



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

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

Attachment A Benefit Schedule

Lifetime Maximum Benefit for all Covered Services: Unlimited.

Calendar Year Deductible ("CYD") – Non-Plan Provider Services Only: \$500 per Insured and \$1,000 per family.

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

Coinsurance and Copayment Maximum: After satisfying your CYD, the sum of your Plan Provider Copayments and Non-Plan Provider Coinsurance is limited to a maximum of \$2,000 of EME per Insured per Calendar Year and \$4,000 of EME per family per Calendar Year. The Coinsurance and Copayment Maximum does not include Prescription Drug Fees or the Calendar Year Deductible.

Please read your Certificate to understand how EME payments to Providers are determined. Plan Providers have agreed to accept SHL's Reimbursement Schedule as payment in full for Covered Services, 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	Plan Provider Benefits ⁽¹⁾	Non-Plan Provider Benefits ⁽¹⁾
<p>Medical - Physician Services and Physician Consultations</p> <ul style="list-style-type: none"> Office Visit/Consultations <i>Includes routine lab and X-ray services provided and billed by the Physician's office.</i> Inpatient Visit/Consultations 	<p>No</p> <p>Yes</p>	<p>Insured pays \$15 per visit.</p> <p>No charge</p>	<p>After CYD, SHL pays 70% of EME.</p>
<p>Laboratory Services - Outpatient</p>	<p>Yes</p>	<p>Insured pays \$15 per visit.</p>	<p>After CYD, SHL pays 70% of EME.</p>
<p>Routine Radiological and Non-Radiological Diagnostic Imaging Services - Outpatient</p>	<p>Yes</p>	<p>Insured pays \$15 per visit.</p>	<p>After CYD, SHL pays 70% of EME.</p>
<p>Emergency Services</p> <ul style="list-style-type: none"> Urgent Care Facility Physician's Services in Emergency Room Emergency Room Facility Hospital Admission – Emergency Stabilization <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 Non-Plan Providers. Such amounts do not accumulate to the Coinsurance Maximum.</i></p>	<p>No</p>	<p>Insured pays \$20 per visit.</p> <p>Insured pays \$25 per visit.</p> <p>Insured pays \$150 per visit.</p> <p>Insured pays \$150 per day, not to exceed \$450 per admission.</p>	<p>After CYD, SHL pays 70% of EME.</p> <p>Insured pays \$25 per visit.</p> <p>Insured pays \$150 per visit.</p> <p>Insured pays \$150 per day, not to exceed \$450 per admission.</p>

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<p>Ambulance Services</p> <ul style="list-style-type: none"> • Emergency – Ground Transport • Emergency – Air Transport • Non-Emergency – SHL Arranged Transfers 	<p>No</p> <p>No</p> <p>Yes</p>	<p>Insured pays \$50 per trip.</p> <p>Insured pays 50% of EME per trip.</p> <p>No charge</p>	<p>After CYD, SHL pays 70% of EME per trip.</p> <p>After CYD, SHL pays 50% of EME per trip.</p> <p>No charge</p>
<p>Inpatient Hospital Facility Services <i>Elective and Emergency post-stabilization admissions.</i></p>	Yes	Insured pays \$150 per day, not to exceed \$450 per admission.	After CYD, SHL pays 70% of EME.
<p>Outpatient Hospital Facility and Ambulatory Surgical Facility Services</p>	Yes	Insured pays \$150 per admission.	After CYD, SHL pays 70% of EME.
<p>Physician Surgical Services – Inpatient and Outpatient</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Hospital Facility • Physician's Office • Sterilizations in Physician's Office 	Yes	<p>Insured pays \$125 per surgery.</p> <p>Insured pays \$15 per visit.</p> <p>Insured pays \$15 per visit.</p> <p>Insured pays \$100 per visit.</p>	After CYD, SHL pays 70% of EME.
<p>Assistant Surgical Services</p>	Yes	No charge	After CYD, SHL pays 70% of EME.
<p>Anesthesia Services</p>	Yes	Insured pays \$100 per surgery.	After CYD, SHL pays 70% of EME.

Legal Documents

Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits ⁽¹⁾	Non-Plan Provider Benefits ⁽¹⁾
<p>Gastric Restrictive Surgery Services <i>The maximum lifetime benefit for all Gastric Restrictive Surgery Services is \$5,000 per Insured.</i></p> <ul style="list-style-type: none"> Physician Surgical Services Complications <i>The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgery Services is \$5,000 per Insured.</i> 	Yes	Insured pays 50% of EME. Subject to maximum benefit.	After CYD, SHL pays 50% of EME. Subject to maximum benefit.
<p>Mastectomy Reconstructive Surgical Services</p> <ul style="list-style-type: none"> Physician Surgical Services Prosthetic Devices for Mastectomy Reconstruction – <i>Unlimited</i> 	Yes	<p>Insured pays \$125 per surgery.</p> <p>Insured pays \$250 per device.</p>	After CYD, SHL pays 70% of EME.
<p>Oral Physician Surgical Services</p> <ul style="list-style-type: none"> Office Visit Physician Surgical and Diagnostic Services <p>Inpatient Hospital Facility</p> <p>Outpatient Hospital Facility</p>	Yes	<p>Insured pays \$15 per visit.</p> <p>Insured pays \$125 per surgery.</p> <p>Insured pays \$15 per visit.</p>	After CYD, SHL pays 70% of EME.
<p>Organ and Tissue Transplant Surgical Services</p> <ul style="list-style-type: none"> Inpatient Hospital Facility Physician Services Office Visit/Consultations Inpatient Visit/Consultations Physician Surgical Services – Inpatient Hospital Facility 	<p>Yes</p> <p>No</p> <p>Yes</p> <p>Yes</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>After CYD, SHL pays 70% of EME.</p> <p>After CYD, SHL pays 70% of EME.</p> <p>After CYD, SHL pays 70% of EME.</p> <p>After CYD, SHL pays 70% of EME.</p>

