



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

MySHL Solutions HSA PPO Silver 1.1

HIOS ID: 83198NV0030026

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. The stated CYD maximum amounts are separate for each tier of benefits and do not accumulate to one another. The Family CYD is a cumulative total of EME for all Insured's within an enrolled Family and must be met in order for benefits to be payable.

(Note: the CYD is applicable to all Covered Services except for preventive medical, preventive pediatric vision and preventive pediatric dental services.)

Coinsurance: After satisfying your CYD, 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.

Calendar Year Out of Pocket Maximum: Your Calendar Year Out of Pocket expenses are limited to a maximum of \$6,500 of EME per Insured per Calendar Year and \$13,000 of EME per Family when using Plan Providers and \$13,000 of EME per Insured per Calendar Year and \$26,000 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.

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 of Coverage (AOC) 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 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 Benefit* ⁽¹⁾	Non-Plan Provider Benefit* ⁽¹⁾
Medical Office Visits and Consultations Non-Specialist Services <ul style="list-style-type: none"> Convenient Care Facility Physician Extender or Assistant Physician Specialist Services 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).	After CYD, Insured pays \$5 per visit. After CYD, Insured pays \$5 per visit. After CYD, Insured pays \$15 per visit. After CYD, Insured pays \$45 per visit. Insured pays \$0 per visit.	After CYD, Insured pays 50% of EME. After CYD, Insured pays 50% of EME. After CYD, Insured pays 50% of EME. After CYD, Insured pays 50% of EME. After CYD, Insured pays 50% of EME.
Non-preventive Routine Lab and X-ray Services 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. <ul style="list-style-type: none"> Lab X-Ray 	After CYD, Insured pays \$20 per visit. After CYD, Insured pays \$20 per visit.	After CYD, Insured pays 50% of EME. After CYD, Insured pays 50% of EME.
Telemedicine Services (Available through select contracted Providers)	After CYD, Insured pays \$10 per visit.	After CYD, Insured pays 50% of EME.
Urgent Care Facility	After CYD, Insured pays \$50 per visit.	After CYD, Insured pays 50% of EME.
Emergency Services <ul style="list-style-type: none"> Emergency Room Facility (includes Physician Services) Hospital Admission - Emergency Stabilization (includes Physician Services) Applies until patient is stabilized and safe for transfer as determined by the attending Physician. 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.	After CYD, Insured pays \$400 per visit; waived if admitted. After CYD, Insured pays \$1,000 per admission.	After CYD, Insured pays \$400 per visit; waived if admitted. After CYD, Insured pays \$1,000 per admission.

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

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit ^{*(1)}	Non-Plan Provider Benefit ^{*(1)}
Ambulance Services <ul style="list-style-type: none"> Emergency Transport Non-Emergency - SHL Arranged Transfers 	<p>After CYD, Insured pays \$250 per trip.</p> <p>After CYD, Insured pays \$0.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays \$0.</p>
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)	After CYD, Insured pays \$1,000 per admission.	After CYD, Insured pays 50% of EME.
Outpatient Hospital Facility Services	After CYD, Insured pays \$300 per surgery.	After CYD, Insured pays 50% of EME.
Ambulatory Surgical Facility Services	After CYD, Insured pays \$150 per surgery.	After CYD, Insured pays 50% of EME.
Anesthesia Services	After CYD, Insured pays \$150 per surgery.	After CYD, Insured pays 50% of EME.
Physician Surgical Services - Inpatient and Outpatient <ul style="list-style-type: none"> Inpatient Hospital Facility Outpatient Hospital Facility Ambulatory Surgical Facility Physician's Office Non-Specialist Physician (Includes all physician services related to the surgical procedure) Specialist (Includes all physician services related to the surgical procedure) 	<p>After CYD, Insured pays \$150 per surgery.</p> <p>After CYD, Insured pays \$150 per surgery.</p> <p>After CYD, Insured pays \$150 per surgery.</p> <p>After CYD, Insured pays \$25 per surgery.</p> <p>After CYD, Insured pays \$50 per surgery.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p>
Gastric Restrictive Surgery Services SHL provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Insured. <ul style="list-style-type: none"> Physician Surgical Services Physician's Office Visit 	<p>After CYD, Insured pays \$2,500 per surgery. Subject to maximum benefit.</p> <p>After CYD, Insured pays \$45 per visit.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p>

