



SIERRA HEALTH AND LIFE  
A UnitedHealthcare Company

*School Administrators' and Professional-technical  
Employees' Welfare Trust ("Trust")  
Out-of-Area PPO Plan 2*

**Attachment A Benefit Schedule**

**Lifetime Maximum Benefit for all Covered Services:** Unlimited.

**Calendar Year Deductible ("CYD"):** Your CYD is \$250 of EME per Insured and \$750 of EME per family. The CYD is a combined total of EME for Covered Services obtained from SHL Plan Providers and Non-Plan Providers.

**Coinsurance:** After satisfying your CYD, your Coinsurance for most SHL Plan Provider services is 10% of EME. Your Coinsurance for most Non-Plan Provider services is 30% of EME. Please reference the following pages for specific Coinsurance responsibilities.

**Coinsurance Maximum:** After satisfying your CYD, your Coinsurance (including office visit Copayments) is limited to a maximum of \$1,000 of EME per Insured per Calendar Year (\$3,000 per family) when using SHL Plan Providers, and \$2,000 of EME per Insured per

Calendar Year (\$6,000 per family) when using Non-Plan Providers. In no event will the Coinsurance Maximum exceed \$3,000 of EME per Insured per Calendar Year (\$9,000 per family). The Coinsurance Maximum does not include Prescription Drug Copayments or the Calendar Year Deductible.

Please read your Certificate to understand how EME payments to Providers are determined. SHL 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.

**Important Note:** When receiving Covered Services from Non-Plan Providers, you are responsible for all charges in excess of EME allowed by SHL.

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<b>Medical - Physician Services and Physician Consultations</b> <ul style="list-style-type: none"> <li>• Non-Specialist Office Visit <i>Includes routine lab and X-ray services provided and billed by the Physician's office.</i></li> <li>• Specialist/Consultations Office Visit <i>Includes routine lab and X-ray services provided and billed by the Physician's office.</i></li> <li>• Inpatient Visit/Consultations</li> </ul>	<p>No</p> <p>No</p> <p>No</p>	<p>\$20 per visit</p> <p>\$20 per visit</p> <p>No charge</p>	<p>After CYD, Insured pays 30% of EME.</p>
<b>Laboratory Services - Outpatient</b> <i>In addition to office visit Copayment.</i>	Yes	\$5 per visit	After CYD, Insured pays 30% of EME.
<b>Routine Radiological and Non-Radiological Diagnostic Imaging Services - Outpatient</b> <i>In addition to office visit Copayment.</i>	Yes	\$15 per visit	After CYD, Insured pays 30% of EME.
<b>Emergency Services <i>Within</i> the Service Area</b> <ul style="list-style-type: none"> <li>• Urgent Care Facility</li> <li>• Physician's Services in Emergency Room</li> <li>• Emergency Room Facility</li> <li>• Hospital Admission – Emergency Stabilization</li> </ul>	No	<p>\$15 per visit</p> <p>\$15 per visit</p> <p>\$50 per visit, waived if admitted.</p> <p>After CYD, Insured pays 10% of EME.</p>	<p>\$15 per visit</p> <p>\$15 per visit</p> <p>\$50 per visit, waived if admitted.</p> <p>After CYD, Insured pays 30% of EME.</p>

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<p><b>Emergency Services <i>Within</i> the Service Area (Continued)</b>  <i>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 the Plan's applicable benefit and amounts exceeding the Plan's EME payment to Tier III Non-Plan Providers. Such amounts do not accumulate to the Coinsurance Maximum.</i></p>			
<p><b>Emergency Services Outside the Service Area</b></p> <ul style="list-style-type: none"> <li>• Urgent Care Facility</li> <li>• Physician's Services in Emergency Room</li> <li>• Emergency Room Facility</li> <li>• Hospital Admission – Emergency Stabilization</li> <li>• Office Visit to Non-Plan Physician</li> </ul> <p><i>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 the Plan's applicable maximum benefit and amounts exceeding the Plan's EME payment to Tier III Non-Plan Providers. Such amounts do not accumulate to the Coinsurance Maximum.</i></p>	No	<p>\$25 per visit</p> <p>\$15 per visit</p> <p>\$50 per visit, waived if admitted.</p> <p>After CYD, Insured pays 10% of EME.</p> <p>Not applicable</p>	<p>\$25 per visit</p> <p>\$15 per visit</p> <p>\$50 per visit, waived if admitted.</p> <p>After CYD, Insured pays 30% of EME.</p> <p>\$25 per visit</p>

