SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

SHL Solutions PPO 10/1000/20%

Attachment A Benefit Schedule

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: 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.

Once the Individual Out of Pocket Maximum is met, benefits for that Individual are payable at 100% of EME for the remainder of the Calendar Year. Once the Family Out of Pocket Maximum is met by two or more enrolled family members, benefits for the entire family are payable at 100% of EME for the remainder of the Calendar Year. 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 of Coverage (COC) to understand how EME payments to Providers are determined. Plan Providers have agreed to accept SHL's Reimbursement Schedule as payment in full for Covered Services, less any applicable Deductibles, Coinsurance and/or Copayments that are payable by you.

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.

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

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Medical Office Visits/Consultations and Visits in an Outpatient Setting (including Telemedicine Services) **Non-Specialist Services**		
• Convenient Care Facility	Insured pays $10 per visit.	After CYD, Insured pays 40% of EME.
• Physician Extender or Assistant	Insured pays $10 per visit.	After CYD, Insured pays 40% of EME.
• Physician	Insured pays $10 per visit.	After CYD, Insured pays 40% of EME.
Specialist Services	Insured pays $20 per visit.	After CYD, Insured pays 40% of EME.
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).	Insured pays $0 per visit.	After CYD, Insured pays 40% of EME.
Non-preventive Routine Lab and X-ray Services The Copayment/Cost-share is in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office or at an independent facility.		
• Lab	Insured pays $0 per visit	After CYD, Insured pays 40% of EME.
• X-Ray	Insured pays $10 per visit.	After CYD, Insured pays 40% of EME.
Virtual Visits (Available through NowClinic or select contracted Providers)	Insured pays $0 per visit.	After CYD, Insured pays 40% of EME.
Urgent Care Facility	Insured pays $40 per visit.	Insured pays $40 per visit.
Emergency Services		
• Emergency Room Facility (includes Physician Services)	Insured pays $80 per visit; waived if admitted.	Insured pays $80 per visit; waived if admitted.
• Hospital Admission - Emergency Stabilization (includes Physician Services) Applies until patient is stabilized and safe for transfer as determined by the attending Physician.	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 20% of EME.
The maximum benefit for Medically Necessary but Non-Emergency Services received in an Emergency Room is 50% of EME. The Insured is responsible for all amounts exceeding any applicable maximum benefit and amounts exceeding the Plan's EME payment to Non-Plan Providers. As a result, the Insured will be responsible for the difference between the amount billed by the Non-Plan Provider and the reimbursement amount determined by SHL, unless prohibited by law. Such amounts do not accumulate to the Calendar Year Out of Pocket Maximum.		

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

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Ambulance Services		
• Emergency Transport	Insured pays $0.	Insured pays $0.
• Non-Emergency - SHL Arranged Transfers	Insured pays $0.	Insured pays $0.
Inpatient Hospital Facility Services (Elective and Emergency Post-Stabilization Admissions)	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
Outpatient Hospital Facility Services	Insured pays $250 per admit.	After CYD, Insured pays 40% of EME.
Ambulatory Surgical Facility Services	Insured pays $250 per admit.	After CYD, Insured pays 40% of EME.
Anesthesia Services	Insured pays $0.	Insured pays $0.
Physician Surgical Services - Inpatient and Outpatient		
• Inpatient Hospital Facility	Insured pays 0% of EME.	Insured pays 0% of EME.
• Outpatient Hospital Facility	Insured pays 0% of EME.	Insured pays 0% of EME.
• Ambulatory Surgical Facility	Insured pays 0% of EME.	Insured pays 0% of EME.
• Physician's Office		
Non-Specialist Physician (Includes all physician services related to the surgical procedure)	Insured pays 0% of EME.	Insured pays 0% of EME.
Specialist (Includes all physician services related to the surgical procedure)	Insured pays 0% of EME.	Insured pays 0% of EME.
Gastric Restrictive Surgery Services SHL provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Insured.		
• Physician Surgical Services	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
• Physician's Office Visit	Insured pays $20 per visit.	After CYD, Insured pays 40% of EME.