**Refer to the Limitations Section of the AOC 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 <ul style="list-style-type: none"> Inpatient Hospital Facility Physician Surgical Services - Inpatient Hospital Facility 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. Procurement The maximum benefit per Insured per Transplant Benefit Period for Procurement of the organ/tissue is \$15,000 of EME. Retransplantation Services Benefits are limited to one (1) Medically Necessary Retransplantation per Insured per type of transplant. 	<p>After CYD, Insured pays \$1,000 per admission.</p> <p>After CYD, Insured pays \$150 per surgery.</p> <p>After CYD, Insured pays 0% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 0% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays \$1,000 per surgery. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p>
Post-Cataract Surgical Services <ul style="list-style-type: none"> Frames and Lenses Contact Lenses <p>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.</p>	<p>After CYD, Insured pays \$10 per pair of glasses. Subject to maximum benefit.</p> <p>After CYD, Insured pays \$10 per set of contact lenses. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p>
Home Healthcare Services (does not include Specialty Prescription Drugs) Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drug. 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 four (4) hours or less of Home Healthcare services equals one visit.	<p>After CYD, Insured pays \$25 per visit. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 50% of EME.</p>

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

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit* ⁽¹⁾	Non-Plan Provider Benefit* ⁽¹⁾
Hospice Care Services <ul style="list-style-type: none"> Inpatient Hospice Facility Outpatient Hospice Services 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. <ul style="list-style-type: none"> Inpatient Outpatient 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. 	<p>After CYD, Insured pays \$250 per admission.</p> <p>After CYD, Insured pays \$15 per visit.</p> <p>After CYD, Insured pays \$250 per admission. Subject to maximum benefit.</p> <p>After CYD, Insured pays \$15 per visit. Subject to maximum benefit.</p> <p>After CYD, Insured pays \$15 per visit. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p>
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 \$500 per admission. Subject to maximum benefit.	After CYD, Insured pays 50% of EME.
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.	After CYD, Insured pays \$15 per visit. Subject to maximum benefit.	After CYD, Insured pays 50% of EME.
Short-Term Rehabilitation and Habilitation Services (including but not limited to Physical, Speech and Occupational Therapy) <ul style="list-style-type: none"> Inpatient Hospital Facility Outpatient All Inpatient and Outpatient Short Term Rehabilitation and Habilitative Services are subject to a to a combined Plan and Non-Plan Provider maximum benefit of one hundred twenty (120) days/visits per Insured per Calendar Year.	<p>After CYD, Insured pays \$250 per admission. Subject to maximum benefit.</p> <p>After CYD, Insured pays \$15 per visit. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p>

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

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit* ⁽¹⁾	Non-Plan Provider Benefit* ⁽¹⁾
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 \$100. Subject to maximum benefit.	After CYD, Insured pays 50% of EME.
Genetic Disease Testing Services <ul style="list-style-type: none"> Office Visit Lab Includes Inpatient, Outpatient and independent Laboratory Services. 	After CYD, Insured pays \$50 per visit. After CYD, Insured pays \$50 per visit.	After CYD, Insured pays 50% 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.	After CYD, Insured pays \$45 per visit.	After CYD, Insured pays 50% of EME.
Medical Supplies (Obtained outside of a medical office visit)	After CYD, Insured pays 0% of EME.	After CYD, Insured pays 50% of EME.
Other Diagnostic and Therapeutic Services 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. <ul style="list-style-type: none"> Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services. Dialysis Therapeutic Radiology Complex Allergy Diagnostic Services (including RAST) and Serum Injections Otologic Evaluations 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. Positron Emission Tomography (PET) scans 	After CYD, Insured pays \$15 per day. After CYD, Insured pays \$15 per day. After CYD, Insured pays \$15 per day. After CYD, Insured pays \$15 per visit. After CYD, Insured pays \$15 per visit. After CYD, Insured pays \$350 per test or procedure. After CYD, Insured pays \$500 per test or procedure.	After CYD, Insured pays 50% of EME. After CYD, Insured pays 50% of EME. After CYD, Insured pays 50% of EME. After CYD, Insured pays 50% of EME. After CYD, Insured pays 50% 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 \$750 per device. Subject to maximum benefit.	After CYD, Insured pays 50% of EME.
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 \$25 per device. Subject to maximum benefit.	After CYD, Insured pays 50% of EME.