Legal Documents

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<b>Ambulance Services</b> <ul style="list-style-type: none"> <li>Emergency – Ground Transport</li> <li>Emergency – Air Transport</li> <li>Non-Emergency – SHL Arranged Transfers</li> </ul>	<p>No</p> <p>No</p> <p>Yes</p>	<p>\$75 per trip</p> <p>50% of EME per trip.</p> <p>No charge</p>	<p>After CYD, Insured pays 30% of EME.</p> <p>50% of EME per trip.</p> <p>No charge</p>
<b>Inpatient Hospital Facility Services</b> <i>Elective and Emergency post-stabilization admissions.</i>	Yes	After CYD, Insured pays 10% of EME.	After CYD, Insured pays 30% of EME.
<b>Outpatient Hospital Facility and Ambulatory Surgical Facility Services</b>	Yes	After CYD, Insured pays 10% of EME.	After CYD, Insured pays 30% of EME.
<b>Physician Surgical Services – Inpatient and Outpatient</b> <ul style="list-style-type: none"> <li>Inpatient Hospital Facility</li> <li>Outpatient Hospital Facility</li> <li>Physician’s Office</li> </ul>	Yes	<p>After CYD, Insured pays 10% of EME.</p> <p>After CYD, Insured pays 10% of EME.</p> <p>After CYD, Insured pays 10% of EME.</p>	After CYD, Insured pays 30% of EME.
<b>Assistant Surgical Services</b>	Yes	After CYD, Insured pays 10% of EME.	After CYD, Insured pays 30% of EME.
<b>Anesthesia Services</b>	Yes	After CYD, Insured pays 10% of EME.	After CYD, Insured pays 30% of EME.



# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<p><b>Organ and Tissue Transplant Surgical Services</b></p> <ul style="list-style-type: none"> <li>Inpatient Hospital Facility</li> <li>Office Visit / Consultation</li> <li>Physician Surgical Services – Inpatient Hospital Facility</li> <li>Transportation, Lodging and Meals <i>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.</i></li> <li>Procurement <i>The maximum benefit per Insured per Transplant Benefit Period for Procurement of the organ/tissue is \$15,000 of EME.</i></li> <li>Retransplantation Services <i>The maximum benefit for Retransplantation Services is 50% of EME, which does not apply towards your Calendar Year Coinsurance Maximum.</i></li> </ul>	Yes	<p>After CYD, Insured pays 10% of EME.</p> <p>\$20 per visit</p> <p>After CYD, Insured pays 10% of EME.</p> <p>No charge. Subject to maximum benefit.</p> <p>No charge. Subject to maximum benefit.</p> <p>50% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 30% of EME. Subject to maximum benefit.</p> <p>After CYD, Insured pays 50% of EME. Subject to maximum benefit.</p>
<p><b>Post-Cataract Surgical Services</b></p> <ul style="list-style-type: none"> <li>Frames and Lenses <i>Maximum frame allowance of \$100.</i></li> </ul>	Yes	<p>After CYD, Insured pays 10% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 30% of EME. Subject to maximum benefit.</p>

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<p><b>Post-Cataract Surgical Services (continued)</b></p> <ul style="list-style-type: none"> <li>• Contact Lenses</li> </ul> <p style="text-align: center;"><i>Maximum contact lenses allowance of \$100.</i></p> <p><i>Benefit limited to one (1) pair of glasses or set of contact lenses as applicable per Insured per surgery.</i></p>	Yes	After CYD, Insured pays 10% of EME. Subject to maximum benefit.	After CYD, Insured pays 30% of EME. Subject to maximum benefit.
<p><b>Home Healthcare Services (does not include Self-Injectable Prescription Drugs)</b></p> <p><i>Refer to your outpatient Prescription Drug Benefit Rider for benefits applicable to outpatient Covered Drugs.</i></p> <ul style="list-style-type: none"> <li>• Physician House Calls</li> <li>• Home Care Services</li> <li>• Private Duty Nurse</li> </ul> <p><i>Limited to a maximum benefit of thirty (30) visits per Insured per Calendar Year.</i></p>	Yes	After CYD, Insured pays 10% of EME. Subject to maximum benefit.	After CYD, Insured pays 30% of EME. Subject to maximum benefit.
<p><b>Hospice Care Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospice Facility</li> <li>• Outpatient Hospice Services</li> <li>• Inpatient Respite Services <i>Limited to a maximum benefit of \$1,500 per Insured per Calendar Year.</i></li> </ul>	Yes	<p>After CYD, Insured pays 10% of EME.</p> <p>No charge</p> <p>After CYD, Insured pays 10% of EME. Subject to maximum benefit.</p>	<p>After CYD, Insured pays 30% of EME.</p> <p>No charge</p> <p>After CYD, Insured pays 30% of EME. Subject to maximum benefit.</p>

