Sierra Health and Life®
A UnitedHealthcare Company

SHL Solutions PPO Silver 45/5000/IP

HIOS ID: 83198NV0010062

Attachment A Benefit Schedule

Amounts which the Insured is required to pay as shown below in the Benefit Schedule are based on Eligible Medical Expenses (EME) or the Recognized Amount, if applicable, as defined in the SHL Certificate of Coverage (COC).

Calendar Year Deductible (CYD): Your CYD is $0 when using Plan Providers.Your CYD is $7,500 of EME per Insured for Non-Plan Providers. Your CYD is $15,000 of EME per family for Non-Plan Providers. 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, if any, your coinsurance for most Plan Provider services is 0% of EME. Your Coinsurance for most Non-Plan Provider services is 50% of EME. Please reference the following pages for specific Coinsurance responsibilities.

The Calendar Year Out of Pocket Maximum: Your Calendar Year Out of Pocket expenses are limited to a maximum of $8,700 of EME per Insured per Calendar Year and $17,400 of EME per Family when using Plan Providers and $15,000 of EME per Insured per Calendar Year and $30,000 of EME per Family when using Non-Plan Providers. The Calendar Year Out of Pocket Maximum amounts include the CYD, Copayments and Coinsurance. Further, the stated maximum amounts are separate for each tier of benefits and do not accumulate to one another.

The Out of Pocket Maximum does not include: 1) amounts charged for non-Covered Services, 2) amounts exceeding applicable Plan benefit maximums or EME payments; or, 3) penalties for not obtaining any required Prior Authorization, or for the Insured otherwise 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.

Please read your 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.

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.

IMPORTANT:

- **Amounts exceeding coverage amounts/limits:** 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.

- **Copayment/Cost-shares:** The Copayments/Cost-shares shown in the following Benefit Schedule apply as shown for Inpatient and Outpatient facilities and provider office visits. Additionally, the Insured is responsible for all other applicable facility and professional Copayments/Cost-share as outlined in this Attachment A Benefit Schedule.

- **Prior Authorization Required**: Please refer to Attachment B to the SHL Certificate of Coverage (COC), List of Services Requiring Prior Authorization, for the list of services and supplies requiring Prior Authorization. If Medically Necessary Covered Services, with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness, Substance Abuse 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.

Covered Services and Limitations	Plan Provider Benefit	Non-Plan Provider Benefit
Medical Office Visits, Primary Care, Consultation – Outpatient (Including Telemedicine Services)		
• Convenient Care	Insured pays $20 per visit.	After CYD, Insured pays 50% of EME.
• Physician Assistant or Extender	Insured pays $20 per visit.	After CYD, Insured pays 50% of EME.
• Physician	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
• Specialist	Insured pays $95 per visit.	After CYD, Insured pays 50% of EME.
Preventive Care Services For a complete list of Preventive Services, including all FDA approved contraceptives, go to https://www.healthcare.gov/coverage/preventive-care-benefits/. If you have a 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.
Diagnostic Breast Cancer Imaging	Insured pays $0 per visit.	After CYD, Insured pays 50% of EME.
Infertility Office Visit Evaluation Limited to 6 cycles of Artificial Insemination; per lifetime. Surgical cost-share applies to all surgical procedures.	Insured pays $95 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 $40 per visit.	After CYD, Insured pays 50% of EME.
• X-Ray	Insured pays $120 per visit.	After CYD, Insured pays 50% of EME.

