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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$250/Insured and $500/Family for Plan Providers and $500/Insured and $1,000/Family for Non-Plan Providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care from Plan Providers is covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$3,000/Insured and $6,000/Family for Plan Providers and $6,000/Insured and $12,000/Family for Non-Plan Providers.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Penalties for not complying with SHL’s Managed Care Program, premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.sierrahealthandlife.com/Member/Doctor-or-Provider">www.sierrahealthandlife.com/Member/Doctor-or-Provider</a> or call 1-800-888-2264 for a list of Plan Providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see 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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>- Primary care visit to treat an injury or illness</td>
<td>- Plan Provider (You will pay the least) $20 copay/visit; deductible does not apply</td>
<td>- Non-Plan Provider (You will pay the most) 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>- Specialist visit</td>
<td>$35 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>- Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>- Diagnostic test (x-ray, blood work)</td>
<td>X-ray: $30 copay/service; deductible does not apply Lab: $10 copay/service; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>- Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

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<table>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Plan Provider (You will pay the least)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Plan Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness</td>
<td>Tier 1</td>
<td>$5 copay/prescription (retail) $12.50</td>
<td>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.</td>
</tr>
<tr>
<td>or condition</td>
<td></td>
<td>copay/prescription (mail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>$25 copay/prescription (retail) $62.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>copay/prescription (mail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$45 copay/prescription (retail) $112.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>copay/prescription (mail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>Insured pays a 50% benefit reduction if prior authorization is not obtained.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>ER Physician: 20% coinsurance; deductible does not apply</td>
<td>You may be balance billed from Non-Plan Providers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER Facility: $100 copay/visit; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER Physician: 20% coinsurance; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER Facility: $100 copay/visit; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>transportation</td>
<td>50% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>$20 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>You may be balance billed from Non-Plan Providers.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>Insured pays a 50% benefit reduction if prior authorization is not obtained.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td></td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services $20 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>Insured pays a 50% benefit reduction if prior authorization is not obtained.</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>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).</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Insured pays a 50% benefit reduction if prior authorization is not obtained.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>Coverage is limited to a Non-Plan benefit of 30 visits. Insured pays a 50% benefit reduction if prior authorization is not obtained.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to a combined benefit of 60 days/visits. Insured pays a 50% benefit reduction if prior authorization is not obtained.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to a combined benefit of 60 days/visits. Insured pays a 50% benefit reduction if prior authorization is not obtained.</td>
</tr>
</tbody>
</table>

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<td></td>
<td>Plan Provider</td>
<td>Non-Plan Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery - One (1) per Lifetime • Hearing aids - One (1) every three (3) years (including repair/replace) • Private-duty nursing • Chiropractic care - 20 visits per calendar year • Limited infertility treatment</td>
</tr>
</tbody>
</table>

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Nevada Department of Insurance at 888-872-3234 or www.doi.nv.gov or call 1-800-888-2264

Does this plan provide Minimum Essential Coverage?

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

Does this plan meet Minimum Value Standards?

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

Language Access Services:

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

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

Chinese (中文): 若需要中文协助，请拨打本文件内的客户服务电话。

Navajo (Dine): Dine k'ehj shich'ii hadoodzih ninizingo, koi' 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---------------------------

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

<table>
<thead>
<tr>
<th>Peg Is Having a baby</th>
<th>Managing Joe’s type 2 diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250.00</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200.00</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,300.00</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>$0.00</th>
</tr>
</thead>
</table>

**The total Peg would pay is**

$2,750.00

**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**

$7,400.00

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0.00</td>
</tr>
<tr>
<td>Copayments</td>
<td>$900.00</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>$0.00</th>
</tr>
</thead>
</table>

**The total Joe would pay is**

$900.00

**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**

$1,900.00

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250.00</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200.00</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300.00</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>$0.00</th>
</tr>
</thead>
</table>

**The total Mia would pay is**

$750.00

*For more information about limitations and exceptions, see plan or policy document at www.sierrahealthandlife.com*
Coverage: SBC (for details, please see the Summary of Benefits and Coverage).

Tagalog (Tangal): Maaaring makapalanggan ng ilahang komunikasyon sa iligal na nakakita sa lupa na ito ng mga benepisyong at saklaw (Summary of Benefits and Coverage). English: You have the right to get help and information in the language at no cost. To request help, please call the phone number listed within this Summary of Benefits and Coverage (SBC), the phone number listed within your Summary of Benefits and Coverage. If you need help with your complaint, please call the phone number listed within your Summary of Benefits and Coverage (SBC). Summary of Benefits and Coverage (SBC).

We provide free services to help you communicate with us, such as letters in other languages, interpreters, and written materials. If you need help with your complaint, please call the phone number listed within this Summary of Benefits and Coverage (SBC). If you disagree with the decision, you have 15 days to ask us to look at it again. 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 think you were treated unfairly, you can send a complaint to the Civil Rights Coordinator.

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