



SIERRA HEALTH AND LIFE  
A UnitedHealthcare Company

***MySHL Solutions PPO***

***Gold 1***

**Attachment A Benefit Schedule**

**Lifetime Maximum Benefit for all Covered Services:**  
Unlimited

**Calendar Year Deductible (“CYD”):** Your CYD is \$1,000 of EME per Insured and \$2,000 of EME per Family for Plan Provider Services and \$2,000 of EME per Insured and \$4,000 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.

**Copayments:** This Plan includes some fixed dollar copayment amounts (which are not subject to the CYD) for certain Covered Services. Please reference the following pages for detailed cost-share information.

**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:** Includes the CYD. Your Out of Pocket expenses are limited to a maximum of \$4,000 of EME per Insured per Calendar Year and \$8,000 of EME per Family when using Plan Providers and \$8,000 of EME per Insured per Calendar Year and \$16,000 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 complying with SHL’s Managed Care Program.

An Insured may not contribute any more than the individual Calendar Year Out Of Pocket Maximum amount toward the Family Calendar Year Out of Pocket Maximum amount. 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 Agreement 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, plus any applicable Deductibles, Coinsurance and/or Copayments.

**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 Agreement, List of Services Requiring Prior Authorization, for the list of services and supplies requiring Prior Authorization.

## Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits <sup>(1)</sup>	Non-Plan Provider Benefits <sup>(1)</sup>
<b>Medical Office Visits and Consultations in a Medical Office Setting</b> <ul style="list-style-type: none"> <li><b>Non-Specialist Services</b> <p>Convenient Care Facility</p> <p>Physician Extender or Assistant</p> <p>Physician</p> </li> <li><b>Specialist Services</b></li> </ul> <p><b>Preventive Healthcare Services</b> - <i>Services include various recommended exams, immunizations, diagnostic tests and screenings. Refer to the SHL Preventive Guidelines on the SHL website <a href="http://www.sierrahealthandlife.com">www.sierrahealthandlife.com</a> located under the "Current Customers" tab or contact the Member Services Department (702-242-7700) for the complete list of covered Adult and Pediatric Preventive Services and Immunizations. These guidelines are updated in accordance with the Federal Government standards.</i></p> <p><b>Routine Lab and X-ray services provided and billed by the Physician's office.</b> <i>(Cost-share is in addition to the Physician office visit Cost-share and applies to services rendered in a Physician's office.)</i></p> <ul style="list-style-type: none"> <li>Lab</li> <li>X-Ray</li> </ul>	<p>Insured pays \$5 per visit.</p> <p>Insured pays \$5 per visit.</p> <p>Insured pays \$10 per visit.</p> <p>Insured pays \$20 per visit.</p> <p>Insured pays \$0 per visit.</p> <p>Insured pays \$20 per visit.</p> <p>Insured pays \$15 per visit.</p>	<p>After CYD, SHL pays 50% of EME.</p> <p>After CYD, SHL pays 50% of EME.</p> <p>After CYD, SHL pays 50% of EME.</p>
<b>Telemedicine Services</b> <i>(Only available through select Providers.)</i>	Insured pays \$5 per visit	After CYD, SHL pays 50% of EME.
<b>Laboratory Services - Outpatient</b> <i>Performed at an independent facility.</i>	Insured pays \$20 per visit.	After CYD, SHL pays 50% of EME.
<b>Routine Radiological and Non-Radiological Diagnostic Imaging Services</b> <i>Performed at a Free-Standing Diagnostic Center.</i>	Insured pays \$15 per visit.	After CYD, SHL pays 50% of EME.

