



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [www.sierrahealthandlife.com](http://www.sierrahealthandlife.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-888-2264 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$1,000/Insured and \$2,000/Family for <u>Plan Providers</u> and \$2,000/Insured and \$4,000/Family for <u>Non-Plan Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> from <u>Plan Providers</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$4,000/Insured and \$8,000/Family for <u>Plan Providers</u> and \$12,000/Insured and \$24,000/Family for <u>Non-Plan Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Penalties for not complying with SHL's Managed Care Program, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.sierrahealthandlife.com/Member/Doctor-or-Provider">www.sierrahealthandlife.com/Member/Doctor-or-Provider</a> or call 1-800-888-2264 for a list of <u>Plan Providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Preventive care/ screening/ immunization</u>	No charge	40% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	X-ray: \$10 <u>copay</u> /service; <u>deductible</u> does not apply Lab: No charge	40% <u>coinsurance</u>	Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
	Imaging (CT/PET scans, MRIs)	PET Scan: \$250 <u>copay</u> /service; <u>deductible</u> does not apply MRI: \$250 <u>copay</u> /service; <u>deductible</u> does not apply CT: \$250 <u>copay</u> /service; <u>deductible</u> does not apply	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.sierrahealthandlife.com">www.sierrahealthandlife.com</a>	Tier 1	\$7 <u>copay</u> /prescription (retail) \$17.50 <u>copay</u> /prescription (mail)	30% <u>coinsurance</u>	You have a 3-Tier pharmacy <u>plan</u> . Covers up to a 30-day retail supply or up to a 90-day mail order supply. Insured pays for cost of services if <u>prior authorization</u> or step therapy is not obtained.
	Tier 2	\$30 <u>copay</u> /prescription (retail) \$75 <u>copay</u> /prescription (mail)	30% <u>coinsurance</u>	
	Tier 3	\$50 <u>copay</u> /prescription (retail) \$125 <u>copay</u> /prescription (mail)	30% <u>coinsurance</u>	
	Tier 4	Not Covered	Not Covered	Not Applicable.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> /admit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
	Physician/surgeon fees	No charge	No charge	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	ER Physician: No charge ER Facility: \$80 <u>copay</u> /visit; <u>deductible</u> does not apply	ER Physician: No charge ER Facility: \$80 <u>copay</u> /visit; <u>deductible</u> does not apply	You may be <u>balance billed</u> from <u>Non-Plan Providers</u> .
	<u>Emergency medical transportation</u>	No charge	No charge	
	<u>Urgent care</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	You may be <u>balance billed</u> from <u>Non-Plan Providers</u> .

\*For more information about limitations and exceptions, see plan or policy document at [www.sierrahealthandlife.com](http://www.sierrahealthandlife.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
	Physician/surgeon fees	No charge	No charge	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you are pregnant</b>	Office visits	No charge	40% <u>coinsurance</u>	Routine prenatal care obtained from a <u>Plan Provider</u> is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab).
	Childbirth/delivery professional services	Surgical: No charge Anesthesia: No charge	Surgical: No charge Anesthesia: No charge	Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services; each service has a separate cost-share. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to a <u>Non-Plan</u> benefit of 30 visits. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Coverage is limited to a combined benefit of 60 days/visits. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Coverage is limited to a combined benefit of 60 days/visits. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.

\*For more information about limitations and exceptions, see plan or policy document at [www.sierrahealthandlife.com](http://www.sierrahealthandlife.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to 100 days. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	For purchase or rental at SHL's option. Purchases are limited to a single type of <u>DME</u> , including repair and replacement, every 3 years. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Your <u>plan</u> may include certain vision and/or dental services. Please refer to your <u>plan</u> documents for more information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Abortion (except for rape, incest, life at risk)</li> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>		
<ul style="list-style-type: none"> <li>• Bariatric surgery - One (1) per Lifetime</li> <li>• Chiropractic care - 20 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids - One (1) every three (3) years (including repair/replace)</li> <li>• Limited infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>

**Your Rights to Continue Coverage:**

There are agencies that can help if you want to continue your coverage after it ends. For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

\*For more information about limitations and exceptions, see plan or policy document at [www.sierrahealthandlife.com](http://www.sierrahealthandlife.com)

## **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Nevada Department of Insurance at 888-872-3234 or [www.doi.nv.gov](http://www.doi.nv.gov) or call 1-800-888-2264

## **Does this plan provide Minimum Essential Coverage?**

**Yes.** If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## **Does this plan meet Minimum Value Standards?**

**Yes.** If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## **Language Access Services:**

Spanish (Español): Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.