**Refer to the Limitations Section of the COC 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		
• Inpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• Physician Surgical Services - Inpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% 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 per surgery. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
Post-Cataract Surgical Services		
• Frames and Lenses	Insured pays $10 per pair of glasses. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
• Contact Lenses	Insured pays $10 per set of contact lenses. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
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.		
Home Healthcare Services (does not include Specialty Prescription Drugs) The Tier II Non-Plan Provider maximum benefit for Home Healthcare Services is limited to thirty (30) visits per Insured per Calendar Year. A period of four (4) hours or less of Home Healthcare services equals one visit.	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
Hospice Care Services		
• Inpatient Hospice Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• Outpatient Hospice Services	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• 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.		
◦ Inpatient	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
◦ Outpatient	After CYD, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
• 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, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.

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

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
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 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
Residential Treatment Center 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 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 40% 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 $20 per visit. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
Short-Term Habilitation Services (including but not limited to Physical, Speech and Occupational Therapy) • Inpatient Hospital Facility • Outpatient All Inpatient and Outpatient Short-Term Habilitation 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, Insured pays 20% of EME. Subject to maximum benefit. Insured pays $20 per visit. Subject to maximum benefit.	 After CYD, Insured pays 40% of EME. Subject to maximum benefit. After CYD, Insured pays 40% of EME. Subject to maximum benefit.
Short-Term Rehabilitation Services (including but not limited to Physical, Speech and Occupational Therapy) • Inpatient Hospital Facility • Outpatient All Inpatient and Outpatient Short-Term Rehabilitation 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, Insured pays 20% of EME. Subject to maximum benefit. Insured pays $20 per visit. Subject to maximum benefit.	 After CYD, Insured pays 40% of EME. Subject to maximum benefit. After CYD, Insured pays 40% of EME. Subject to maximum benefit.
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 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
Genetic Disease Testing Services • Office Visit • Lab Includes Inpatient, Outpatient and independent Laboratory Services.	 After CYD, Insured pays 20% of EME. After CYD, Insured pays 20% of EME.	 After CYD, Insured pays 40% of EME. After CYD, Insured pays 40% of EME.

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

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
Infertility Office Visit Evaluation Please refer to applicable surgical procedure Copayment/Cost-share and/or Coinsurance amount herein for any surgical infertility procedures performed.	Insured pays $20 per visit.	After CYD, Insured pays 40% of EME.
Medical Supplies (Obtained outside of a medical office visit)	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
Other Diagnostic and Therapeutic Services The 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.		
• Anti-cancer drug therapy, non-cancer related drug therapy or other Medically Necessary therapeutic drug services.	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• Dialysis	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• Therapeutic Radiology	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• Complex Allergy Diagnostic Services (including RAST) and Serum Injections	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• Otologic Evaluations	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• 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.	Insured pays $250 per visit	After CYD, Insured pays 40% of EME.
• Positron Emission Tomography (PET) scans	Insured pays $250 per visit	After CYD, Insured pays 40% 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 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.

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

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(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, Insured pays 20% of EME. Subject to maximum benefit.	After CYD, Insured pays 40% of EME. Subject to maximum benefit.
Self-Management and Treatment of Diabetes		
• Education and Training	Insured pays $20 per visit.	After CYD, Insured pays 40% of EME.
• Supplies (except for Insulin Pump Supplies)	Insured pays $5 per therapeutic supply.	After CYD, Insured pays 40% of EME.
Insulin Pump Supplies	Insured pays $10 per therapeutic supply.	After CYD, Insured pays 40% of EME.
• Equipment (except for Insulin Pump)	Insured pays $20 per device.	After CYD, Insured pays 40% of EME.
Insulin Pump	Insured pays $100 per device.	After CYD, Insured pays 40% 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, Insured pays 40% of EME. Subject to maximum benefit.
Temporomandibular Joint Treatment	After CYD, Insured pays 50% of EME.	After CYD, Insured pays 50% of EME.
Mental Health and Severe Mental Illness Services		
• Inpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• Outpatient Treatment (Including Telemedicine Services)	Insured pays $10 per visit.	After CYD, Insured pays 40% of EME.
Substance-Related and Addictive Disorder Services		
• Inpatient Hospital Facility	After CYD, Insured pays 20% of EME.	After CYD, Insured pays 40% of EME.
• Outpatient Treatment (Including Telemedicine Services)	Insured pays $10 per visit.	After CYD, Insured pays 40% of EME.
Hearing Aids Purchases are limited to a single purchase of a type of Hearing Aid per hearing impaired ear, 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.

