Sierra Health and Life Insurance Company, Inc.

Sierra 2000 Plan 250/1586

	Plan Provider Benefits	Non-Plan Provider Benefits
Lifetime Maximum	$2,000,000 of EME*	
Calendar Year Deductible (CYD) *combined Plan and Non-Plan Provider*	$250 per Insured/$750 per Family	
Annual Coinsurance Maximum (after CYD) *separate Plan and Non-Plan Provider*	$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	$15 per visit	After CYD, Insured pays 40% of EME plus all charges in excess of EME.
Consultation	$15 per visit	
Hospital Services		
Inpatient	After CYD, Insured pays 20% of EME.	
Outpatient		
Physician Surgical Services		
Inpatient Facility		
Outpatient Facility		
Physician's Office		
Anesthesia		
Emergency Services		
Urgent Care Facility	$20 per visit	
Emergency Room Facility	After CYD, Insured pays 20% of EME.	
Emergency Room Physician		
Ground Ambulance (when Medically Necessary)		
Diagnostic Services		
Routine Laboratory		
Routine X-ray		

*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 Certificate of Coverage, Attachment A Benefit Schedule, Form No. S2KMASBS2000, 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.

(01/06-2,000)
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PD-4091

Sierra Health and Life Insurance Company, Inc.

$8/$25 Outpatient Group Prescription Drug Benefit Summary

Sierra Health and Life Insurance Company, Inc., (SHL) offers access to one of the largest pharmacy networks locally and nationwide. A list of Plan Pharmacies can be found in the SHL Provider Directory or by calling our Member Services Department at (702) 242-7700.

Plan Retail Pharmacy

Generic Covered Drugs	$8 Drug Fee - up to a 30-day Therapeutic Supply
Brand Name Covered Drugs *(without a Generic Equivalent)*	$25 Drug Fee - up to a 30-day Therapeutic Supply
Brand Name Covered Drugs *(with a Generic Equivalent)*	$8 Drug Fee - plus the difference between the EME* of the Generic and the EME of the Brand Name Covered Drug - 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 or Brand Name Drug Fee per Therapeutic Supply.

Plan Mail Order Pharmacy

Maintenance Covered Drugs	The Insured pays two of the applicable Drug Fees as outlined above, up to a 90-day Maintenance Supply, for Generic or Brand Name Covered Drugs. Benefits for Mail Order prescriptions are available through the contracted SHL Mail Order Plan Pharmacy.

*EME (Eligible Medical Expenses) means the Plan Pharmacy contracted cost of the Covered Drug to SHL. This is a summary of covered benefits under the SHL Group Prescription Drug Benefit Rider, Form No. SHL-NV-2TierRx-(06/06). This Plan includes additional benefits, Exclusions and Limitations which are shown in the 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.

(09/07-2,000) (2X M.O.)
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