addition to specified surgical Copayments and/or Coinsurance amounts, Insured is also responsible for all other applicable facility and professional Copayments and/or Coinsurance amounts as outlined in the Attachment A Benefit Schedule.

The Insured is responsible for any/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 Out of Pocket Maximum.

(1) If Medically Necessary Covered Services, with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness, Substance-Related and Addictive Disorder Services, are provided without obtaining the required Prior Authorization, benefits are reduced to 50% of what the Insured would have received if Prior Authorization had been obtained.