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Plan Provider Benefit	Non-Plan Provider Benefit
Genetic Disease Testing Services		
• Office Visit	Insured pays $95 per visit.	After CYD, Insured pays 50% of EME.
• Lab *Includes inpatient, outpatient, and independent lab services.*	Insured pays $95 per visit.	After CYD, Insured pays 50% of EME.
Urgent Care NowClinic Virtual Visits (Available through NowClinic) Scheduled visits subject to applicable Office Visit Cost Share.	Insured pays $0 per visit.	After CYD, Insured pays 50% of EME.
Urgent Care Facility	Insured pays $50 per visit.	Insured pays 50% of EME.
Emergency Services		
• Emergency Room Facility (Includes Physician Services) Copay, if any, is waived if admitted.	Insured pays $1,500 per visit.	Insured pays $1,500 per visit.
• Hospital Admission - Emergency Stabilization (Includes Physician Services) *Applies until patient is stabilized and safe for transfers as determined by the attending Physician*.	Insured pays $5,000 per admission.	Insured pays $5,000 per admission.
The maximum benefit for Medically Necessary but Non-Emergency Services received in an Emergency Room is 50% of EME. The Insured is responsible for all amounts exceeding any applicable maximum benefit and amounts exceeding the Plan's EME payment to Non-Plan Providers. As a result, the Insured will be responsible for the difference between the amount billed by the Non-Plan Provider and the reimbursement amount determined by SHL, unless prohibited by law. Such amounts do not accumulate to the Calendar Year Out of Pocket Maximum.		
Ambulance Services		
• Emergency Transport (Ground/Air)	Insured pays $350 per trip.	After CYD, Insured pays 50% of EME.
• Non-Emergency (SHL Arranged Transfer)	Insured pays $0 per trip.	Insured pays 0% of EME.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions) Includes Inpatient Physician Fees/Medical Services and Inpatient Physician Surgical Services	Insured pays $5,000 per admission.	After CYD, Insured pays 50% of EME.

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Plan Provider Benefit	Non-Plan Provider Benefit
Gastric Restrictive Surgery Services Lifetime benefit maximum of one (1) Medically Necessary surgery per Covered Person.	Insured pays $5,000 per surgery.	After CYD, Insured pays 50% of EME.
• Physician's Office Visit	Insured pays $95 per visit.	After CYD, Insured pays 50% of EME.
Outpatient Facility and Physician Surgical Services		
Outpatient Facility Surgery - Hospital based (Per Surgery)	Insured pays $500 per visit.	After CYD, Insured pays 50% of EME.
• Outpatient Hospital Physician Surgical Services (Per Surgery)	Insured pays $500 per visit.	After CYD, Insured pays 50% of EME.
Ambulatory Surgical Facility Services (ASC) (Per Surgery)	Insured pays $500 per visit.	After CYD, Insured pays 50% of EME.
• ASC Physician Surgical Services (Per Surgery)	Insured pays $500 per visit.	After CYD, Insured pays 50% of EME.
Professional Office Surgical Services		
• Primary Care Physician Treatment and Surgical Services	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
• Specialist Treatment and Surgical Services	Insured pays $95 per visit.	After CYD, Insured pays 50% of EME.
Anesthesia Services	Insured pays $350 per surgery.	Insured pays 50% of EME.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Insured pays $5,000 per visit.	After CYD, Insured pays 50% of EME.
• Physician Surgical Services	Insured pays $5,000 per surgery.	After CYD, Insured pays 50% of EME.
• Transportation, Lodging and Meals *The maximum benefit per Covered Person 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 visit.	Insured pays 50%.

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Plan Provider Benefit	Non-Plan Provider Benefit
Mental Health/Severe Mental Illness and Substance-Related/Addictive Disorder Services		
• Inpatient Hospital Facility	Insured pays $5,000 per visit.	After CYD, Insured pays 50% of EME.
• Outpatient Office-based Individual and Group Therapy, and Medical Management (Including Telemedicine Services)	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
• All other Outpatient Treatment (Including Telemedicine Services)	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
Post Cataract Surgical Services		
• Frames and Lenses	Insured pays $10 per pair of glasses.	Insured pays 50% of EME.
• Contact Lenses Limited to one pair of Medically Necessary glasses or set of contact lenses as applicable per Covered Person per surgery for all covered tiers combined.	Insured pays $10 per set of contact lenses.	Insured pays 50% of EME.
Home Healthcare Services (Does not include Specialty Prescription Drugs) Tier II maximum benefit limited to 30 visits per Covered Person per Calendar Year.	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
Hospice Care Services		
• Inpatient Hospice Facility	Insured pays $1,000 per visit.	Insured pays 50% of EME.
• Inpatient Respite *Respite Care limited to a combined max of 5 inpatient and/or outpatient visits per 90 days of Home Hospice.*	Insured pays $1,000 per visit.	Insured pays 50% of EME.
• Outpatient Hospice Services	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
• Outpatient Respite Respite Care limited to a combined max of 5 inpatient and/or outpatient visits per 90 days of Home Hospice.	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
• Bereavement Services *Bereavement limited to 5 group therapy sessions within 6-months of the death of a Covered Hospice Patient.*	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
Skilled Nursing Facility 100 days combined for all covered tiers.	Insured pays $1,000 per visit.	Insured pays 50% of EME.