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

Benefit Schedule

Covered Services and Limitations	Plan Provider Benefit*(1)	Non-Plan Provider Benefit*(1)
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 one thousand five hundred (1,500) 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.

The Insured is responsible for any/all amounts exceeding any stated maximum benefit amounts and/or any/all amounts exceeding the Plan's payment to Non-Plan Providers under this Plan. Further, such amounts do not accumulate to the calculation of the Calendar Year Out of Pocket Maximum.

(1) If Medically Necessary Covered Services, with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness, Substance-Related and Addictive Disorder 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.*

SIERRA HEALTH AND LIFE
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3-Tier Outpatient Prescription Drug Rider to the SHL Group Certificate of Coverage

Plan Retail Prescription Drug Benefits		
Prescription Drug Tier	**Plan Provider Benefit**	**Non-Plan Provider Benefit**
Tier I	Insured pays $7 Copayment per Designated Plan Pharmacy Therapeutic Supply.	Insured pays 30% of EME for Covered Drugs less the Copayment per Therapeutic Supply.
Tier II	Insured pays $30 Copayment per Designated Plan Pharmacy Therapeutic Supply.	Insured pays 30% of EME for Covered Drugs less the Copayment per Therapeutic Supply.
Tier III	Insured pays $50 Copayment per Designated Plan Pharmacy Therapeutic Supply.	Insured pays 30% of EME for Covered Drugs less the Copayment per Therapeutic Supply.
Prescription Drug Products from a Mail Order Network Pharmacy or 90 Day Retail Plan Network Pharmacy Insured pays up to 2.5 times the applicable Tier Cost-share per Pharmacy Therapeutic Supply.		
Please refer to the SHL Prescription Drug List (PDL) for the listing of Covered Drugs and for any Covered Drugs requiring Prior Authorization and/or Step Therapy as outlined in the SHL COC. NOTE: Prescription Drugs for which Prior Authorization is required but not obtained are excluded from coverage.		

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, 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 COC and herein.

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.

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. 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 or call 1-800-888-2264 to request a copy.

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

*For more information about limitations and exceptions, see the plan or policy document at www.sierrahealthandlife.com

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 copay/visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$20 copay/visit; deductible does not apply	40% coinsurance	
	Preventive care/ screening/ immunization	No charge	40% coinsurance	Deductible applies when services are obtained from Non-Plan Providers. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $10 copay/service; deductible does not apply Lab: No charge	40% coinsurance	Insured pays a 50% benefit reduction if prior authorization is not obtained.
	Imaging (CT/PET scans, MRIs)	PET Scan: $250 copay/service; deductible does not apply MRI: $250 copay/service; deductible does not apply CT: $250 copay/service; deductible does not apply	40% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sierrahealthandlife.com	Tier 1	$7 copay/prescription (retail) $17.50 copay/prescription (mail)	30% coinsurance	You have a 3-Tier pharmacy plan. Covers up to a 30-day retail supply or up to a 90-day mail order supply. Insured pays for cost of services if prior authorization or step therapy is not obtained.
	Tier 2	$30 copay/prescription (retail) $75 copay/prescription (mail)	30% coinsurance	
	Tier 3	$50 copay/prescription (retail) $125 copay/prescription (mail)	30% coinsurance	
	Tier 4	Not Covered	Not Covered	Not Applicable.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/admit; deductible does not apply	40% coinsurance	Insured pays a 50% benefit reduction if prior authorization is not obtained.
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	Emergency room care	ER Physician: No charge ER Facility: $80 copay/visit; deductible does not apply	ER Physician: No charge ER Facility: $80 copay/visit; deductible does not apply	You may be balance billed from Non-Plan Providers.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$40 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	You may be balance billed from Non-Plan Providers.