*Refer to the Limitations Section of the AOC 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 <ul style="list-style-type: none"> Education and Training Supplies (except for Insulin Pump Supplies) Insulin Pump Supplies Equipment (except for Insulin Pump) Insulin Pump <p>Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.</p>	<p>After CYD, Insured pays \$15 per visit.</p> <p>After CYD, Insured pays \$5 per therapeutic supply.</p> <p>After CYD, Insured pays \$10 per therapeutic supply.</p> <p>After CYD, Insured pays \$20 per device.</p> <p>After CYD, Insured pays \$100 per device.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p>
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.	<p>After CYD, Insured pays \$0. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 50% of EME.</p>
Temporomandibular Joint Treatment	<p>After CYD, Insured pays \$50 per visit.</p>	<p>After CYD, Insured pays 50% of EME.</p>
Mental Health and Severe Mental Illness Services <ul style="list-style-type: none"> Inpatient Hospital Facility Outpatient Treatment 	<p>After CYD, Insured pays \$1,000 per admission.</p> <p>After CYD, Insured pays \$15 per visit.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p>
Substance Abuse Services <ul style="list-style-type: none"> Inpatient Hospital Facility Outpatient Treatment 	<p>After CYD, Insured pays \$1,000 per admission.</p> <p>After CYD, Insured pays \$15 per visit.</p>	<p>After CYD, Insured pays 50% of EME.</p> <p>After CYD, Insured pays 50% of EME.</p>
Hearing Aids Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.	<p>After CYD, Insured pays \$100. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 50% of EME.</p>
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 two hundred fifty (250) visits per Insured not to exceed seven hundred fifty (750) total hours of therapy per Insured per Calendar Year.	<p>After CYD, Insured pays \$15 per visit. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 50% of EME.</p>

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

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit* ⁽¹⁾	Non-Plan Provider Benefit* ⁽¹⁾
Prescription Covered Drugs (Retail and Mail Order Pharmacy*) <div style="text-align: center;"> Tier I Tier II Tier III Tier IV </div> <p><i>*Insured pays 2.5 times the applicable Tier Copayment per Plan Mail Order Pharmacy Therapeutic Supply.</i></p>	After CYD, Insured pays: <div style="text-align: center;"> \$10 \$50 \$75 \$250 </div>	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
Pediatric Vision Services for Insureds up to age 19 Vision Examination Limited to a combined Plan and Non-Plan Provider maximum benefit of one (1) vision examination, covered once every Calendar Year, to include a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. Lenses Limited to a combined Plan and Non-Plan Provider maximum benefit of one (1) pair of lenses, 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. Frames Limited to a combined Plan and Non-Plan Provider maximum benefit of one (1) pair of frames, covered once every Calendar Year, from the approved Formulary frame series. Charges for frames selected outside of the approved Formulary frame series are the responsibility of the Insured. Discounts for non-Formulary frames may be available through the Plan Provider. Contact Lenses Limited to a combined Plan and Non-Plan Provider maximum benefit. Contact lenses are covered once every Calendar Year in lieu of eye glasses. Charges for contact lenses considered to be cosmetic in purposes shall be the responsibility of the Insured. Low Vision Exam Limited to a combined Plan and Non-Plan Provider maximum benefit of one (1) comprehensive evaluation every five (5) years. Optional Lenses and Treatments <ul style="list-style-type: none"> • Standard Anti-Reflective (AR) Coating • UV Treatment • Tint (Fashion & Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Photocromatic/Transitions Plastic (Other optional lenses and treatment services may be available to the Insured at a discount. Please consult with your Provider.)	Insured pays \$0 per visit. Subject to maximum benefit. After CYD, Insured pays \$0 per visit. Subject to maximum benefit. After CYD, Insured pays \$0 per visit. Subject to maximum benefit. Insured pays \$0 per visit. Subject to maximum benefit. After CYD, Insured pays \$0.	After CYD, Insured pays 50% of EME. Subject to maximum benefit. After CYD, Insured pays 50% of EME. Subject to maximum benefit. After CYD, Insured pays 50% of EME. Subject to maximum benefit. After CYD, Insured pays 50% of EME. Subject to maximum benefit. After CYD, Insured pays 50% of EME.