Legal Documents

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<p><b>Hospice Care Services (continued)</b></p> <ul style="list-style-type: none"> <li>Outpatient Respite Services <i>Limited to a maximum benefit of \$1,000 per Insured per Calendar Year.</i></li> <li>Bereavement Services <i>Limited to a maximum benefit of five (5) therapy sessions or \$500, whichever is less. Treatment must be completed within six (6) months of the date of death.</i></li> </ul>	Yes	<p>\$10 per visit. Subject to maximum benefit.</p> <p>\$10 per visit. Subject to maximum benefit.</p>	<p>\$10 per visit. Subject to maximum benefit.</p> <p>\$10 per visit. Subject to maximum benefit.</p>
<p><b>Skilled Nursing Facility</b> <i>Limited to a maximum benefit of one hundred (100) days per Insured per Calendar Year.</i></p>	Yes	After CYD, Insured pays 10% of EME. Subject to maximum benefit.	After CYD, Insured pays 30% of EME. Subject to maximum benefit.
<p><b>Manual Manipulation</b> <i>Applies to Medical – Physician Services and Chiropractic office visit.</i></p> <p><i>Limited to a maximum benefit of \$1,000 per Insured per Calendar Year and \$5,000 per lifetime.</i></p>	Yes	\$20 per visit. Subject to maximum benefit.	After CYD, Insured pays 30% of EME. Subject to maximum benefit.
<p><b>Short-Term Rehabilitation Services</b></p> <ul style="list-style-type: none"> <li>Inpatient Hospital Facility</li> <li>Outpatient</li> </ul>	Yes	After CYD, Insured pays 10% of EME.	After CYD, Insured pays 30% of EME.

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<p><b>Durable Medical Equipment</b>  <i>DME benefit includes rental or purchase at SHL's option. Limited to a maximum lifetime benefit of \$4,000 per Insured.</i></p>	Yes	After CYD, Insured pays 10% of EME. Subject to maximum benefit.	After CYD, Insured pays 30% of EME. Subject to maximum benefit.
<p><b>Genetic Disease Testing Services</b>  <i>Includes Inpatient, Outpatient and independent Laboratory Services.</i></p>	Yes	After CYD, Insured pays 25% of EME per test.	After CYD, Insured pays 25% of EME per test.
<p><b>Infertility Office Visit Evaluation</b>  <i>Please refer to applicable surgical procedure Copayment and/or Coinsurance amount herein for any surgical infertility procedures performed.</i></p>	Yes	After CYD, Insured pays 10% of EME.	After CYD, Insured pays 30% of EME.
<p><b>Medical Supplies</b></p>	Yes	After CYD, Insured pays 10% of EME.	After CYD, Insured pays 30% of EME.
<p><b>Other Diagnostic and Therapeutic Services</b>  <i>Copayment and/or CYD plus Coinsurance amount is in addition to the Physician office visit Copayment and/or CYD plus Coinsurance amount and applies to services rendered in a Physician's office or at an independent facility.</i></p> <ul style="list-style-type: none"> <li>• Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services.</li> <li>• Dialysis</li> </ul>	Yes	After CYD, Insured pays 10% of EME.	After CYD, Insured pays 30% of EME.

Legal Documents

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<p><b>Other Diagnostic and Therapeutic Services (continued)</b></p> <ul style="list-style-type: none"> <li>• Therapeutic Radiology</li> <li>• Otologic Evaluations</li> <li>• Other services such as complex diagnostic imaging (i.e., CAT scan, MRI); complex neurological or psychiatric testing or therapeutic services; pulmonary diagnostic services; vascular diagnostic and therapeutic services.</li> <li>• Positron Emission Tomography (PET Scan)</li> <li>• Allergy Testing and Serum Injections</li> </ul>	Yes	After CYD, Insured pays 10% of EME.	After CYD, Insured pays 30% of EME.
<p><b>Prosthetics and Orthotic Devices</b>  <i>Maximum lifetime benefit of \$10,000 per Insured, includes:</i></p> <ul style="list-style-type: none"> <li>• Repairs; and</li> <li>• Post-mastectomy external prosthetic device.</li> </ul>	Yes	After CYD, Insured pays 10% of EME. Subject to maximum benefit.	After CYD, Insured pays 30% of EME. Subject to maximum benefit.
<p><b>Self-Management and Treatment of Diabetes</b></p> <ul style="list-style-type: none"> <li>• Education and Training</li> <li>• Supplies</li> <li>• Insulin Pump Supplies</li> <li>• Equipment</li> </ul>	<p>No</p> <p>No</p> <p>Yes</p> <p>Yes</p>	<p>\$30 per visit</p> <p>\$5 per therapeutic supply</p> <p>\$10 per therapeutic supply</p> <p>\$20 per device</p>	After CYD, Insured pays 30% of EME.