Tagalog (Tagalog): Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.

Chinese (中文): 若需要中文协助, 请拨打本文件内的客户服务电话。

Navajo (Dine): Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section*-----

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a baby**  
(9 months of in-network pre-natal care and a hospital delivery)

■ <b>The plan's overall deductible</b>	\$1,000.00
■ <b>Specialist copayment</b>	\$20.00
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other copayment</b>	\$0.00

**This EXAMPLE event includes services like:**

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700.00</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000.00
Copayments	\$100.00
Coinsurance	\$1,300.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Peg would pay is</b>	<b>\$2,400.00</b>

**Managing Joe's type 2 diabetes**  
(a year of routine in-network care of a well-controlled condition)

■ <b>The plan's overall deductible</b>	\$1,000.00
■ <b>Specialist copayment</b>	\$20.00
■ <b>Hospital (facility) copayment</b>	\$250.00
■ <b>Other copayment</b>	\$0.00

**This EXAMPLE event includes services like:**

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400.00</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$900.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Joe would pay is</b>	<b>\$900.00</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

■ <b>The plan's overall deductible</b>	\$1,000.00
■ <b>Specialist copayment</b>	\$20.00
■ <b>Hospital (facility) copayment</b>	\$250.00
■ <b>Other copayment</b>	\$10.00

**This EXAMPLE event includes services like:**

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900.00</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$200.00
Copayments	\$200.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$400.00</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.



We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

**Mail:** Civil Rights Coordinator, UnitedHealthcare Civil Rights Grievance, P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

**English:** You have the right to get help and information in your language at no cost. To request an interpreter, call the phone number listed within this Summary of Benefits and Coverage (SBC).

This letter is also available in other formats like large print. To request the document in another format, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

**Español (Spanish):** Usted tiene derecho a recibir ayuda e información en su idioma sin costo. Para pedir un intérprete, llame al número de teléfono que figura en este Resumen de Beneficios y Cobertura.

**Tagalog (Tagalog):** May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang libre. Upang humiling ng interpreter, tawagan ang numero ng telepono na nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

**繁體中文 (Chinese):**

您有權利以您的母語免費取得協助和資訊。若需申請口譯服務，請打本福利摘要 (SBC) 內含的電話號碼。

**한국어(Korean):** 귀하는 무료로 귀하의 언어를 통해 도움 및 정보를 받으실 권리가 있습니다. 통역사를 요청하시려면 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 전화번호로 전화하십시오.



**Tiếng Việt (Vietnamese):** Quý vị có quyền nhận hỗ trợ và thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu thông dịch viên, hãy gọi số điện thoại được liệt kê trong Tóm tắt quyền lợi và khoản đãi tho (Summary of Benefits and Coverage, SBC) này.

**አማርኛ (Amharic):-** የሰዎችዎ ወጪ አርዳታና ወረጃ የማግኘት መብት አለዎት። አስተርጓሚ ለመጠየቅ፣ በዚህ Summary of Benefits and Coverage/የጥቅምጥቅምችና የገደብ ማጠቃለያ (SBC) ውስጥ የተዘረዘረውን የቅጽደግ ቁጥር ይይዙ።

**ภาษาไทย (Thai):**

คุณมีสิทธิรับความช่วยเหลือและข้อมูลเป็นภาษาของตนเองได้โดยไม่เสียค่าใช้จ่ายใด ๆ

ถ้าต้องการล่ามแปล โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่ในเอกสาร

"สารบัญเกี่ยวกับผลประโยชน์และการคุ้มครอง (Summary of Benefits and Coverage หรือ SBC)" นี้

**日本語 (Japanese):**

ご希望の言語でサポートを受けたり、情報を入手したりすることができません。料金はかかりません。通訳をご希望の場合は、本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されている電話番号にお電話ください。

العربية (Arabic): لديك الحق في الحصول على المساعدة بلغة من لكافة. اطلب مترجم، اتصل برقم الهاتف المدرج في موجز المزايا والتغطية هنا (SBC).