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

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit* ⁽¹⁾	Non-Plan Provider Benefit* ⁽¹⁾
Pediatric Dental Services for Insureds up to age 19		
Diagnostic and Preventive <ul style="list-style-type: none"> 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. Subject to maximum benefit.	After CYD, Insured pays 0% of EME. Subject to maximum benefit.
Restorative <ul style="list-style-type: none"> Amalgam or composite fillings as needed Crowns as needed Sedative fillings 	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 20% of EME.
Endodontics <ul style="list-style-type: none"> Root canal therapy Pulpal therapy 	After CYD, Insured pays 50% of EME.	After CYD, Insured pays 50% of EME.
Periodontics Usually limited to Insureds at least fourteen (14) years of age.	After CYD, Insured pays 50% of EME.	After CYD, Insured pays 50% of EME.
Prosthodontics <ul style="list-style-type: none"> Partial and complete dentures Limited to one unit once every sixty (60) months.	After CYD, Insured pays 50% of EME.	After CYD, Insured pays 50% of EME.
Orthodontics Coverage provided for Medically Necessary Services only.	After CYD, Insured pays 50% of EME.	After CYD, Insured pays 50% of EME.
Oral Surgery (includes Anesthesia) <ul style="list-style-type: none"> Extractions 	After CYD, Insured pays 50% of EME.	After CYD, Insured pays 50% of EME.
Emergency Dental Services <ul style="list-style-type: none"> 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. 	After CYD, Insured pays 50% of EME.	After CYD, Insured pays 50% of EME.

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.

⁽¹⁾ 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.

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



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

HSA Outpatient Prescription Drug Attachment C to the SHL Individual Agreement of Coverage

**Please refer to your Attachment A Benefit Schedule for the applicable Calendar Year
Deductible, Out of Pocket Maximums and Cost-Share amounts.**

Please refer to the SHL Prescription Drug List (PDL) for the listing of Covered Drugs.

This Prescription Drug Benefit Rider is issued in consideration of: (a) your election of coverage under this Rider, (b) your eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Prescription Drug Benefit Rider is a supplement to your Agreement of Coverage (AOC) and Attachment A Benefit Schedule issued by Sierra Health and Life Insurance Co., Inc., and amends your coverage to include benefits for Covered Drugs. This coverage is subject to the applicable terms, conditions, limitations and exclusions contained in your SHL AOC and herein.

NOTE: After meeting the CYD, an Insured's Cost-share for oral cancer prescription drugs under this plan will not exceed the lesser of one hundred dollars (\$100) per prescription or the amount of the Cost-share for an injected or infused cancer drug.

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the SHL Attachment A Benefit Schedule.

