SHL Solutions PPO

Platinum 10/100/90%

Attachment A Benefit Schedule

Lifetime Maximum Benefit for all Covered Services: Unlimited

Calendar Year Deductible ("CYD"): Your CYD is $100 of EME per Insured and $200 of EME per Family for Plan Provider Services and $200 of EME per Insured and $400 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 (most copayments 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 10% 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 Out of Pocket expenses are limited to a maximum of $3,000 of EME per Insured per Calendar Year and $6,000 of EME per Family when using Plan Providers and $6,000 of EME per Insured per Calendar Year and $12,000 of EME per Family when using Non-Plan Providers. The Calendar Year Out of Pocket Maximum amounts include the applicable 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 Provides; 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 Benefits [1]	Non-Plan Provider Benefits [1]
Medical Office Visits and Consultations in a Medical Office Setting		After CYD, SHL pays 60% of EME.
• **Non-Specialist Services** Convenient Care Facility	Insured pays $10 per visit.	
Physician Extender or Assistant	Insured pays $10 per visit.	
Physician	Insured pays $10 per visit.	
• **Specialist Services**	Insured pays $10 per visit.	
Preventive Healthcare Services - *Services include various recommended exams, immunizations, diagnostic tests and screenings. Refer to the SHL Preventive Guidelines on the SHL website www.sierrahealthandlife.com located under the "Current Customers" tab or contact the Member Services Department (702-242-7700) for the complete list of covered Adult and Pediatric Preventive Services and Immunizations. These guidelines are updated in accordance with the Federal Government standards.*	Insured pays $0 per visit.	
Routine Lab and X-ray services provided and billed by the Physician's office. (*Cost-share is in addition to the Physician office visit Cost-share and applies to services rendered in a Physician's office.)* • Lab	Insured pays $5 per visit.	
• X-Ray	Insured pays $10 per visit.	
Telemedicine Services *(Only available through select Providers.)*	Insured pays $10 per visit	After CYD, SHL pays 60% of EME.
Laboratory Services - Outpatient *Performed at an independent facility.*	Insured pays $5 per visit.	After CYD, SHL pays 60% of EME.
Routine Radiological and Non-Radiological Diagnostic Imaging Services *Performed at a Free-Standing Diagnostic Center.*	Insured pays $10 per visit.	After CYD, SHL pays 60% of EME.

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits [1]	Non-Plan Provider Benefits [1]
Emergency Services		
• Urgent Care Facility	Insured pays $35 per visit.	After CYD, SHL pays 60% of EME.
• Emergency Room Facility and Physician's Services	Insured pays $150 per visit; waived if admitted.	Insured pays $150 per visit; waived if admitted.
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 90% of EME.
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.		
Ambulance Services		
• Emergency Transport	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.
• Non-Emergency – SHL Arranged Transfers	Insured pays $0.	Insured pays $0.
Inpatient Hospital Facility Services *Elective and Emergency Post-Stabilization Admissions*	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.
Outpatient Hospital Facility Services	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.
Ambulatory Surgical Facility Services	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.
Anesthesia Services	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.
Physician Surgical Services – Inpatient and Outpatient • Inpatient Facility • Ambulatory Surgical and Outpatient Hospital Facility • Physician's Office (Includes all physician services related to the surgical procedure)	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits [1]	Non-Plan Provider Benefits [1]
Gastric Restrictive Surgery Services *SHL provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Insured.*		After CYD, SHL pays 60% of EME. Subject to maximum benefit.
• Physician Surgical Services	After CYD, SHL pays 90% of EME. Subject to maximum benefit.	
• Physicians Office Visit	Insured pays $10 per visit.	
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.
• Physician Surgical Services – Inpatient Hospital Facility	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.
• 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.*	Insured pays $0. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.
• Procurement *Benefits for procurement procedures and/or services are limited to those deemed by SHL to be Medically Necessary and appropriate for an approved Organ Transplant in a single Transplant Benefit Period.*	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.
• Retransplantation Services *Benefits are limited to one Medically Necessary Retranplantation per Insured per type of transplant.*	After CYD, SHL pays 50% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
Post-Cataract Surgical Services		After CYD, SHL pays 60% of EME. Subject to maximum benefit.
• Frames and Lenses	$10 per pair of glasses. Subject to maximum benefit.	
• Contact Lenses *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.*	$10 per set of contact lenses. Subject to maximum benefit.	

