MySHL Solutions PPO Silver 2

Attachment A Benefit Schedule

Lifetime Maximum Benefit for all Covered Services: Unlimited.

Calendar Year Deductible (CYD): Your CYD is $2,500 of EME per Insured and $5,000 of EME per Family for Plan Provider Services and $5,000 of EME per Insured and $10,000 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.
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 complying with SHL's Managed Care Program.

Coinsurance: After satisfying your CYD, your Coinsurance for most Plan Provider services is 30% of EME. Your Coinsurance for most Non-Plan Provider services is 50% of EME. Please reference the following pages for specific Coinsurance responsibilities.

Calendar Year Out of Pocket Maximum: Includes the CYD. Your Calendar Year Out of Pocket expenses are limited to a maximum of $6,250 of EME per Insured per Calendar Year and $12,500 of EME per Family when using Plan Providers and $12,500 of EME per Insured per Calendar Year and $25,000 of EME per Family when using Non-Plan Providers. The Calendar Year Out of Pocket Maximum amounts include the CYD, Copayments and Coinsurance.

An Insured may not contribute any more than the individual Calendar Year Out Of Pocket Maximum amount toward the Family Calendar Year Out of Pocket Maximum amount. Further, the stated Out of Pocket Maximum amounts are separate for each tier of benefits and do not accumulate to one another.

Please read your Agreement to understand how EME payments to Providers are determined. Plan Providers have agreed to accept SHL's Reimbursement Schedule as payment in full for Covered Services, plus any applicable Deductibles, Coinsurance and/or Copayments.

Important Note: When receiving Covered Services from Non-Plan Providers, you are responsible for all amounts exceeding the applicable benefit maximums, EME payments to Tier II Non-Plan Providers and any penalties for not complying with SHL's Managed Care Program. Further, such amounts do not accumulate to the Calendar Year Out of Pocket Maximum.

Please refer to Attachment B to the SHL Agreement, List of Services Requiring Prior Authorization, for the list of services and supplies requiring Prior Authorization.

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

4-Tier Outpatient Prescription Drug Rider to the SHL Small Business 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
$20 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier II: Insured pays
$40 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier III: Insured pays
$70 Copayment per Designated Plan Pharmacy Therapeutic Supply

Tier IV: Insured pays
$250 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

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.

to the applicable terms, conditions, 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, III or IV 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). **Tier IV –** is the highest cost option for Covered Drugs.

(e). **Mandatory Generic benefit provision applies when:**

- a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The Insured will pay the Covered Copayment or Coinsurance plus the difference between the Eligible Medical Expenses ("EME") of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Designated Plan Pharmacy for each Therapeutic Supply.

(f). When a Drug is dispensed through the Mail Order Plan Pharmacy, the applicable Tier I, Tier II, Tier III or Tier IV 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, III or IV Copayment or Coinsurance 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 or Coinsurance. 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 or Coinsurance.

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, Tier III or Tier IV 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.

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 or Tier IV).

3.23 Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.

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 Pharmacy's contracted cost of the Covered Drug to SHL but not more than the actual charge to the Insured.

4.8 "Generic Drug" is an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.

4.9 "Mail Order Plan Pharmacy" is a duly licensed pharmacy that has an independent contractor agreement with SHL to provide certain Tier I, Tier II, Tier III and Tier IV Drugs to Insureds by mail.

4.10 "Non-Plan Pharmacy" is a duly licensed pharmacy that does not have an independent contractor agreement with SHL to provide Covered Drugs to Insureds.

4.11 "Plan Pharmacy" is a duly licensed pharmacy that has an independent contractor agreement with SHL to provide Covered Drugs to Insureds. Unless otherwise specified as Mail Order Plan Pharmacy herein, Plan Pharmacy services are retail services only and do not include Mail Order services.

4.12 "Prescription Drug List (PDL)" means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by SHL.

4.13 "Prescription Drug" is any drug required by federal law or regulation to be dispensed upon written prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.

4.14 "Specialty Drugs" are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by SHL's P&T Committee that are either self-administered or administered by a healthcare Provider and used or obtained in either an outpatient or home setting.

4.15 "Step Therapy" is a program for Insureds who take Prescription Drugs for an ongoing medical condition, such as arthritis, asthma or high blood pressure, which ensures the Insured receives the most appropriate and cost-effective drug therapy for their condition. The Step Therapy program requires that before benefits are payable for a high cost Covered Drug that may have initially been prescribed, the Insured try a lower cost first-step Covered Drug. If the prescribing Physician has documented with SHL why the Insured's condition cannot be stabilized with the first-step Covered Drug, SHL will review a request for Prior Authorization to move the Insured to a second-step drug, and so on, until it is determined by SHL that the prescribed Covered Drug is Medically Necessary and eligible for benefit payment.

4.16 "Therapeutic Equivalent" means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.