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Plan Provider Benefit	Non-Plan Provider Benefit
Residential Treatment Center	Insured pays $1,000 per visit.	Insured pays 50% of EME.
Manual Manipulation Applies to Medical-Physician Services and Chiropractic office visit. Limited to 20 visits per Covered Person per Calendar Year for all covered tiers combined.	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
Short-Term Habilitation Services • Inpatient Hospital Facility • Outpatient Limited to 120 combined Inpatient days and Outpatient visits per Calendar Year for all covered tiers combined.	Insured pays $1,000 per visit. Insured pays $45 per visit.	Insured pays 50% of EME. After CYD, Insured pays 50% of EME.
Short-Term Rehabilitation Services • Inpatient Hospital Facility • Outpatient Limited to 120 combined Inpatient days and Outpatient visits per Calendar Year for all covered tiers combined.	Insured pays $1,000 per visit. Insured pays $45 per visit.	Insured pays 50% of EME. After CYD, Insured pays 50% of EME.
Other Diagnostic and Therapeutic 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.		
• **Medically Necessary therapeutic treatment and drug services** (Includes, but not limited to anti-cancer or non-cancer related, drug services)	Insured pays $120 per visit.	After CYD, Insured pays 50% of EME.
• **Diagnostic Testing** (Includes, but not limited to Complex Allergy Diagnostic Services (including RAST), Serum Injections and Otologic Evaluations)	Insured pays $120 per visit.	After CYD, Insured pays 50% of EME.
• **Dialysis**	Insured pays $120 per visit.	After CYD, Insured pays 50% of EME.
• **Therapeutic Radiology**	Insured pays $120 per visit.	After CYD, Insured pays 50% of EME.
• **Complex Diagnostic Imaging (**MRI/CT/PET, pulmonary and vascular diagnostic and therapeutic services; complex neurological or psychiatric testing or therapeutic services)	Insured pays $550 per visit.	After CYD, Insured pays 50% of EME.

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.

Covered Services and Limitations	Plan Provider Benefit	Non-Plan Provider Benefit
Durable Medical Equipment (DME) **(**Monthly rental or purchase at SHL option) Purchase/repair/replace of a single type limited to 1 per 3 years for all covered tiers combined.	Insured pays 20% of EME.	Insured pays 50% of EME.
Medical Supplies (Obtained outside of providers office)	Insured pays $0.	Insured pays 50% of EME.
Prosthetic Devices Purchase/repair/replace of a single type limited to 1 per 3 years for all covered tiers combined.	Insured pays 20% of EME.	Insured pays 50% of EME.
Orthotic Devices Purchase/repair/replace of a single type limited to 1 per 3 years for all covered tiers combined.	Insured pays 20% of EME.	Insured pays 50% of EME.
Self-Management and Treatment of Diabetes		
• Education and Training	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.
• Equipment (Except for Insulin Pump)	Insured pays $25 per device.	Insured pays 50% of EME.
• Insulin Pump	Insured pays $100 per device.	Insured pays 50% of EME.
• Supplies (Except for Insulin Pump Supplies)	Insured pays $5 per therapeutic supply.	Insured pays 50% of EME.
• Insulin Pump Supplies	Insured pays $10 per therapeutic supply.	Insured pays 50% of EME.
Special Food Products and Enteral Formulas	Insured pays $0.	Insured pays 50% of EME.
Temporomandibular Joint (TMJ) Treatment	Insured pays 50% of EME.	Insured pays 50% of EME.
Hearing Aids Purchase/repair/replace of a single type limited to 1 per 3 years for all covered tiers combined.	Insured pays the lesser of $150 or 50% of EME.	After CYD, Insured pays 50% of EME.
Applied Behavioral Analysis (ABA) for the treatment of Autism Limited to a maximum of 1500 hours per Covered Person per Calendar Year.	Insured pays $45 per visit.	After CYD, Insured pays 50% of EME.

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.