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Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits ⁽¹⁾	Non-Plan Provider Benefits ⁽¹⁾
<p>Home Healthcare Services (does not include Self-Injectable Prescription Drugs (continued))</p> <ul style="list-style-type: none"> Physician House Calls Home Care Services Private Duty Nurse <p><i>Limited to a maximum benefit of forty (40) visits per Insured per Calendar Year.</i></p>	Yes	Insured pays \$15 per visit. Subject to maximum benefit.	After CYD, SHL pays 70% of EME. Subject to maximum benefit.
<p>Hospice Care Services</p> <ul style="list-style-type: none"> Inpatient Hospice Facility <i>If the Insured is transferred from a Hospital, the Inpatient Copayment is waived.</i> Outpatient Hospice Services Inpatient Respite Services <i>Limited to a maximum benefit of \$1,500 per Insured per Calendar Year.</i> • Outpatient Respite Services <i>Limited to a maximum benefit of \$1,000 per Insured per Calendar Year.</i> 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> 	Yes	<p>Insured pays \$150 per day, not to exceed \$450 per admission.</p> <p>No charge</p> <p>Insured pays \$150 per day, not to exceed \$450 per admission. Subject to maximum benefit.</p> <p>No charge. Subject to maximum benefit.</p> <p>Insured pays \$15 per visit. Subject to maximum benefit.</p>	After CYD, SHL pays 70% of EME. Subject to applicable maximum benefit.
<p>Skilled Nursing Facility <i>If the Insured is transferred from a Hospital, the Inpatient Copayment is waived.</i></p>	Yes	Insured pays \$150 per day, not to exceed \$450 per admission.	After CYD, SHL pays 70% of EME.
<p>Manual Manipulation, except for reduction of fractures or dislocation. <i>Applies to Medical – Physician Services and Chiropractic office visit.</i></p>	Yes	Insured pays \$15 per visit. Subject to maximum benefit.	After CYD, SHL pays 70% of EME. Subject to maximum benefit.

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<p>Manual Manipulation (continued) <i>Limited to a maximum benefit of \$500 per Insured per Calendar Year and \$5,000 per lifetime.</i></p>			
<p>Short-Term Rehabilitation Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility or Skilled Nursing Facility • Outpatient 	Yes	<p>Insured pays \$150 per day, not to exceed \$450 per admission.</p> <p>Insured pays \$15 per visit.</p>	After CYD, SHL pays 70% of EME.
<p>Genetic Disease Testing Services <i>Includes Inpatient, Outpatient and independent Laboratory Services.</i></p>	Yes	Insured pays 25% of EME per test.	After CYD, SHL pays 75% of EME per test.
<p>Infertility Office Visit Evaluation <i>Please refer to applicable surgical procedure Copayment and/or Coinsurance amount herein for any surgical infertility procedures performed.</i></p>	Yes	Insured pays \$15 per visit.	After CYD, SHL pays 70% of EME.
<p>Medical Supplies</p>	Yes	No charge	After CYD, SHL pays 70% of EME.
<p>Other Diagnostic and Therapeutic Services <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"> • Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services. 	Yes	Insured pays \$15 per day.	After CYD, SHL pays 70% of EME.

Legal Documents

Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits ⁽¹⁾	Non-Plan Provider Benefits ⁽¹⁾
<p>Severe Mental Illness Services</p> <ul style="list-style-type: none"> • Inpatient Hospital Facility • Outpatient Treatment 	Yes	<p>Insured pays \$150 per day, not to exceed \$450 per admission.</p> <p>Insured pays \$15 per visit.</p>	After CYD, SHL pays 70% of EME.
<p>Substance Abuse Services</p> <ul style="list-style-type: none"> • Inpatient Detoxification (treatment for withdrawal) • Outpatient Detoxification • Inpatient Rehabilitation • Outpatient Rehabilitation Counseling Group, Individual, Family and Partial Care Therapy** <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>Insured pays \$150 per day, not to exceed \$450 per admission.</p> <p>Insured pays \$15 per visit.</p> <p>Insured pays \$150 per day, not to exceed \$450 per admission.</p> <p>Insured pays \$15 per visit.</p>	After CYD, SHL pays 70% of EME.

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<p>Preventive Healthcare Services <i>Includes routine lab and X-ray services provided and billed by the Physician's office.</i></p>	No	No charge	After CYD, SHL pays 70% of EME.
<p>Hearing Aids <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></p>	Yes	Insured pays \$15 per device. Subject to maximum benefit.	After CYD, SHL pays 70% of EME. Subject to maximum benefit.
<p>Applied Behavioral Analysis (ABA) for the treatment of Autism <i>Limited to a maximum benefit of \$36,000 per Insured per Calendar Year.</i></p>	Yes	Insured pays \$15 per visit. Subject to maximum benefit.	After CYD, SHL pays 70% 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.

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.

⁽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.