## ***Benefit Schedule***

<b>Covered Services and Limitations</b>	<b>Plan Provider Benefits <sup>(1)</sup></b>	<b>Non-Plan Provider Benefits <sup>(1)</sup></b>
<b>Emergency Services</b> <ul style="list-style-type: none"> <li>Urgent Care Facility</li> <li>Emergency Room Facility and Physician's Services</li> <li>Hospital Admission – Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i></li> </ul> <p><i>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.</i></p>	<p>Insured pays \$40 per visit.</p> <p>After CYD, SHL pays 80% of EME.</p> <p>After CYD, SHL pays 80% of EME.</p>	<p>After CYD, SHL pays 50% of EME.</p> <p>After CYD, SHL pays 80% of EME.</p> <p>After CYD, SHL pays 80% of EME.</p>
<b>Ambulance Services</b> <ul style="list-style-type: none"> <li>Emergency Transport</li> <li>Non-Emergency – SHL Arranged Transfers</li> </ul>	<p>After CYD, SHL pays 80% of EME.</p> <p>Insured pays \$0.</p>	<p>After CYD, SHL pays 50% of EME.</p> <p>Insured pays \$0.</p>
<b>Inpatient Hospital Facility Services</b> <i>Elective and Emergency Post-Stabilization Admissions</i>	After CYD, SHL pays 80% of EME.	After CYD, SHL pays 50% of EME.
<b>Outpatient Hospital Facility Services</b>	After CYD, SHL pays 80% of EME.	After CYD, SHL pays 50% of EME.
<b>Ambulatory Surgical Facility Services</b>	After CYD, SHL pays 80% of EME.	After CYD, SHL pays 50% of EME.
<b>Anesthesia Services</b>	After CYD, SHL pays 80% of EME.	After CYD, SHL pays 50% of EME.
<b>Physician Surgical Services – Inpatient and Outpatient</b> <ul style="list-style-type: none"> <li>Inpatient and Outpatient Hospital Facility</li> <li>Ambulatory Surgical Facility</li> <li>Physician's Office (Includes all physician services related to the surgical procedure)</li> </ul>	After CYD, SHL pays 80% of EME.	After CYD, SHL pays 50% of EME.

## Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits <sup>(1)</sup>	Non-Plan Provider Benefits <sup>(1)</sup>
<b>Gastric Restrictive Surgery Services</b> <i>SHL provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Insured.</i> <ul style="list-style-type: none"> <li>Physician Surgical Services</li> <li>Physicians Office Visit</li> </ul>	<p>After CYD, SHL pays 80% of EME. Subject to maximum benefit.</p> <p>Insured pays \$20 per visit.</p>	<p>After CYD, SHL pays 50% of EME. Subject to maximum benefit.</p>
<b>Organ and Tissue Transplant Surgical Services</b> <ul style="list-style-type: none"> <li>Inpatient Hospital Facility</li> <li>Physician Surgical Services – Inpatient Hospital Facility</li> <li>Transportation, Lodging and Meals  <i>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.</i> </li> <li>Procurement  <i>Benefits for procurement procedures and/or services are limited to those deemed by SHL to be Medically Necessary and appropriate for an approved Organ Transplant in a single Transplant Benefit Period.</i> </li> <li>Retransplantation Services  <i>Benefits are limited to one Medically Necessary Retranplantation per Insured per type of transplant.</i> </li> </ul>	<p>After CYD, SHL pays 80% of EME.</p> <p>After CYD, SHL pays 80% of EME.</p> <p>After CYD, SHL pays 80% of EME. Subject to maximum benefit.</p> <p>After CYD, SHL pays 80% of EME.</p> <p>After CYD, SHL pays 50% of EME. Subject to maximum benefit.</p>	<p>After CYD, SHL pays 50% of EME.</p> <p>After CYD, SHL pays 50% of EME.</p> <p>After CYD, SHL pays 50% of EME. Subject to maximum benefit.</p> <p>After CYD, SHL pays 50% of EME.</p> <p>After CYD, SHL pays 50% of EME. Subject to maximum benefit.</p>
<b>Post-Cataract Surgical Services</b> <ul style="list-style-type: none"> <li>Frames and Lenses</li> <li>Contact Lenses  <i>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.</i> </li> </ul>	<p>\$10 per pair of glasses. Subject to maximum benefit.</p> <p>\$10 per set of contact lenses. Subject to maximum benefit.</p>	<p>After CYD, SHL pays 50% of EME. Subject to maximum benefit.</p>

## Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits <sup>(1)</sup>	Non-Plan Provider Benefits <sup>(1)</sup>
<p><b>Home Healthcare Services</b> (<i>does not include Specialty Prescription Drugs</i>) Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drugs.</p> <p><i>Home Healthcare Services are limited to a combined Plan and Non-Plan Provider maximum benefit of sixty (60) visits per Insured per Calendar Year. A period of 4 hours or less of Home Healthcare services equals one visit.</i></p>	<p>After CYD, SHL pays 80% of EME. Subject to maximum benefit.</p>	<p>After CYD, SHL pays 50% of EME. Subject to maximum benefit.</p>
<p><b>Hospice Care Services</b></p> <ul style="list-style-type: none"> <li>Inpatient Hospice Facility</li> <li>Outpatient Hospice Services</li> <li>Inpatient and Outpatient Respite Services <i>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.</i></li> <li>Bereavement Services <i>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.</i></li> </ul>	<p>After CYD, SHL pays 80% of EME. Respite and Bereavement Services are subject to applicable maximum benefits.</p>	<p>After CYD, SHL pays 50% of EME. Respite and Bereavement Services are subject to applicable maximum benefits.</p>
<p><b>Skilled Nursing Facility</b> <i>Limited to a combined Plan and Non-Plan Provider maximum benefit of one hundred (100) days per Insured per Calendar Year.</i></p>	<p>After CYD, SHL pays 80% of EME. Subject to maximum benefit.</p>	<p>After CYD, SHL pays 50% of EME. Subject to maximum benefit.</p>
<p><b>Manual Manipulation</b> (<i>Applies to Medical-Physician Services and Chiropractic office visit.</i>)  <i>Limited to a combined Plan and Non-Plan Provider maximum benefit of twenty (20) visits per Insured per Calendar Year.</i></p>	<p>Insured pays \$10 per visit. Subject to maximum benefit.</p>	<p>After CYD, SHL pays 50% of EME. Subject to maximum benefit.</p>
<p><b>Short-Term Rehabilitation and Habilitative Services</b></p> <ul style="list-style-type: none"> <li>Inpatient Hospital Facility</li> <li>Outpatient <i>All Inpatient and Outpatient Short-Term Rehabilitation and Habilitative Services are subject to a combined Plan and Non-Plan Provider maximum benefit of one hundred twenty (120) days/visits per Insured per Calendar Year.</i></li> </ul>	<p>After CYD, SHL pays 80% of EME. Subject to maximum benefit.</p> <p>Insured pays \$10 per visit. Subject to maximum benefit.</p>	<p>After CYD, SHL pays 50% of EME. Subject to maximum benefit.</p>

## Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits <sup>(1)</sup>	Non-Plan Provider Benefits <sup>(1)</sup>
<b>Genetic Disease Testing Services</b> <ul style="list-style-type: none"> <li>Office Visit</li> <li>Lab</li> </ul> <i>Includes Inpatient, Outpatient and independent Laboratory Services.</i>	After CYD, SHL pays 75% of EME.	After CYD, SHL pays 50% of EME.
<b>Infertility Office Visit Evaluation</b> <i>Please refer to applicable surgical procedure cost-share herein for any surgical infertility procedures performed.</i>	Insured pays \$20 per visit.	After CYD, SHL pays 50% of EME.
<b>Medical Supplies</b>	After CYD, SHL pays 80% of EME.	After CYD, SHL pays 50% of EME.
<b>Other Diagnostic and Therapeutic Services</b> <i>Cost-share amounts are in addition to the Physician office visit cost-share and applies to services rendered in a Physician's office or at an independent facility.</i> <ul style="list-style-type: none"> <li>Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services.</li> <li>Dialysis</li> <li>Therapeutic Radiology</li> <li>Complex Allergy Diagnostic Services (including RAST) and Serum Injections</li> <li>Otologic Evaluations</li> <li>Other complex diagnostic imaging services such as Positron Emission Tomography (PET) scans, CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.</li> </ul>	Insured pays \$50 per visit.  Insured pays \$50 per visit.  Insured pays \$50 per visit.  Insured pays \$50 per day.  Insured pays \$50 per day.  After CYD, SHL pays 80% of EME.	After CYD, SHL pays 50% of EME.
<b>Durable Medical Equipment</b> <i>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.</i>	After CYD, SHL pays 80% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
<b>Prosthetic Devices</b> <i>Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.</i>	After CYD, SHL pays 80% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.

## Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits <sup>(1)</sup>	Non-Plan Provider Benefits <sup>(1)</sup>
<b>Orthotic Devices</b> <i>Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.</i>	After CYD, SHL pays 80% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
<b>Self-Management and Treatment of Diabetes</b> <ul style="list-style-type: none"> <li>Education and Training</li> <li>Supplies (except for Insulin Pump Supplies) <ul style="list-style-type: none"> <li>Insulin Pump Supplies</li> </ul> </li> <li>Equipment (except for Insulin Pump) <ul style="list-style-type: none"> <li>Insulin Pump</li> </ul> </li> </ul> <i>Refer to the Outpatient Prescription Drug Rider for the benefits applicable to the diabetic supplies and equipment obtained at a retail Plan Pharmacy.</i>	Insured pays \$10 per visit.  Insured pays \$5 per therapeutic supply.  Insured pays \$10 per therapeutic supply.  Insured pays \$20 per device.  Insured pays \$100 per device.	After CYD, SHL pays 50% of EME.
<b>Special Food Products and Enteral Formulas</b> <i>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.</i>	Insured pays \$0. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
<b>Temporomandibular Joint Treatment</b>	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
<b>Mental Health and Severe Mental Illness Services</b> <ul style="list-style-type: none"> <li>Inpatient Hospital Facility</li> <li>Outpatient Treatment</li> </ul>	After CYD, SHL pays 80% of EME.  Insured pays \$10 per visit.	After CYD, SHL pays 50% of EME.
<b>Substance Abuse Services</b> <ul style="list-style-type: none"> <li>Inpatient Hospital Facility</li> <li>Outpatient Treatment</li> </ul>	After CYD, SHL pays 80% of EME.  Insured pays \$10 per visit.	After CYD, SHL pays 50% of EME.

## *Benefit Schedule*

[illegible]



## Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits <sup>(1)</sup>	Non-Plan Provider Benefits <sup>(1)</sup>
<b>Pediatric Vision Services for Insureds up to age 19 (continued)</b>  <b>Optional Lenses and Treatments</b> <ul style="list-style-type: none"> <li>Standard Anti-Reflective (AR) Coating</li> <li>UV Treatment</li> <li>Tint (Fashion &amp; Gradient &amp; Glass-Grey)</li> <li>Standard Plastic Scratch Coating</li> <li>Photocromatic/Transitions Plastic</li> </ul> <p><i>(Other optional lenses and treatment services may be available to the Insured at a discount. Please consult with your Provider.)</i></p>	Insured pays \$0.	SHL pays 50% of EME. Subject to maximum benefit.
<b>Pediatric Dental Services for Insureds up to age 19</b>		
<b>Diagnostic and Preventive</b> <ul style="list-style-type: none"> <li>Oral exam every six (6) months</li> <li>Periodic X-rays</li> <li>Diagnostic procedures</li> <li>Prophylaxis every six (6) months</li> <li>Topical fluoride treatment every six (6) months</li> <li>Sealants once per permanent molar</li> <li>Space maintenance therapy</li> </ul>	SHL pays 100% of EME.	After CYD, SHL pays 100% of EME.
<b>Restorative</b> <ul style="list-style-type: none"> <li>Amalgam or composite fillings as needed</li> <li>Crowns as needed</li> <li>Sedative fillings</li> </ul>	After CYD, SHL pays 80% of EME.	After CYD, SHL pays 80% of EME.
<b>Endodontics</b> <ul style="list-style-type: none"> <li>Root canal therapy</li> <li>Pulpal therapy</li> </ul>	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
<b>Periodontics</b> <i>Usually limited to Insureds at least fourteen (14) years of age.</i>	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
<b>Prosthodontics</b> <ul style="list-style-type: none"> <li>Partial and complete dentures</li> </ul> <i>Limited to one unit once every sixty (60) months.</i>	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
<b>Orthodontics</b> <i>Coverage provided for Medically Necessary Services only.</i>	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
<b>Oral Surgery (includes Anesthesia)</b> <ul style="list-style-type: none"> <li>Extractions</li> </ul>	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
<b>Emergency Dental Services</b> <ul style="list-style-type: none"> <li>Services or procedures necessary to control bleeding, relieve significant pain and/or eliminate acute infection</li> <li>Services or procedures required to prevent pulpal death and/or imminent loss of teeth</li> </ul>	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.

## ***Benefit Schedule***

Please read the SHL Agreement 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.

Insured is responsible for any and 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.

<sup>(1)</sup> 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.