*For more information about limitations and exceptions, see the plan or policy document at 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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Insured pays a 50% benefit reduction if prior authorization is not obtained.
	Physician/surgeon fees	No charge	No charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit; deductible does not apply	40% coinsurance	Insured pays a 50% benefit reduction if prior authorization is not obtained.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No charge	40% coinsurance	Routine prenatal care obtained from a Plan Provider 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 prior authorization is not obtained.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Insured pays a 50% benefit reduction if prior authorization is not obtained.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to a Non-Plan benefit of 30 visits. Insured pays a 50% benefit reduction if prior authorization is not obtained.
	Rehabilitation services	$20 copay/visit; deductible does not apply	40% coinsurance	Coverage is limited to a combined Inpatient and Outpatient Plan/Non-Plan benefit of 120 days/visits. Insured pays a 50% benefit reduction if prior authorization is not obtained.
	Habilitation services	$20 copay/visit; deductible does not apply	40% coinsurance	Coverage is limited to a combined Inpatient and Outpatient Plan/Non-Plan benefit of 120 days/visits. Insured pays a 50% benefit reduction if prior authorization is not obtained.

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% coinsurance	40% coinsurance	Coverage is limited to 100 days. Insured pays a 50% benefit reduction if prior authorization is not obtained.
	Durable medical equipment	20% coinsurance	40% coinsurance	For purchase or rental at SHL's option. Purchases are limited to a single type of DME, including repair and replacement, every 3 years. Insured pays a 50% benefit reduction if prior authorization is not obtained.
	Hospice services	20% coinsurance	40% coinsurance	Insured pays a 50% benefit reduction if prior authorization is not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Your plan may include certain vision and/or dental services. Please refer to your plan 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:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except for rape, incest, life at risk)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - One (1) per Lifetime
- Chiropractic care - 20 visits per calendar year
- Hearing aids - One (1) every three (3) years (including repair/replace)
- Limited infertility treatment
- Private-duty nursing

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.

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 or call 1-800-318-2596.

*For more information about limitations and exceptions, see the plan or policy document at 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 on how 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 888-872-3234or www.doi.nv.gov or call 1-800-888-2264

Does this plan provide Minimum Essential Coverage?

Yes. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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)

The plan's overall deductible	$1,000.00
Specialist copayment	$20.00
Hospital (facility) coinsurance	20%
Other copayment	$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)*

Total Example Cost	$12,700.00
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000.00
Copayments	$30.00
Coinsurance	$1,300.00
What isn't covered	
Limits or exclusions	$80.00
The total Peg would pay is	$2,410.00

Managing Joe's type 2 diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000.00
Specialist copayment	$20.00
Hospital (facility) copayment	$250.00
Other copayment	$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*)

Total Example Cost	$5,600.00
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0.00
Copayments	$500.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$40.00
The total Joe would pay is	$540.00

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000.00
Specialist copayment	$20.00
Hospital (facility) copayment	$250.00
Other copayment	$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*)

Total Example Cost	$2,800.00
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300.00
Copayments	$200.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	$500.00

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
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 đài thọ (Summary of Benefits and Coverage, SBC) này.

አማርኛ (Amharic):- የለምንም ወጪ እርዳታና መረጃ የማግኘት መብት አለዎት። አስተርጓሚ ለመጠየቅ፣ በዚህ Summary of Benefits and Coverage/የጥቅማጥቅሞችና የሽፋን ማጠቃለያ (SBC) ውስጥ የተዘረዘረውን የቴሌፎን ቁጥር ይደውሉ።

ภาษาไทย (Thai):
คุณมีสิทธิ์รับความช่วยเหลือและข้อมูลเป็นภาษาของคุณเองได้โดยไม่เสียค่าใช้จ่ายใด ๆ ถ้าต้องการล่ามแปล โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่ในเอกสาร "สาระสำคัญเกี่ยวกับผลประโยชน์และการคุ้มครอง (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す。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 بلغتك دون تكلفة. لطلب مترجم، اتصل برقم الهاتف المدرج في موجز المزايا والتغطية هذا (SBC).

Русский (Russian): Вы вправе получать помощь и информацию на родном языке без дополнительной 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 (Samoan): 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 faaliliu, telefoni i le numera o lisi atu i totonu o lenei Otootoga 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 lenguahem nga awan bayad na. Tapno agkiddaw iti tagapataros, awagan ti numero ti telepono nga nakalista iti uneg iti Dagup dagiti Benipisyo ken Pannakasakup (SBC).

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