SECTION 1. Obtaining Covered Drugs

Benefits for Covered Drugs are payable under the terms of this Rider subject to the following conditions:

- A **Designated** Plan Pharmacy must dispense the Covered Drug, except as otherwise specifically provided in Section 1.2 herein.
- A Generic Covered Drug will be dispensed when available, subject to the prescribing Provider's "Dispense as written" requirements.
- Benefits for Specialty Covered Drugs as defined herein are payable subject to the applicable CYD and Tier I, II, III or IV Cost-share as set forth in the Attachment A Schedule of Benefits and in accordance with the applicable benefit tier placement of such Specialty Drug in the PDL. If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, SHL may direct you to a Designated Plan Pharmacy with whom

ATTACHMENT C

SHL has an arrangement to provide those Covered Drugs.

1.1 Designated Plan Pharmacy Benefit Payments

Benefits for Covered Drugs obtained at a Designated Plan Pharmacy are payable according to the applicable benefit tiers described below, subject to the Insured obtaining any required Prior Authorization or meeting any applicable Step Therapy requirement.

- (a). **Tier I** – is the lowest Cost-share option for Covered Drugs.
- (b). **Tier II** – is the low Cost-share option for Covered Drugs.
- (c). **Tier III** – is the midrange Cost-share option for Covered Drugs.
- (d). **Tier IV** – is the highest Cost-share option for Covered Drugs.
- (e). **Mandatory Generic benefit provision applies when:**
 - a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. After satisfying the CYD, the Insured will pay the Brand Name Covered Drug Cost-share plus the difference between the Eligible Medical Expenses (“EME”) of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Designated Plan Pharmacy for each Therapeutic Supply.
- (f). When a Drug is dispensed through the Mail Order Plan Pharmacy, the applicable CYD and Tier I, II, III or IV Mail Order Plan Pharmacy Cost-share benefit tier will apply per Therapeutic Supply.

1.2 Non-Plan Pharmacy Benefit Payments

(a). In order that claims for Covered Drugs obtained at a Non-Plan Pharmacy be eligible for benefit payment, the Insured must complete and submit a Pharmacy Reimbursement Claim Form with the prescription label and register receipt to SHL or its designee.

(b). Benefit payments are subject to the limitations and exclusions set forth in the SHL AOC and this Rider as follows:

- 1. When any Covered Drug is dispensed, the benefit payment will be subject to SHL’s EME and the applicable Tier I, II, III or IV CYD and Copayment amount. The Insured is responsible for any amounts exceeding SHL’s benefit payment. .
- 2. The Mandatory Generic benefit provision applies when any Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The benefit payment is subject to SHL’s EME of the Generic Covered Drug less the applicable tier Copayment. The Insured is responsible for any amounts exceeding SHL’s benefit payment.
- 3. No benefits are payable if SHL’s EME of the Covered Drug is less than the applicable Cost-share.

1.4 Mail Order Plan Pharmacy Benefit Payments

(a). Benefits for Covered Drugs are available when dispensed by an SHL Mail Order Plan Pharmacy subject to the applicable CYD and Tier I, II, III or IV Cost-share.

- (b). Information on how to obtain Mail Order Drugs is provided in the Mail Order Brochure provided after enrollment with SHL.

SECTION 2. Limitations

- 2.1** Prior Authorization or Step Therapy may be required for certain Covered Drugs in order for full Prescription Drug benefits to be payable. If any required Prior Authorization or Step Therapy is not obtained, benefits will be reduced up to 50% of the otherwise applicable benefit payment for such Covered Drugs.
- 2.2** A pharmacy may refuse to fill or refill a prescription order when in the professional judgment of the pharmacist the prescription should not be filled.
- 2.3** Benefits for prescriptions for Mail Order Drugs submitted following SHL's receipt of notice of Insured's termination will be limited to the appropriate Therapeutic Supply from the date such notice of termination is received to the Effective Date of termination of the Insured.
- 2.4** Benefits are not payable if the Insured is directed to a Designated Plan Pharmacy and chooses not to obtain the Covered Drug from that Designated Plan Pharmacy.
- 2.5** If SHL determines that the Insured may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, the Insured's selection of Plan Pharmacies may be limited. If this happens, SHL may require the Insured to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if the Insured uses the assigned single Plan Pharmacy. If a selection is not made by the Insured within thirty-one (31) days of the date of

notification, then SHL will select a single Plan Pharmacy for the Insured.

