

Sierra Health and Life Insurance Company, Inc.



Distinct Advantage PPO Plan 1

	Plan Provider Benefits	Non-Plan Provider Benefits
Lifetime Maximum	\$2,000,000 of EME*	
Calendar Year Deductible (CYD) <i>combined Plan and Non-Plan Provider</i>	\$1,000 per Insured/\$2,000 per Family	
Annual Coinsurance Maximum (after CYD) <i>separate Plan and Non-Plan Provider</i>	\$1,000 of EME per Insured \$2,000 of EME per Family	\$2,000 of EME per Insured \$4,000 of EME per Family
Covered Services	Insured Pays	Insured Pays
Physician Services		
Office Visit	\$35 per visit	After CYD, Insured pays 50% of EME plus all charges in excess of EME
Consultation	\$35 per visit	
Hospital Services		
Inpatient	After CYD, Insured pays 20% of EME	↓
Outpatient		
Physician Surgical Services		
Inpatient Facility	↓	
Outpatient Facility		
Anesthesia		
Physician's Office		
Emergency Services		
Urgent Care Facility	\$50 per visit	
Emergency Room Facility	After CYD, Insured pays 20% of EME	
Emergency Room Physician		
Ground Ambulance		
Diagnostic Services		
Routine Laboratory	↓	
Routine X-ray		

This plan does not include maternity coverage.

*EME (Eligible Medical Expenses) means the maximum amount the Plan will pay for a Covered Service in accordance with the Plan Reimbursement Schedule. The Plan Provider and Non-Plan Provider Annual Coinsurance Maximums are separate and do not accumulate to one another. Non-Plan Provider charges in excess of EME may be substantial and do not accrue toward the Annual Coinsurance Maximum. This Plan includes additional benefits, exclusions and limitations which are shown in the SHL Agreement of Coverage, Attachment A Benefit Schedule, Form No. SHL-IndDAP-masBS-2005, any other applicable Riders and the Disclosure Summary. Copies of these documents are available upon request. Plan documents govern in resolving any benefit questions or payments.

Sierra Health and Life Insurance Company, Inc.



Distinct Advantage PPO Plan 2

	Plan Provider Benefits	Non-Plan Provider Benefits
Lifetime Maximum	\$2,000,000 of EME*	
Calendar Year Deductible (CYD) <i>combined Plan and Non-Plan Provider</i>	\$1,500 per Insured/\$3,000 per Family	
Annual Coinsurance Maximum (after CYD) <i>separate Plan and Non-Plan Provider</i>	\$1,500 of EME per Insured \$3,000 of EME per Family	\$3,000 of EME per Insured \$6,000 of EME per Family

Covered Services	Insured Pays	Insured Pays
Physician Services		
Office Visit	\$35 per visit	After CYD, Insured pays 40% of EME plus all charges in excess of EME
Consultation	\$35 per visit	
Hospital Services		
Inpatient	After CYD, Insured pays 20% of EME	↓
Outpatient		
Physician Surgical Services		
Inpatient Facility	After CYD, Insured pays 20% of EME	↓
Outpatient Facility		
Anesthesia		
Physician's Office		
Emergency Services		
Urgent Care Facility	\$50 per visit	After CYD, Insured pays 20% of EME
Emergency Room Facility	After CYD, Insured pays 20% of EME	
Emergency Room Physician		
Ground Ambulance		
Diagnostic Services		
Routine Laboratory		↓
Routine X-ray		

This plan does not include maternity coverage.

*EME (Eligible Medical Expenses) means the maximum amount the Plan will pay for a Covered Service in accordance with the Plan Reimbursement Schedule. The Plan Provider and Non-Plan Provider Annual Coinsurance Maximums are separate and do not accumulate to one another. Non-Plan Provider charges in excess of EME may be substantial and do not accrue toward the Annual Coinsurance Maximum. This Plan includes additional benefits, exclusions and limitations which are shown in the SHL Agreement of Coverage, Attachment A Benefit Schedule, Form No. SHL-IndDAP-masBS-2005, any other applicable Riders and the Disclosure Summary. Copies of these documents are available upon request. Plan documents govern in resolving any benefit questions or payments.

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Distinct Advantage PPO Plan 3

Plan Provider Benefits

Non-Plan Provider Benefits

Lifetime Maximum
Calendar Year Deductible (CYD)
combined Plan and Non-Plan Provider
Annual Coinsurance Maximum (after CYD)
separate Plan and Non-Plan Provider

\$2,000,000 of EME*
\$2,500 per Insured/\$5,000 per Family
\$2,500 of EME per Insured
\$5,000 of EME per Family
\$5,000 of EME per Insured
\$10,000 of EME per Family

Covered Services	Insured Pays	Insured Pays
Physician Services		
Office Visit	\$40 per visit	After CYD, Insured pays 30% of EME plus all charges in excess of EME
Consultation	\$40 per visit	
Hospital Services		
Inpatient	After CYD, Insured pays 10% of EME	
Outpatient		
Physician Surgical Services		
Inpatient Facility	\$40 per visit	
Outpatient Facility		
Anesthesia		
Physician's Office		
Emergency Services		
Urgent Care Facility	\$55 per visit	
Emergency Room Facility	After CYD, Insured pays 10% of EME	
Emergency Room Physician		
Ground Ambulance		
Diagnostic Services		
Routine Laboratory		
Routine X-ray		

This plan does not include maternity coverage.