4.17 "Therapeutic Supply" is the maximum quantity of a Covered Drug for which benefits are available for the applicable 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

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

limited to, available rebates and assessments of the cost effectiveness of the Prescription Drug.

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

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.uhcnevada.com/ which leads to SHL's portal www.myshlonline.com.

Covered Services and Limitations	Plan Provider Benefit [1]	Non-Plan Provider Benefit [1]
Medical Office Visits and Consultations in a Medical Office Setting		
Non-Specialist Services		
• Convenient Care Facility	Insured pays $20 per visit.	After CYD, SHL pays 50% of EME.
• Physician Extender or Assistant	Insured pays $20 per visit.	After CYD, SHL pays 50% of EME.
• Physician	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.
Specialist Services	Insured pays $50 per visit.	After CYD, SHL pays 50% of EME.
Preventive Healthcare Services - *Services include various recommended exams, immunizations, diagnostic tests and screenings and all FDA approved contraceptive methods. Refer to the SHL Preventive Guidelines on the SHL website www.myshlonline.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.	After CYD, SHL pays 50% of EME.
Routine Lab and X-ray services provided and billed by the Physician's office. *Copayment/Cost-share is in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office.*		
• Lab	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.
• X-Ray	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.
Telemedicine Services *(Only available through select Providers.)*	Insured pays $20 per visit.	After CYD, SHL pays 50% of EME.
Laboratory Services - Outpatient *Performed at an independent facility.*	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.
Routine Radiological and Non-Radiological Diagnostic Imaging Services *Performed at a Free-Standing Diagnostic Center*	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.

Covered Services and Limitations	Plan Provider Benefit [1]	Non-Plan Provider Benefit [1]
Emergency Services		
• Urgent Care Facility	Insured pays $50 per visit.	After CYD, SHL pays 50% of EME.
• Emergency Room Facility (includes Physician Services)	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 70% of EME.
• Hospital Admission - Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 70% 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 70% of EME.	After CYD, SHL pays 50% 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 70% of EME.	After CYD, SHL pays 50% of EME.
Outpatient Hospital Facility Services	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
Ambulatory Surgical Facility Services	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
Anesthesia Services	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
Physician Surgical Services - Inpatient and Outpatient		
• Inpatient Hospital Facility	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
• Ambulatory Surgical Facility or Outpatient Hospital Facility	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
• Physician's Office		
Non-Specialist Physician (Includes all physician services related to the surgical procedure)	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
Specialist (Includes all physician services related to the surgical procedure)	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.

Covered Services and Limitations	Plan Provider Benefit [1]	Non-Plan Provider Benefit [1]
Gastric Restrictive Surgery Services *SHL provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Insured.*		
• Physician Surgical Services	After CYD, SHL pays 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
• Physician's Office Visit	Insured pays $50 per visit.	After CYD, SHL pays 50% of EME.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
• Physician Surgical Services - Inpatient Hospital Facility	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% 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.*	After CYD, SHL pays 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% 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 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
• Retransplantation Services *Benefits are limited to one (1) Medically Necessary Retransplantation 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		
• Frames and Lenses	Insured pays $10 per pair of glasses. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
• Contact Lenses	Insured pays $10 per set of contact lenses. Subject to maximum benefit.	After CYD, SHL pays 50% 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.		

Covered Services and Limitations	Plan Provider Benefit [1]	Non-Plan Provider Benefit [1]
Home Healthcare Services (does not include Specialty Prescription Drugs) *Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drug.* *Home Healthcare Services are limited to a combined Plan and Non-Plan Provider maximum benefit of sixty (60) visits per Insured per Calendar Year. A period of four (4) hours or less of Home Healthcare services equals one visit.*	After CYD, SHL pays 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
Hospice Care Services		
• Inpatient Hospice Facility	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
• Outpatient Hospice Services	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% 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, SHL pays 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
◦ Outpatient	After CYD, SHL pays 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% 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, SHL pays 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
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 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% 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 $25 per visit. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.

Covered Services and Limitations	Plan Provider Benefit [1]	Non-Plan Provider Benefit [1]
Short-Term Rehabilitation and Habilitation Services		
• Inpatient Hospital Facility	After CYD, SHL pays 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
• Outpatient	Insured pays $25 per visit. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
All Inpatient and Outpatient Short Term Rehabilitation and Habilitative Services are subject to a to a combined Plan and Non-Plan Provider maximum benefit of one hundred twenty (120) days/visits per Insured per Calendar Year.		
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 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
Genetic Disease Testing Services		
• Office Visit	After CYD, SHL pays 75% of EME.	After CYD, SHL pays 50% of EME.
• Lab *Includes Inpatient, Outpatient and independent Laboratory Services.*	After CYD, SHL pays 75% of EME.	After CYD, SHL pays 50% of EME.
Infertility Office Visit Evaluation *Please refer to applicable surgical procedure Copayment/Cost-share herein for any surgical infertility procedures performed.*	Insured pays $50 per visit.	After CYD, SHL pays 50% of EME.
Medical Supplies	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
Other Diagnostic and Therapeutic Services *Copayment/Cost-share amounts are in addition to the Physician office visit Copayment/Cost-share and applies to services rendered in a Physician's office or at an independent facility.*		
• Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services.	Insured pays $25 per day.	After CYD, SHL pays 50% of EME.
• Dialysis	Insured pays $25 per day.	After CYD, SHL pays 50% of EME.