SECTION 3. Exclusions

No benefits are payable for the following drugs, devices and supplies as well as for any complications resulting from their use except when prescribed in connection with the treatment of Diabetes:

- 3.1** Prescription Drug furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- 3.2** Prescription Drugs for any condition, Injury, Illness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- 3.3** Devices of any type, including those prescribed by a licensed Provider, except for prescription contraceptive devices.
- 3.4** Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- 3.5** Any product dispensed for the purpose of appetite suppression or weight loss.
- 3.6** Medications used for cosmetic purposes.
- 3.7** Prescription Drug Products for smoking cessation.
- 3.8** Prescription Drug Products when prescribed to treat infertility.

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- 3.9** Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
- 3.10** Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs.
- 3.11** Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the SHL AOC.
- 3.12** Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members.
- 3.13** Prescription Drugs dispensed prior to the Insured's Effective Date of coverage or after Insured's termination date of coverage under the Plan.
- 3.14** Prescription Drugs, including Covered Drugs, dispensed by a Non-Plan Provider, except in the case of Emergency Services and Urgently Needed Services.
- 3.15** Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless SHL has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that SHL has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and SHL may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
- 3.16** General vitamins, except the following which require a prescription order or refill: prenatal vitamins; vitamins with fluoride; and single entity vitamins.
- 3.17** Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury except for Prescription Drug Products that are enteral formulas prescribed for the treatment of inherited metabolic diseases as defined by state law.
- 3.18** Any Prescription Drug for which the actual charge to the Insured is less than the amount due under this Rider.
- 3.19** Any refill dispensed more than one (1) year from the date of the latest prescription order or as permitted by applicable law of the jurisdiction in which the drug is dispensed.
- 3.20** Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- 3.21** Medical supplies unless listed on the PDL or Prior Authorized by SHL.
- 3.22** Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- 3.23** Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- 3.24** Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that

requires a Prescription Order or Refill are assigned to Tier III or IV).

- 3.25** Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.
- 3.26** Experimental or investigational or unproven services and medications; medication used for experimental indications and/or dosage regimens determined by the Plan to be experimental, investigational or unproven except when prescribed for the treatment of cancer or other life-threatening diseases or conditions, chronic fatigue syndrome, cardiovascular disease, surgical musculoskeletal disorder of the spine, hip and knees, and other diseases or disorders which are not life threatening or study approved by the Plan.
- 3.27** A Prescription Drug that contains an active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to a Covered Drug may be excluded as determined by the Plan.
- 3.28** Prescription Drugs dispensed outside the United States, except as required for emergency treatment.
- 3.29** Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission.
- 3.30** Covered Drugs that are not FDA approved for a specific diagnosis.
- 3.31** Drugs and medicine approved by the FDA for experimental or investigational use or any drug that has been approved by the FDA for less than one (1) year unless Prior Authorized by SHL.
- 3.32** Unit dose packaging of Prescription Drugs.

