SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.®
a subsidiary of Sierra Health Services, Inc.®

Distinct Advantage – PPO
Plan 3 – 2500(40)97

Attachment A Benefit Schedule

This Plan does not include maternity coverage.

Lifetime Maximum Benefit for all Covered Services: $2,000,000 of Eligible Medical Expenses ("EME").

Calendar Year Deductible ("CYD"): $2,500 per Insured and $5,000 per family. The CYD is a combined total of Plan and Non-Plan EME. The CYD does not accumulate toward the Calendar Year Coinsurance Maximum.

Coinsurance: After satisfying your CYD, your Coinsurance for most 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 is limited to a maximum of $2,500 of EME per Insured per Calendar Year ($5,000 per family) when using Plan Providers, and $5,000 of EME per Insured per Calendar Year ($10,000 per family) when using Non-Plan Providers.

In no event will the Coinsurance Maximum exceed $7,500 of EME per Insured per Calendar Year ($15,000 per family). The Coinsurance Maximum does not include Copayments, Prescription Drug Fees, or CYD.

Please read your SHL Agreement of Coverage 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 CYD, Copayments and/or Coinsurance due from the Insured.

Important Note: You are responsible for all amounts exceeding the applicable benefit maximums, EME payments to Non-Plan Providers, and penalties for not complying with the Managed Care Program. Please reference the following pages for specific Coinsurance responsibilities.

Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits[1]	Non-Plan Provider Benefits[1]
Medical - Physician Services and Physician Consultations			After CYD, SHL pays 70% of EME.
Office Visit/Consultations *Includes routine lab and x-ray services provided and billed by the Physician's office.*	No	Insured pays $40 per visit.	
Inpatient Visit/Consultations	Yes	After CYD, SHL pays 90% of EME.	
Preventive Healthcare Services *Includes routine lab and x-ray services provided and billed by the Physician's office.* *Maximum benefit is $500 per Calendar Year.*	No	Insured pays $40 per visit. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the maximum benefit.
Laboratory Services - Outpatient	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Routine Radiological and Non-Radiological Diagnostic Imaging Services - Outpatient	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Emergency Services			After CYD, SHL pays 70% of EME.
Urgent Care Facility	No	Insured pays $55 per visit.	
Physician's Services in Emergency Room	No	After CYD, SHL pays 90% of EME.	
Emergency Room Facility	No	After CYD, SHL pays 90% of EME.	
Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.* *Maximum benefit for Medically Necessary but Non-Emergency Services received in an emergency room is 50% of EME.*	No	After CYD, SHL pays 90% of EME.	

Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits[1]	Non-Plan Provider Benefits[1]
Ambulance Services			
Emergency – Ground Transport	No	After CYD, SHL pays 90% of EME per trip.	After CYD, SHL pays 70% of EME per trip.
Emergency – Air Transport	No	After CYD, SHL pays 50% of EME per trip.	After CYD, SHL pays 50% of EME per trip.
SHL Arranged Transfers	Yes	No charge per trip.	No charge per trip.
Inpatient Hospital Facility Services *Elective and Emergency post-stabilization admission.*	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Outpatient Hospital Facility and Ambulatory Surgical Facility Services, includes Sterilization	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Inpatient and Outpatient Physician Surgical Services, includes Sterilization			After CYD, SHL pays 70% of EME.
Inpatient Hospital Facility	Yes	After CYD, SHL pays 90% of EME.	
Outpatient Hospital Facility	Yes	After CYD, SHL pays 90% of EME.	
Physician's Office (In addition to office visit Copayment and/or Coinsurance.)	Yes	Insured pays $40 per visit.	
Assistant Surgical Services	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Anesthesia Services	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Gastric Restrictive Surgical Services			
Physician Surgical Services *The maximum lifetime benefit for all Gastric Restrictive Surgical Services is $5,000 per Insured.*	Yes	After CYD, SHL pays 50% of EME. Subject to the Maximum benefit.	After CYD, SHL pays 50% of EME. Subject to the maximum benefit.