**Русский (Russian):** Вы вправе получить помощь и информацию на родном языке без дополнительного оплаты. Чтобы заказать услуги переводчика, обращайтесь по номеру, указанному в данном Обзоре льгот и страхового покрытия (Summary of Benefits and Coverage, SBC)

**Français (French):** Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander l'aide d'un interprète, veuillez appeler le numéro de téléphone figurant dans ce Sommaire des prestations et de la couverture.

فارسی (Persian): شما حق دارید که راهنمایی و اطلاعات را به طور رایگان به زبان خودتان دریافت کنید. برای درخواست مترجم شفاهی، با شماره ای که در این خلاصه مزایا و پوشش (SBC) قید شده تماس بگیرید.

**Gagana fa'a Sāmoa (Samoa):** E iai lau aia tatau e maua ai le fesoasoani ma faamatalaga i lau gagana e aunoa ma se totogi. Ina ia talosaga mo se tagata faailiū, telefoni i le numera o lisi atu i totonu o lenei Ototoga o Faamanuiaga ma le Kavaina (SBC).

**Deutsch (German):** Sie haben das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Zur Anforderung eines Dolmetschers wenden Sie sich bitte telefonisch an die in dieser Zusammenfassung der Leistungen und des Versicherungsschutzes aufgeführte Rufnummer.

**Ilokano (Ilocano):** Addaan ka ti karbengan nga makaala iti tulong ken impormasion ayan iti lenguaheg nga awan bayad na. Tapno agkidaw iti tagapataros, awagan ti numero ti telepono nga nakalista iti uneg iti Dagup dagiti Benipisyo ken Panpakasakup (SBC).

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SIERRA HEALTH AND LIFE  
A UnitedHealthcare Company

## SHL Solutions PPO 10/1000/80%

### 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 40% of EME. Please reference the following pages for specific Coinsurance responsibilities.

**Calendar Year Out of Pocket Maximum:** Includes the CYD. Your Calendar Year 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 \$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.

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 Certificate 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 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* <sup>(1)</sup>	Non-Plan Provider Benefit* <sup>(1)</sup>
<p><b>Medical Office Visits and Consultations</b></p> <p><b>Non-Specialist Services</b></p> <ul style="list-style-type: none"> <li>• Convenient Care Facility</li> <li>• Physician Extender or Assistant</li> <li>• Physician</li> </ul> <p><b>Specialist Services</b></p> <p><b>Preventive Healthcare Services</b> - For a complete list of Preventive Services, including all FDA approved contraceptives, go to <a href="http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/">http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/</a>.</p> <p>If you have a question about whether or not a service is “Preventive”, please contact the HPN Member Services Department (1-800-777-1840).</p>	<p>Insured pays \$10 per visit.</p> <p>Insured pays \$10 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>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p>
<p><b>Non-preventive Routine Lab and X-ray Services</b> 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.</p> <ul style="list-style-type: none"> <li>• Lab</li> <li>• X-Ray</li> </ul>	<p>Insured pays \$0 per visit.</p> <p>Insured pays \$10 per visit.</p>	<p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p>
<p><b>Telemedicine Services</b> (Only available through select contracted Providers.)</p>	<p>Insured pays \$10 per visit.</p>	<p>After CYD, Insured pays 40% of EME.</p>
<p><b>Urgent Care Facility</b></p>	<p>Insured pays \$40 per visit.</p>	<p>Insured pays \$40 per visit</p>