Covered Services and Limitations	Plan Provider Benefits [1]	Non-Plan Provider Benefits [1]
Home Healthcare Services (*does not include Specialty Prescription Drugs)* *Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drugs.* *Home Healthcare Services are limited to a combined Plan and Non-Plan Provider maximum benefit of sixty (60) visits per Insured per Calendar Year. A period of 4 hours or less of Home Healthcare services equals one visit.*	Insured pays $10 per visit. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.
Hospice Care Services • 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.* • 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.*	After CYD, SHL pays 90% of EME. Respite and Bereavement Services are subject to applicable maximum benefits.	After CYD, SHL pays 60% of EME. Respite and Bereavement Services are subject to applicable maximum benefits.
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, SHL pays 90% of EME. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.
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.*	Insured pays $10 per visit. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.
Short-Term Rehabilitation and Habilitative Services • Inpatient Hospital Facility • Outpatient *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.*	After CYD, SHL pays 90% of EME. Subject to maximum benefit. Insured pays $10 per visit. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits [1]	Non-Plan Provider Benefits [1]
Genetic Disease Testing Services • Office Visit • Lab *Includes Inpatient, Outpatient and independent Laboratory Services.*	Insured pays $10 per visit. Insured pays $10 per test.	After CYD, SHL pays 60% of EME.
Infertility Office Visit Evaluation *Please refer to applicable surgical procedure cost-share herein for any surgical infertility procedures performed.*	Insured pays $10 per visit.	After CYD, SHL pays 60% of EME.
Medical Supplies	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 60% of EME.
Other Diagnostic and Therapeutic Services *Cost-share amounts are in addition to the Physician office visit cost-share and applies to services rendered in a Physician's office or at an independent facility.* • 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 such as Positron Emission Tomography (PET) scans, CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.	Insured pays $10 per visit. Insured pays $10 per visit. Insured pays $10 per visit. Insured pays $10 per day. Insured pays $10 per day. After CYD, Insured pays $100 per test or procedure.	After CYD, SHL pays 60% of EME.
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, SHL pays 90% of EME. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.
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, SHL pays 90% of EME. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.

Covered Services and Limitations	Plan Provider Benefits [1]	Non-Plan Provider Benefits [1]
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, SHL pays 90% of EME. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.
Self-Management and Treatment of Diabetes • Education and Training • Supplies (except for Insulin Pump Supplies) Insulin Pump Supplies • Equipment (except for Insulin Pump) Insulin Pump *Refer to the Outpatient Prescription Drug Rider for the benefits applicable to the diabetic supplies and equipment obtained at a retail Plan Pharmacy.*	 Insured pays $10 per visit. Insured pays $5 per therapeutic supply. Insured pays $10 per therapeutic supply. Insured pays $20 per device. Insured pays $100 per device.	After CYD, SHL pays 60% of EME.
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.*	Insured pays $0. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.
Temporomandibular Joint Treatment	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 60% of EME.
Mental Health and Severe Mental Illness Services • Inpatient Hospital Facility • Outpatient Treatment	 After CYD, SHL pays 90% of EME. Insured pays $10 per visit.	After CYD, SHL pays 60% of EME.
Substance Abuse Services • Inpatient Hospital Facility • Outpatient Treatment	 After CYD, SHL pays 90% of EME. Insured pays $10 per visit.	After CYD, SHL pays 60% of EME.

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefits [1]	Non-Plan Provider Benefits [1]
Hearing Aids *Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.*	After CYD, SHL pays 90% of EME. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.
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.*	Insured pays $10 per visit. Subject to maximum benefit.	After CYD, SHL pays 60% of EME. Subject to maximum benefit.
Pediatric Vision Services for Insureds up to age 19		SHL pays 50% of EME. Subject to maximum benefit.
Vision Examination *Limited to a combined Plan and Non-Plan Provider maximum benefit of one (1) vision examination to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be covered once every calendar year.*	Insured pays $0 per visit. Subject to maximum benefit.	
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 be Medically Necessary. Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal and lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglasses.*	Insured pays $0 per visit. Subject to maximum benefit.	
Frames *Limited to a combined Plan and Non-Plan Provider maximum benefit of one (1) pair of frames, from the approved Formulary frame series, covered once every calendar year. 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 Provider.*	Insured pays $0 per visit. Subject to maximum benefit.	
Contact Lenses *Limited to a combined Plan and Non-Plan Provider maximum benefit 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; discounts may be available through the Provider.*	Insured pays $0 per visit. Subject to maximum benefit.	
Low Vision Exam *One comprehensive evaluation every five (5) years.*	Insured pays $0 per visit. Subject to maximum benefit.	

Covered Services and Limitations	Plan Provider Benefits [1]	Non-Plan Provider Benefits [1]
Pediatric Vision Services for Insureds up to age 19 (continued) **Optional Lenses and Treatments** • 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 Member at a discount. Please consult with your Provider.)*	Insured pays $0.	SHL pays 50% of EME. Subject to maximum benefit.
Pediatric Dental Services for Insureds up to age 19		
Diagnostic and Preventive • Oral exam every six (6) months • Periodic X-rays • Diagnostic procedures • Prophylaxis every six (6) months • Topical fluoride treatment every six (6) months • Sealants once per permanent molar • Space maintenance therapy	Insured pays $0 per visit. Subject to maximum benefit.	After CYD, SHL pays 100% of EME.
Restorative • Amalgam or composite fillings as needed • Crowns as needed • Sedative fillings	After CYD, SHL pays 80% of EME.	After CYD, SHL pays 80% of EME.
Endodontics • Root canal therapy • Pulpal therapy	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
Periodontics *Usually limited to Insureds at least fourteen (14) years of age.*	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
Prosthodontics • Partial and complete dentures *Limited to one unit once every sixty (60) months.*	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
Orthodontics *Coverage provided for Medically Necessary Services only.*	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
Oral Surgery (includes Anesthesia) • Extractions	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
Emergency Dental Services • Services or procedures necessary to control bleeding, relieve significant pain and/or eliminate acute infection • Services or procedures required to prevent pulpal death and/or imminent loss of teeth	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.

Benefit Schedule

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.

(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.