Covered Services and Limitations	Plan Provider Benefit [1]	Non-Plan Provider Benefit [1]
Other Diagnostic and Therapeutic Services (continued)		
• Therapeutic Radiology	Insured pays $25 per day.	After CYD, SHL pays 50% of EME.
• Complex Allergy Diagnostic Services (including RAST) and Serum Injections	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.
• Otologic Evaluations	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.
• Other complex diagnostic imaging services including: Positron Emission Tomography (PET) scans; CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; and complex neurological or psychiatric testing or therapeutic services.	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
Prosthetic Devices *Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.*	After CYD, SHL pays 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
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 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
Self-Management and Treatment of Diabetes		
• Education and Training	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.
• Supplies (except for Insulin Pump Supplies)	Insured pays $5 per therapeutic supply.	After CYD, SHL pays 50% of EME.
Insulin Pump Supplies	Insured pays $10 per therapeutic supply.	After CYD, SHL pays 50% of EME.
• Equipment (except for Insulin Pump)	Insured pays $20 per device.	After CYD, SHL pays 50% of EME.
Insulin Pump	Insured pays $100 per device.	After CYD, SHL pays 50% of EME.
Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.		

Covered Services and Limitations	Plan Provider Benefit (1)	Non-Plan Provider Benefit (1)
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 50% of EME. Subject to maximum benefit.
Temporomandibular Joint Treatment	After CYD, SHL pays 50% of EME.	After CYD, SHL pays 50% of EME.
Mental Health and Severe Mental Illness Services		
• Inpatient Hospital Facility	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
• Outpatient Treatment	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.
Substance Abuse Services		
• Inpatient Hospital Facility	After CYD, SHL pays 70% of EME.	After CYD, SHL pays 50% of EME.
• Outpatient Treatment	Insured pays $25 per visit.	After CYD, SHL pays 50% of EME.
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 70% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% 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 $25 per visit. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.

Covered Services and Limitations	Plan Provider Benefit [1]	Non-Plan Provider Benefit [1]
Pediatric Vision Services for Insureds up to age 19		
Vision Examination *Limited to a combined Plan and Non-Plan Provider maximum benefit of one (1) vision examination, covered once every calendar year, to include a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.*	Insured pays $0 per visit. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. 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 to be Medically Necessary. Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal and lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglasses.*	Insured pays $0 per visit. Subject to maximum benefit.	After CYD, SHL pays 50% of EME.
Frames *Limited to a combined Plan and Non-Plan Provider maximum benefit of one (1) pair of frames, covered once every calendar year, from the approved Formulary frame series. Charges for frames selected outside of the approved Formulary frame series are the responsibility of the Insured. Discounts for non-Formulary frames may be available through the Plan Provider.*	Insured pays $0 per visit. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
Contact Lenses *Limited to a combined Plan and Non-Plan Provider maximum benefit. Contact lenses are covered once every calendar year in lieu of eye glasses. Charges for contact lenses considered to be cosmetic in purposes shall be the responsibility of the Insured.*	Insured pays $0 per visit. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
Low Vision Exam *Limited to a combined Plan and Non-Plan Provider maximum benefit of one (1) comprehensive evaluation every five (5) years.*	Insured pays $0 per visit. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
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 Insured at a discount. Please consult with your Provider.)*	Insured pays $0.	After CYD, SHL pays 50% of EME.

Covered Services and Limitations	Plan Provider Benefit [1]	Non-Plan Provider Benefit [1]
Pediatric Dental Services for Insureds up to age 19		
Diagnostic and Preventive • Oral exam every six (6) months • Periodic X-rays • Diagnostic procedures • Prophylaxis every six (6) months • Topical fluoride treatment every six (6) months • Sealants once per permanent molar • Space maintenance therapy	Insured pays $0. Subject to maximum benefit.	After CYD, SHL pays 100% of EME. Subject to maximum benefit.
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.

Please read the SHL Agreement of Coverage to determine the governing contractual provisions, exclusions and limitations.

Please note: For Inpatient and Outpatient admissions, in addition to specified surgical Copayments and/or Coinsurance amounts, Insured is also responsible for all other applicable facility and professional Copayments and/or Coinsurance amounts as outlined in the Attachment A Benefit Schedule.

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

[1] If Medically Necessary Covered Services, with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness, Substance Abuse Services, are provided without obtaining the required Prior Authorization, benefits are reduced to 50% of what the Insured would have received if Prior Authorization had been obtained.