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

## *Benefit Schedule*

Covered Services and Limitations	Plan Provider Benefit* <sup>(1)</sup>	Non-Plan Provider Benefit* <sup>(1)</sup>
<p><b>Emergency Services</b></p> <ul style="list-style-type: none"> <li>• Emergency Room Facility (includes Physician Services)</li>   <li>• Hospital Admission - Emergency Stabilization (includes Physician Services) Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</li> </ul> <p>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.</p>	<p>Insured pays \$80 per visit; waived if admitted.</p> <p>After CYD, Insured pays 20% of EME.</p>	<p>Insured pays \$80 per visit; waived if admitted.</p> <p>After CYD, Insured pays 20% of EME.</p>
<p><b>Ambulance Services</b></p> <ul style="list-style-type: none"> <li>• Emergency Transport</li>   <li>• Non-Emergency - SHL Arranged Transfers</li> </ul>	<p>Insured pays \$0.</p> <p>Insured pays \$0.</p>	<p>Insured pays \$0.</p> <p>Insured pays \$0.</p>
<p><b>Inpatient Hospital Facility Services</b> Elective and Emergency Post-Stabilization Admissions</p>	<p>After CYD, Insured pays 20% of EME.</p>	<p>After CYD, Insured pays 40% of EME.</p>
<p><b>Outpatient Hospital Facility Services</b></p>	<p>Insured pays \$250 per admit.</p>	<p>After CYD, Insured pays 40% of EME.</p>
<p><b>Ambulatory Surgical Facility Services</b></p>	<p>Insured pays \$250 per admit.</p>	<p>After CYD, Insured pays 40% of EME.</p>
<p><b>Anesthesia Services</b></p>	<p>Insured pays \$0.</p>	<p>Insured pays \$0.</p>

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

# Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit* <sup>(1)</sup>	Non-Plan Provider Benefit* <sup>(1)</sup>
<p><b>Physician Surgical Services - Inpatient and Outpatient</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Facility</li> <li>• Outpatient Hospital Facility</li> <li>• Ambulatory Surgical Facility</li> <li>• Physician's Office</li> </ul> <p>Non-Specialist Physician (Includes all physician services related to the surgical procedure)</p> <p>Specialist (Includes all physician services related to the surgical procedure)</p>	<p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p>	<p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p> <p>Insured pays 0% of EME.</p>
<p><b>Gastric Restrictive Surgery Services</b> SHL provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Insured.</p> <ul style="list-style-type: none"> <li>• Physician Surgical Services</li> <li>• Physician's Office Visit</li> </ul>	<p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p> <p>Insured pays \$20 per visit.</p>	<p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 40% of EME.</p>
<p><b>Organ and Tissue Transplant Surgical Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Facility</li> <li>• Physician Surgical Services - Inpatient Hospital Facility</li> <li>• 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.</li> <li>• Procurement The maximum benefit per Insured per Transplant Benefit Period for Procurement of the organ/tissue is \$15,000 of EME.</li> <li>• Retransplantation Services Benefits are limited to one (1) Medically Necessary Retransplantation per Insured per type of transplant.</li> </ul>	<p>After CYD, Insured pays 20% of EME.</p> <p>After CYD, Insured pays 20% of EME.</p> <p>Insured pays \$0 per surgery. Subject to maximum benefit.</p> <p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 50% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 50% of EME. Subject to maximum benefit.</p>

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

## Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit* <sup>(1)</sup>	Non-Plan Provider Benefit* <sup>(1)</sup>
<p><b>Post-Cataract Surgical Services</b></p> <ul style="list-style-type: none"> <li>• Frames and Lenses</li> <li>• Contact Lenses</li> </ul> <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>Insured pays \$10 per pair of glasses. Subject to maximum benefit.</p> <p>Insured pays \$10 per set of contact lenses. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p>
<p><b>Home Healthcare Services (does not include Specialty Prescription Drugs)</b> Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drug.</p> <p>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>	<p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% 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 Benefits are 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"> <li>◦ Inpatient</li> <li>◦ Outpatient</li> </ul> </li> <li>• Bereavement Services Benefits are 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.</li> </ul>	<p>After CYD, Insured pays 20% of EME.</p> <p>After CYD, Insured pays 20% of EME.</p> <p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p>

