SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

SHL Vision PPO – SB 14
Adult Only Coverage

Attachment A Benefit Schedule
12/12/12 $0/$130

Covered Services and Limitations	Plan Provider	Non-Plan Provider
Vision Examination One (1) vision examination by a Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be provided each twelve (12) consecutive calendar month period.	$0 copay for each exam by a Plan Provider. Subject to limitation.	$30 maximum allowance per exam. Subject to limitation.
Lenses (Plastic) One (1) pair of Lenses will be provided during any \twelve (12) consecutive calendar month period, when a prescription change is determined Medically Necessary by a Provider. Lenses are limited to single vision, bifocal, trifocal, lenticular and other complex Lenses.	$0 copay for one pair of Lenses (Plastic). Subject to limitation.	$25 maximum allowance for single vision lenses, Subject to limitation. $40 maximum allowance for bifocal lenses, Subject to limitation. $63 maximum allowance for trifocal or lenticular lenses, Subject to limitation.
Frames Expenses incurred in connection with Frames, from an approved frame selection will be considered covered vision expenses once during each twelve (12) consecutive calendar month period. Charges for Frames in excess of the maximum allowance shall be the responsibility of the Subscriber. Discounts may be available through the Provider for those charges in excess of the maximum allowance.	$130 maximum allowance. Subject to limitation.	$65 maximum allowance. Subject to limitation.
Contact Lenses Expenses incurred in connection with the purchase of one (1) pair of Contact Lenses prescribed by a Provider may be considered covered vision expense on the condition that the Subscriber elects to receive an allowance for the purchase of such Contact Lenses in lieu of all other vision benefit once during any twelve (12) consecutive month period (with the exception of the annual vision examination which shall continue to be available). Charges for Contact Lenses in excess of the maximum allowance shall be the responsibility of the Subscriber. Discounts may be available through the Provider for those charges in excess of the maximum allowance.	Insured pays 0% of EVE for medically necessary Contact Lenses. Subject to limitation. $130 maximum allowance for conventional or disposable Contact Lenses. Subject to limitation.	$210 maximum allowance for medically necessary Contact Lenses. Subject to limitation. $104 maximum allowance for conventional or disposable Contact Lenses. Subject to limitation.