SECTION 4. Glossary

- 4.1** “**Brand Name Drug**” is a Prescription Drug which is marketed under or protected by:
 - a registered trademark;
 - or a registered trade name;
 - or a registered patent.
- 4.2** “**Compound**” means to form or create a Medically Necessary customized composite product by combining two (2) or more different ingredients according to a Physician’s specifications to meet an individual patient’s need.
- 4.3** “**Covered Drug**” is a Brand Name or Generic Prescription Drug or diabetic supply or equipment which:
 - can only be obtained with a prescription;
 - has been approved by the Food and Drug Administration (“FDA”) for general marketing, subject to 3.31 herein;
 - is dispensed by a licensed pharmacist;
 - is prescribed by a Plan Provider, except in the case of Emergency Services and Urgently Needed Services;
 - is a Prescription Drug that does not have an over-the-counter Therapeutic Equivalent available; and
 - is not specifically excluded herein.
- 4.4** “**Copayment**” or “**Cost-share**” means the amount the Insured pays when a Covered Service is received.
- 4.5** “**Designated Plan Pharmacy**” means a pharmacy that has entered into an agreement with SHL to provide specific Covered Drugs and/or supplies to Insureds. The fact that a pharmacy is a Plan Pharmacy does not mean that it is a Designated Plan Pharmacy. For the purposes of the Prescription Drug Benefit Rider, please refer to the SHL

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- PDL on the website or contact Member Services for the specific Designated Plan Pharmacy for your Covered Drug and/or supply/equipment.
- 4.6 “Dispensing Period”** as established by SHL means 1) a predetermined period of time; or 2) a period of time up to a predetermined age attained by the Insured that a specific Covered Drug is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition.
- 4.7 “Eligible Medical Expense (EME)”** for purposes of this Rider, means the Plan Pharmacy’s contracted cost of the Covered Drug to SHL but not more than the actual charge to the Insured.
- 4.8 “Generic Drug”** is an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.
- 4.9 “Mail Order Plan Pharmacy”** is a duly licensed pharmacy that has an independent contractor agreement with SHL to provide certain Tier I, Tier II, Tier III and Tier IV Drugs to Insureds by mail.
- 4.10 “Non-Plan Pharmacy”** is a duly licensed pharmacy that does not have an independent contractor agreement with SHL to provide Covered Drugs to Insureds.
- 4.11 “Plan Pharmacy”** is a duly licensed pharmacy that has an independent contractor agreement with SHL to provide Covered Drugs to Insureds. Unless otherwise specified as Mail Order Plan Pharmacy herein, Plan Pharmacy services are retail services only and do not include Mail Order services.
- 4.12 “Prescription Drug List (PDL)”** means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by SHL.
- 4.13 “Prescription Drug”** is any drug required by federal law or regulation to be dispensed upon written prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.
- 4.14 “Specialty Drugs”** are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by SHL’s P&T Committee that are either self-administered or administered by a healthcare Provider and used or obtained in either an outpatient or home setting.
- 4.15 “Step Therapy”** is a program for Insureds who take Prescription Drugs for an ongoing medical condition, such as arthritis, asthma or high blood pressure, which ensures the Insured receives the most appropriate and cost-effective drug therapy for their condition. The Step Therapy program requires that before benefits are payable for a high cost Covered Drug that may have initially been prescribed, the Insured try a lower cost first-step Covered Drug. If the prescribing Physician has documented with SHL why the Insured’s condition cannot be stabilized with the first-step Covered Drug, SHL will review a request for Prior Authorization to move the Insured to a second-step drug, and so on, until it is determined by SHL that the prescribed Covered Drug is Medically Necessary and eligible for benefit payment.
- 4.16 “Therapeutic Equivalent”** means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.
- 4.17 “Therapeutic Supply”** is the maximum quantity of a Covered Drug for which benefits are available for the applicable Drug Fee or the applicable Cost-share

amount and may be less than but shall not exceed a 30-day retail supply or 90-day mail order supply.

you may be required to pay more or less for that Prescription Drug.

Coverage Policies and Guidelines

SHLs Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on SHL's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug to a certain tier by considering a number of factors including but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug's acquisition cost including, but not limited to, available rebates and assessments of the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others; therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed, or according to whether it was prescribed by a Specialist Physician.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: the tier status of a Prescription Drug may change periodically based on the process described above. As a result of such changes,

Questions about SHL's PDL should be directed to the Member Services Department at 1-800-888-2264 or the PDL and the Pharmacy Reimbursement Claim Form is available at <http://www.uhcnevada.com/> which leads to SHL's portal www.myshlonline.com.