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



## ***Benefit Schedule***

<b>Covered Services and Limitations</b>	<b>Plan Provider Benefit*<sup>(1)</sup></b>	<b>Non-Plan Provider Benefit*<sup>(1)</sup></b>
<p><b>Skilled Nursing Facility</b> Subject to a combined Plan and Non-Plan Provider maximum benefit of one hundred (100) days per Insured per Calendar Year.</p>	<p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p>
<p><b>Manual Manipulation</b> Applies to Medical-Physician Services and Chiropractic office visit.</p> <p>Limited to a combined Plan and Non-Plan Provider maximum benefit of twenty (20) visits per Insured per Calendar Year.</p>	<p>Insured pays \$20 per visit. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p>
<p><b>Short-Term Rehabilitation and Habilitation Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Facility</li>   <li>• Outpatient</li> </ul> <p>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.</p>	<p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p> <p>Insured pays \$20 per visit. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p>
<p><b>Durable Medical Equipment</b> 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.</p>	<p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p>
<p><b>Genetic Disease Testing Services</b></p> <ul style="list-style-type: none"> <li>• Office Visit</li>   <li>• Lab Includes Inpatient, Outpatient and independent Laboratory Services.</li> </ul>	<p>After CYD, Insured pays 20% of EME.</p> <p>After CYD, Insured pays 20% of EME.</p>	<p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p>

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

## *Benefit Schedule*

Covered Services and Limitations	Plan Provider Benefit* <sup>(1)</sup>	Non-Plan Provider Benefit* <sup>(1)</sup>
<p><b>Infertility Office Visit Evaluation</b> Please refer to applicable surgical procedure Copayment/Cost-share amount herein for any surgical infertility procedures performed.</p>	Insured pays \$20 per visit.	After CYD, Insured pays 40% of EME.
<p><b>Medical Supplies</b> (Obtained outside of a medical office visit)</p>	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
<p><b>Other Diagnostic and Therapeutic Services</b> 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.</p> <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 including: CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; and complex neurological or psychiatric testing or therapeutic services.</li> <li>• Positron Emission Tomography (PET) scans</li> </ul>	<p>After CYD, Insured pays 20% of EME.</p> <p>After CYD, Insured pays 20% of EME.</p> <p>After CYD, Insured pays 20% of EME.</p> <p>After CYD, Insured pays 20% of EME.</p> <p>After CYD, Insured pays 20% of EME.</p> <p>Insured pays \$250 per visit</p> <p>Insured pays \$250 per visit</p>	<p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p>

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

# Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit* <sup>(1)</sup>	Non-Plan Provider Benefit* <sup>(1)</sup>
<p><b>Prosthetic Devices</b> Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.</p>	<p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p>
<p><b>Orthotic Devices</b> Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.</p>	<p>After CYD, Insured pays 20% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p>
<p><b>Self-Management and Treatment of Diabetes</b></p> <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> <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>Insured pays \$20 per visit.</p> <p>Insured pays \$5 per therapeutic supply.</p> <p>Insured pays \$10 per therapeutic supply.</p> <p>Insured pays \$20 per device.</p> <p>Insured pays \$100 per device.</p>	<p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p>
<p><b>Special Food Products and Enteral Formulas</b> 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>	<p>Insured pays \$0. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 40% of EME. Subject to maximum benefit.</p>
<p><b>Temporomandibular Joint Treatment</b></p>	<p>After CYD, Insured pays 50% of EME.</p>	<p>After CYD, Insured pays 50% of EME.</p>
<p><b>Mental Health and Severe Mental Illness Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Facility</li> <li>• Outpatient Treatment</li> </ul>	<p>After CYD, Insured pays 20% of EME.</p> <p>Insured pays \$10 per visit.</p>	<p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p>
<p><b>Substance Abuse Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Facility</li> <li>• Outpatient Treatment</li> </ul>	<p>After CYD, Insured pays 20% of EME.</p> <p>Insured pays \$10 per visit.</p>	<p>After CYD, Insured pays 40% of EME.</p> <p>After CYD, Insured pays 40% of EME.</p>

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

## *Benefit Schedule*

Covered Services and Limitations	Plan Provider Benefit* <sup>(1)</sup>	Non-Plan Provider Benefit* <sup>(1)</sup>
<b>Hearing Aids</b> 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 40% of EME. Subject to maximum benefit.
<b>Applied Behavioral Analysis (ABA) for the treatment of Autism for Insureds up to age 22</b> 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.	Insured pays \$20 per visit. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.