Pediatric Vision Services for Insureds up to age 19		
Covered Services and Limitations	**Plan Provider Benefit**	**Non-Plan Provider Benefit**
Vision Examinations One (1) vision examination, covered once every Calendar Year, by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.	Insured pays $0 per visit.	Insured pays 50% of EME.
Lenses One (1) pair of lenses will be covered once every Calendar Year when a prescription change is determined to be Medically Necessary. Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal and lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglasses.	Insured pays 0% of EME.	Insured pays 50% of EME.
Frames One (1) pair of frames, from the approved Formulary frame series, will be covered every Calendar Year. Charges for frames selected outside of the approved Formulary frame series are the responsibility of the Covered Person. Discounts for non-Formulary frames may be available through the Plan Provider.	Insured pays 0% of EME.	Insured pays 50% of EME.
Contact Lenses Contact lenses are covered once every Calendar Year in lieu of eyeglasses. Charges for contact lenses considered cosmetic in purpose shall be the responsibility of the Covered Person.	Insured pays 0% of EME.	Insured pays 50% of EME.
Low Vision Exam One comprehensive evaluation every five (5) Calendar Years.	Insured pays 0% of EME.	Insured pays 50% of EME.
Optional Lenses and Treatments • Standard Anti Reflective (AR) Coating • UV Treatment • Tint (Fashion, Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Photochromatic Transition Plastic (Other optional lenses and treatment services may be available to the Covered Person at a discount. Please consult with your provider)	Insured pays 0% of EME.	Insured pays 50% of EME.

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.

Pediatric Dental Services for Insureds up to age 19		
Covered Services and Limitations	**Plan Provider Benefit**	**Non-Plan Provider Benefit**
Diagnostic and Preventive • Oral exam every six (6) months • Periodic X-rays • Diagnostic procedures • Prophylaxis every six (6) months • Topical fluoride treatment every six (6) months • Sealants once per permanent molar • Space maintenance therapy	Insured pays $0 per visit.	Insured pays 0% of EME.
Restorative • Amalgam or composite fillings as needed • Crowns as needed • Sedative fillings	Insured pays 20% of EME.	Insured pays 20% of EME.
Endodontics • Root canal therapy • Pulpal therapy	Insured pays 50% of EME.	Insured pays 50% of EME.
Periodontics *Usually limited to Insureds at least fourteen (14) years of age*	Insured pays 50% of EME.	Insured pays 50% of EME.
Prosthodontics • Partial and complete dentures *Limited to one unit every sixty (60) months*	Insured pays 50% of EME.	Insured pays 50% of EME.
Orthodontics *Coverage provided for Medically Necessary services only*	Insured pays 50% of EME.	Insured pays 50% of EME.
Oral Surgery (Includes Anesthesia) • Extractions	Insured pays 50% of EME.	Insured pays 50% of EME.
Emergency Dental Services • Services or procedures necessary to control bleeding, relieve significant pain and/or eliminate acute infection. • Services or procedures required to prevent pulpal death and/or imminent loss of teeth.	Insured pays 50% of EME.	Insured pays 50% of EME.

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.

Prescription Drug Products from a Network Retail Pharmacy, Network Mail Order Pharmacy, or 90 Day Retail Plan Network Pharmacy Your CYD for Prescription Drugs is $100 per individual, up to $200 per family, and CYD applies to Tiers III - V, for both Non-Specialty and Specialty Drugs.	
Prescription Drug Tier	**Plan Provider Benefit for Non-Specialty Drugs**
Tier I	Insured pays $25 Per Designated Plan Pharmacy Therapeutic Supply.
Tier II	Insured pays $50 Per Designated Plan Pharmacy Therapeutic Supply.
Tier III	After CYD, Insured pays $100 Per Designated Plan Pharmacy Therapeutic Supply.
Tier IV	After CYD, Insured pays $500 Per Designated Plan Pharmacy Therapeutic Supply.
Non-Plan Provider Benefit	After CYD, Insured pays 50% of EME.
Prescription Drug Tier	**Plan Provider Benefit for Specialty Drugs**
Tier I	Insured pays $25 Per Designated Plan Pharmacy Therapeutic Supply.
Tier II	Insured pays $150 Per Designated Plan Pharmacy Therapeutic Supply.
Tier III	After CYD, Insured pays $400 Per Designated Plan Pharmacy Therapeutic Supply.
Non-Plan Provider Benefit	After CYD, Insured pays 50% of EME.
Insured pays up to 2.5 times the applicable Tier Copayment per Pharmacy Therapeutic Supply.	
Please refer to the SHL Prescription Drug List (PDL) for the listing of Covered Drugs and for any covered drugs requiring Prior Authorization and/or Step Therapy as outlined in the Certificate of Coverage (COC).	

Refer to the Limitations Section of the Certificate of Coverage (COC) for information regarding EME and benefit maximums.