Legal Documents

Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits(1)	Non-Plan Provider Benefits(1)
Gastric Restrictive Surgical Services (continued)			
Complications *The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgical Services is $5,000 per Insured.*	Yes	After CYD, SHL 50 pays % of EME. Subject to the maximum benefit.	After CYD, SHL pays 50% of EME. Subject to the maximum benefit.
Mastectomy Reconstructive Surgical Services		After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Physician Surgical Services	Yes		
Prosthetic Devices for Mastectomy Reconstruction – *Unlimited.*	Yes		
Oral Surgical Services			After CYD, SHL pays 70% of EME.
Office Visit	Yes	Insured pays $40 per visit.	
Physician Surgical Services • Inpatient Hospital Facility	Yes	After CYD, SHL pays 90% of EME.	
• Outpatient Hospital Facility	Yes	After CYD, SHL pays 90% of EME.	
Organ and Tissue Transplant Surgical Services			
Inpatient Hospital Facility Services	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Physician Surgical Services	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% 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.*	Yes	After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the maximum benefit.

Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits[1]	Non-Plan Provider Benefits[1]
Organ and Tissue Transplant Surgical Services (continued)			
Procurement *The maximum benefit per Insured per Transplant Benefit Period for procurement of the organ/tissue is $15,000 of EME.*	Yes	After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the maximum benefit.
Retransplantation Services *The 50% of EME for Retransplantation Services does not apply towards your Calendar Year Coinsurance maximum.* *The maximum lifetime benefit that will be paid for an Insured for all Covered Transplant Procedures combined is* ***$100,000****.*	Yes	After CYD, SHL pays 50% of EME. Subject to the maximum benefit.	After CYD, SHL pays 50% of EME. Subject to the maximum benefit.
Home Healthcare Services *Refer to your outpatient Prescription Drug Benefit Rider, if applicable, for your outpatient self-injectable covered drug benefit.*		After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the Maximum benefit.
Physician House Calls	Yes		
Home Care Services	Yes		
Private Duty Nurse *Maximum benefit is limited to $5,000 per Insured per Calendar Year.*	Yes		
Hospice Care Services			
Inpatient Hospice Services	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Outpatient Hospice Services	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Inpatient Respite Services *Limited to $1,500 per Insured per Calendar Year.*	Yes	After CYD, SHL pays 90% of EME. Subject to the Maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the maximum benefit.

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Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits[1]	Non-Plan Provider Benefits[1]
Hospice Care Services (continued) Outpatient Respite Services *Limited to $1,000 per Insured per Calendar Year.* Bereavement Services *Limited to five (5) group therapy sessions or $500 per Insured, whichever is less. Treatment must be completed within six (6) months of the date of death.*	 Yes Yes	 After CYD, SHL pays 90% of EME. Subject to the maximum benefit. After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	 After CYD, SHL pays 70% of EME. Subject to the maximum benefit. After CYD, SHL pays 70% of EME. Subject to the maximum benefit.
Skilled Nursing Facility *Maximum benefit is $3,500 per Insured per Calendar Year.*	Yes	After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the maximum benefit.
Manual Manipulation (except for reduction of fractures or dislocation) *Maximum benefit is $500 per Insured per Calendar Year and $5,000 per lifetime.*	Yes	After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the Maximum benefit.
Short-Term Rehabilitation Services Inpatient Hospital Facility or Skilled Nursing Facility *Maximum benefit is $20,000 per Insured per Calendar Year.* Outpatient Hospital Facility *Maximum benefit is $2,500 per Insured per Calendar Year.*	 Yes Yes	After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the maximum benefit.
Genetic Disease Testing Services *Includes Inpatient, outpatient and independent laboratory services.*	Yes	After CYD, SHL pays 50% of EME per test.	After CYD, SHL pays 50% of EME per test.
Infertility Office Visit Evaluation *Please refer to Covered Services Copayments and/or Coinsurance amounts for any infertility procedures performed.*	Yes	Insured pays $40 per visit.	After CYD, SHL pays 70% of EME.

Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits[1]	Non-Plan Provider Benefits[1]
Medical Supplies	Yes	After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Other Diagnostic and Therapeutic Services		After CYD, SHL pays 90% of EME.	After CYD, SHL pays 70% of EME.
Allergy Testing/Serum Injections	Yes		
Amniocentesis	Yes		
Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services.	Yes		
Dialysis	Yes		
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.	Yes		
Otologic Evaluations	Yes		
Therapeutic Radiology	Yes		
Positron Emission Tomography (PET) Scans	Yes	After CYD, SHL pays 50% of EME per test	After CYD, SHL Pays 50% of EME Per test
Prosthetics, Orthotic Devices and Durable Medical Equipment *DME benefit includes rental or purchase at SHL's option.* *Lifetime maximum benefit per Insured is $10,000 for Prosthetics, Orthotics and Durable Medical Equipment combined.*	Yes	After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the Maximum benefit.
Self-Management and Treatment of Diabetes			After CYD, SHL pays 70% of EME.
Education and Training	No	Insured pays $40 per visit.	

Legal Documents

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Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits[(1)]	Non-Plan Provider Benefits[(1)]
Self-Management and Treatment of Diabetes (continued) Supplies (except for Insulin Pump Supplies) • Insulin Pump Supplies Equipment (except for Insulin Pumps) • Insulin Pumps	 No Yes Yes Yes	 Insured pays $5 per therapeutic supply. Insured pays $40 per therapeutic supply. Insured pays $20 per device. Insured pays $100 per device.	After CYD, SHL pays 70% of EME.
Special Food Products and Enteral Formulas *Special Food Products are limited to a maximum benefit of $2,500 per Insured per Calendar Year.*	Yes	After CYD, SHL pays 90% of EME. See maximum benefit.	After CYD, SHL pays 70% of EME. See maximum benefit.
Temporomandibular Joint Treatment *Maximum benefit is $2,500 per Insured per Calendar Year and $4,000 per lifetime.*	Yes	After CYD, SHL pays 50% of EME. Subject to the maximum benefit.	After CYD, SHL pays 50% of EME. Subject to the maximum benefit.
Mental Health Services Inpatient Hospital Facility *Maximum benefit is thirty (30) days per Insured per Calendar Year.* Outpatient Treatment • Group Therapy *Limited to twenty (20) visits per Insured per Calendar Year.* • Individual, Family and Partial Care Therapy** *Limited to twenty (20) visits per Insured per Calendar Year.* *Benefit maximum does not apply to visits for medication management.*	 Yes Yes Yes	After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the maximum benefit.

Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits[1]	Non-Plan Provider Benefits[1]
Mental Health Services (continued) *** Partial Care 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.*			
Severe Mental Illness Services			After CYD, SHL pays 70% of EME. Subject to the maximum benefit.
Inpatient Hospital Facility *Maximum benefit is forty (40) days per Insured per Calendar Year.*	Yes	After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	
Outpatient Hospital Facility *Maximum benefit is forty (40) visits per Insured per Calendar Year for all outpatient services combined.* *Two (2) visits for partial or respite care,or a combination thereof, may be substituted for each (1) day of Inpatient hospitalization not used by the Insured.* *Benefit maximum does not apply to visits for medication management.*	Yes	Insured pays $40 per visit. Subject to the maximum benefit.	
Substance Abuse Services		After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the maximum benefit.
Inpatient Rehabilitation *Maximum benefit is $9,000 per Insured per Calendar Year.*	Yes		
Outpatient Rehabilitation* • Group Therapy • Individual, Family and Partial Care Therapy** **Rehabilitation counseling services for all group, individual, family and partial care therapy is limited to a maximum benefit of $2,500 per Insured per Calendar Year.*	Yes		

Benefit Schedule

Covered Services and Limitations	Prior Auth Required	Plan Provider Benefits[1]	Non-Plan Provider Benefits[1]
Substance Abuse Services (continued) Inpatient Detoxification (treatment for withdrawal) Outpatient Detoxification *Limited to a maximum benefit of $1,500 per Insured per Calendar Year.* *** Partial Care 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.*	 Yes Yes	After CYD, SHL pays 90% of EME. Subject to the maximum benefit.	After CYD, SHL pays 70% of EME. Subject to the maximum benefit.

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

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

Any and all amounts exceeding any stated maximum benefit amounts under the Plan do not accumulate to the calculation of the Calendar Year Coinsurance Maximum.

[1] **If Medically Necessary Covered Services are provided without Prior Authorization, benefits are reduced to 50% of what the Insured would have received with Prior Authorization.**