*EME (Eligible Medical Expenses) means the maximum amount the Plan will pay for a Covered Service in accordance with the Plan Reimbursement Schedule. The Plan Provider and Non-Plan Provider Annual Coinsurance Maximums are separate and do not accumulate to one another. Non-Plan Provider charges in excess of EME may be substantial and do not accrue toward the Annual Coinsurance Maximum. This Plan includes additional benefits, exclusions and limitations which are shown in the SHL Agreement of Coverage, Attachment A Benefit Schedule, Form No. SHL-IndDAP-masBS-2005, any other applicable Riders and the Disclosure Summary. Copies of these documents are available upon request. Plan documents govern in resolving any benefit questions or payments.

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Distinct Advantage PPO Plan 4

	Plan Provider Benefits	Non-Plan Provider Benefits
Lifetime Maximum		\$2,000,000 of EME*
Calendar Year Deductible (CYD) <i>combined Plan and Non-Plan Provider</i>		\$5,000 per Insured/\$10,000 per Family
Annual Coinsurance Maximum (after CYD) <i>separate Plan and Non-Plan Provider</i>	\$2,500 of EME per Insured \$5,000 of EME per Family	\$5,000 of EME per Insured \$10,000 of EME per Family

Covered Services	Insured Pays	Insured Pays
Physician Services		
Office Visit	\$50 per visit	After CYD, Insured pays 40% of EME plus all charges in excess of EME
Consultation	\$50 per visit	
Hospital Services		
Inpatient	After CYD, Insured pays 20% of EME	
Outpatient		
Physician Surgical Services		
Inpatient Facility	\$50 per visit	
Outpatient Facility		
Anesthesia		
Physician's Office		
Emergency Services		
Urgent Care Facility	\$65 per visit	
Emergency Room Facility	After CYD, Insured pays 20% of EME	
Emergency Room Physician		
Ground Ambulance		
Diagnostic Services		
Routine Laboratory		
Routine X-ray		

This plan does not include maternity coverage.

*EME (Eligible Medical Expenses) means the maximum amount the Plan will pay for a Covered Service in accordance with the Plan Reimbursement Schedule. The Plan Provider and Non-Plan Provider Annual Coinsurance Maximums are separate and do not accumulate to one another. Non-Plan Provider charges in excess of EME may be substantial and do not accrue toward the Annual Coinsurance Maximum. This Plan includes additional benefits, exclusions and limitations which are shown in the SHL Agreement of Coverage, Attachment A Benefit Schedule, Form No. SHL-IndDAP-masBS-2005, any other applicable Riders and the Disclosure Summary. Copies of these documents are available upon request. Plan documents govern in resolving any benefit questions or payments.

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Distinct Advantage - PPO \$7/\$35/\$55 Prescription Drug Benefit Summary

This is a summary of benefits and Drug Fees under the Sierra Health and Life (SHL) Prescription Drug Benefit Rider. A complete list of Preferred Covered Drugs can be obtained by calling SHL's Member Services Department at (702) 242-7700 or for more information, visit our web site at www.sierrahealthandlife.com. Insured will pay the lowest Drug Fee when his/her Provider prescribes Preferred Generic Covered Drugs.

Commonly Used Plan Terms

Covered Drugs

All prescriptions must be written for Covered Drugs in order to be eligible for payment under the Plan. Covered Drugs are those which are obtained with a prescription, approved by the FDA, dispensed by a licensed pharmacist, and not excluded by the Plan. Benefits for certain medically necessary Covered Drugs may require prior authorization from SHL. If such Covered Drugs are provided without prior authorization, benefits are reduced by 50% of what the Insured would have received with prior authorization.

Plan Pharmacies

Insured has access to local outlets of nationally recognized pharmacy chains. Plan Pharmacies are listed in the SHL Provider Directory.

Maintenance Drugs

Certain Preferred Maintenance Drugs may be available for up to a 90-day Maintenance Supply. This benefit allows the Insured to take advantage of our money-saving Mail Order prescription program. Examples of Preferred Maintenance Drugs include medications that are used to treat certain chronic, life threatening or long-term conditions such as diabetes, heart disease, high blood pressure and arthritis.

Plan Retail Pharmacy

Preferred Generic Covered Drugs	\$7 Drug Fee - up to a 30-day Therapeutic Supply
Preferred Brand Name Covered Drugs <i>(without a Generic Equivalent)</i>	\$35 Drug Fee - up to a 30-day Therapeutic Supply
Preferred Brand Name Covered Drugs <i>(with a Generic Equivalent)</i>	\$7 Drug Fee - plus the difference between the EME* of the Generic Covered Drug and the EME of the Brand Name Covered Drug - up to a 30-day Therapeutic Supply
Non-Preferred Generic or Brand Name Covered Drugs	\$55 Drug Fee - up to a 30-day Therapeutic Supply

Non-Plan Retail Pharmacy

Prescriptions can also be filled at Non-Plan Pharmacies. When a Covered Drug is dispensed by a Non-Plan Pharmacy, the Insured will pay the full cost of the Covered Drug and submit a claim form to SHL for reimbursement. SHL pays 70% of EME for Covered Drugs less the applicable Generic, Brand Name or Non-Preferred Drug Fee per Therapeutic Supply.

Plan Mail Order Pharmacy

Preferred Maintenance Covered Drugs	The Insured pays two of the applicable Drug Fees as outlined above, up to a 90-day Maintenance Supply, for Preferred Generic or Brand Name Covered Drugs. Benefits for Mail Order prescriptions are available through the contracted SHL Mail Order Plan Pharmacy.
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*EME (Eligible Medical Expenses) means the network pharmacy contracted cost of the Covered Drug to the Plan. This Plan includes Exclusions and Limitations that are shown in the Prescription Drug Benefit Rider, Form No. SHL-IPPO-3TierSIO-2004, SHL Certificate of Coverage, Attachment A Benefit Schedule and any other applicable Riders. Copies of these documents are available upon request. Plan documents govern in resolving any benefit questions or payments. This is a summary of covered prescription drugs.