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<p><b>Self-Management and Treatment of Diabetes (continued)</b>            Insulin Pumps  <i>Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail pharmacy.</i></p>	Yes	\$100 per device	After CYD, Insured pays 30% of EME.
<p><b>Special Food Products and Enteral Formulas</b>  <i>Limited to a maximum benefit of \$2,500 per Insured per Calendar Year for Special Food Products only.</i></p>	Yes	After CYD, Insured pays 10% of EME. Subject to maximum benefit.	After CYD, Insured pays 30% of EME. Subject to maximum benefit.
<p><b>Temporomandibular Joint Treatment</b>  <i>Dental related treatment is limited to \$2,500 per Insured per Calendar Year and \$4,000 maximum lifetime benefit per Insured.</i></p>	Yes	Insured pays 50% of EME. Subject to maximum benefit.	Insured pays 50% of EME. Subject to maximum benefit.
<p><b>Mental Health Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Facility</li> <li>• Outpatient Treatment Group Therapy</li> <li>• Individual, Marital, Family and Partial Care Therapy**</li> </ul> <p><i>**Partial Care Therapy refers to a coordinated outpatient program of treatment that provides structured daytime, evening and/or weekend services for a minimum of four (4) hours per session as an alternative to Inpatient care.</i></p>	Yes	After CYD, Insured pays 10% of EME.  \$10 per visit  \$10 per visit	After CYD, Insured pays 30% of EME.

Legal Documents

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<p><b>Severe Mental Illness Services</b></p> <ul style="list-style-type: none"> <li>Inpatient Hospital Facility</li> <li>Outpatient Treatment</li> </ul>	Yes	<p>After CYD, Insured pays 10% of EME.</p> <p>\$10 per visit</p>	<p>After CYD, Insured pays 30% of EME.</p>
<p><b>Substance Abuse Services</b></p> <ul style="list-style-type: none"> <li>Inpatient Detoxification (treatment for withdrawal)</li> <li>Outpatient Detoxification</li> <li>Inpatient Rehabilitation</li> <li>Outpatient Rehabilitation Counseling</li> <li>Group Therapy</li> <li>Individual, Marital, Family and Partial Care Therapy**</li> </ul> <p><i>**Partial Care Therapy refers to a coordinated outpatient program of treatment that provides structured daytime, evening and/or weekend services for a minimum of four (4) hours per session as an alternative to Inpatient care.</i></p>	Yes	<p>After CYD, Insured pays 10% of EME.</p> <p>\$10 per visit</p> <p>After CYD, Insured pays 10% of EME.</p> <p>\$10 per visit</p> <p>\$10 per visit</p>	<p>After CYD, Insured pays 30% of EME.</p>

# Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Tier I Plan Provider Benefits <sup>(1)</sup>	Tier II Non-Plan Provider Benefits <sup>(1)</sup>
		Insured pays amounts listed below plus any amounts exceeding the benefit maximums	Insured pays amounts listed below plus any amounts exceeding EME and the benefit maximums
<b>Hearing Aids</b> <i>Limited to a combined maximum benefit of \$5,000 per Insured per Calendar Year and further limited to a single purchase. Repairs and Replacement are limited to once every three (3) years.</i>	Yes	After CYD, Insured pays 10% of EME. Subject to maximum benefit.	After CYD, Insured pays 30% of EME. Subject to maximum benefit.
<b>Preventive Healthcare Services</b>	No	No charge.	Not subject to CYD. Insured pays 30% of EME.
<b>Applied Behavioral Analysis (ABA) for the treatment of Autism</b>  Limited to a maximum benefit or \$36,000 per Insured per Calendar Year.	Yes	\$20 per visit. Subject to maximum benefit.	After CYD, Insured pays 30% of EME. Subject to maximum benefit.

Legal Documents

Please read the SHL Trust 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 this 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 Coinsurance Maximum.

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