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.

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.

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



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## 3-Tier Outpatient Prescription Drug Rider to the SHL Group Certificate of Coverage

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

### Plan Retail Prescription Drug Benefits

**Tier I: Insured pays**  
**\$7 Copayment per Designated Plan Pharmacy Therapeutic Supply**

**Tier II: Insured pays**  
**\$30 Copayment per Designated Plan Pharmacy Therapeutic Supply**

**Tier III: Insured pays**  
**\$50 Copayment per Designated Plan Pharmacy Therapeutic Supply**

### Plan Mail Order Prescription Drug Benefit

**Insured pays:**  
**2.5 times the applicable Tier Copayment per Plan Mail Order Pharmacy Therapeutic Supply**

**Non-Plan Pharmacy:**  
**SHL pays 70% of Eligible Medical Expense (“EME”) for Covered Drugs less the Copayment per Therapeutic Supply**

This Prescription Drug Benefit Rider is issued in consideration of: (a) Group’s 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 Certificate of Coverage (COC) 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,

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.

## **PRESCRIPTION DRUG RIDER**

limitations and exclusions contained in your SHL COC and herein.

### **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 Tier I, II or III benefit level. If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, SHL may direct you to a Designated Plan Pharmacy with whom SHL have 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 low cost option for Covered Drugs.
- (b). **Tier II** – is the midrange cost option for Covered Drugs.
- (c). **Tier III** – is the high cost option for Covered Drugs.

#### **(d). Mandatory Generic benefit provision applies when:**

- a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The Insured will pay the Covered Copayment 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.

- (e). When a Drug is dispensed through the Mail Order Plan Pharmacy, the applicable Tier I, Tier II or Tier III Mail Order Plan Pharmacy 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 COC 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 or III 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 Copayment.

**1.3 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 Tier I, Tier II or Tier III Mail Order benefit.
- (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.
- 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 individual'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 individual.
- 2.4 Benefits are not payable if you are directed to a Designated Plan Pharmacy and you choose not to obtain your Covered Drug from that Designated Plan Pharmacy.
- 2.5 If SHL determines that you may be using Prescription Drugs in a harmful or abusive

manner, or with harmful frequency, your selection of Plan Pharmacies may be limited. If this happens, SHL may require you to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if you use the assigned single Plan Pharmacy. If you do not make a selection within thirty-one (31) days of the date you are notified, then SHL will select a single Plan Pharmacy for you.

**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.



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- 3.6** Medications used for cosmetic purposes.
- 3.7** Prescription Drug Products when prescribed to treat infertility
- 3.8** Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
- 3.9** Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs.
- 3.10** Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the SHL COC.
- 3.11** Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members.
- 3.12** Prescription Drugs dispensed prior to the Insured's Effective Date of coverage or after Insured's termination date of coverage under the Plan.
- 3.13** 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.
- 3.14** General vitamins, except the following which require a prescription order or refill;
- prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- 3.15** 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.
- 3.16** Any Prescription Drug for which the actual charge to the Insured is less than the amount due under this Rider.
- 3.17** 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.
- 3.18** Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- 3.19** Medical supplies unless listed on the PDL or Prior Authorized by SHL.
- 3.20** Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- 3.21** Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- 3.22** 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).
- 3.23** Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.

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- 3.24** 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;
- 3.25** 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.
- 3.26** Prescription Drugs dispensed outside the United States, except as required for emergency treatment.
- 3.27** Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission.
- 3.28** Covered Drugs that are not FDA approved for a specific diagnosis.
- 3.29** 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 3.16 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**” 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 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

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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 and Tier III 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 Copayment or the applicable Coinsurance amount and may be less than but shall not exceed a 30-day retail supply or 90- day mail order supply.

### **Coverage Policies and Guidelines**

SHL's 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.

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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.

SHL may periodically change the placement of a Prescription Drug among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

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

Questions about SHL's PDL should be directed to the Member Services Department at (702) 242-7300 or 1-800-777-1840 or the PDL and the Pharmacy Reimbursement Claim Form is available at <http://www.uhnevada.com/> which leads to SHL's portal [www.myshlonline.com](http://www.myshlonline.com).