SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Attachment A - Benefit Schedule

To The Sierra Health and Life Insurance Company, Inc.
Dental Insurance Certificate
A Preferred Provider Organization ("PPO") Plan

DENTAL PPO PLAN 3

Please read the definition of Eligible Dental Expenses ("EDE") and SHL Reimbursement Schedule in the Certificate. When accessing a Non-Plan Dentist, you are responsible for any charges over EDE.

Your Calendar Year Deductible for In-Plan Dentist Type II and Type III services is $50 per Insured, with a maximum of 3 per family. Your Calendar Year Deductible for Non-Plan Dentist Type II and Type III services is $50 per Insured, with a maximum of 3 per family. Your Calendar Year plan maximum benefit is $1,500 per Insured.

Type III Covered Services Waiting Period

You will not be eligible to receive any benefits for Type III Covered Services until you have been covered under this Certificate for 12 consecutive months. For Groups of 15 or more Employees who meet the following two requirements, Waiting Period Credit will be allowed for the amount of time an Insured had continuous coverage under the Group's previous dental plan. First, the previous plan had been in force at least twelve (12) consecutive months immediately prior to the Effective Date of this plan. And, second, this certificate was issued within sixty (60) days after the date the previous dental plan was discontinued. Credit will be applied only for those Insureds covered under the Group's prior dental plan on the Effective Date of this Certificate.

Predetermination

Predetermination is recommended for all Type III services. Please see Section 4 and 5 of your Dental Certificate for additional information about Predetermination.

Deductible Credit

Dental Expenses incurred by an individual on or after January 1st of the Calendar Year in which this Certificate becomes effective, will apply to the current Calendar Year Deductible for this plan if: 1) proof is furnished to SHL that such dental expenses were covered under the Group's dental insurance policy in force immediately prior to the Effective Date of this Certificate; and 2) such expenses would have been considered Covered Services under this Certificate had this Certificate been in force at the time expenses were incurred.

Dental Benefit Schedule

COVERED SERVICES	IN-PLAN COINSURANCE **Plan Dentist** No Calendar Year Deductible applies to Type I services. **Insured pays**	NON-PLAN COINSURANCE **Non-Plan Dentist** No Calendar Year Deductible applies to Type I services. **Insured pays**
TYPE I SERVICES DIAGNOSTIC AND PREVENTIVE		
Routine Evaluation (exams limited to twice per Calendar Year)	0% of EDE	20% of EDE
Limited to Oral Evaluation – problem-focused/emergency	0% of EDE	20% of EDE
Detailed and Extensive Oral Evaluation – problem-focused (exam limited to specialists only, i.e. Periodontal Exam)	0% of EDE	20% of EDE
Intraoral Radiograph – Complete Series or Panoramic Survey Film (limited to one or the other, once every three Calendar Years)	0% of EDE	20% of EDE
Intraoral or Extraoral Radiographs	0% of EDE	20% of EDE
Bitewing Radiographs – (limited to twice per Calendar Year)	0% of EDE	20% of EDE
Cephalometric film	0% of EDE	20% of EDE
Oral/facial images, Pulp Vitality Tests and Diagnostic Casts	0% of EDE	20% of EDE
Prophylaxis, Adult or Child (limited to twice per Calendar Year)	0% of EDE	20% of EDE
Topical Application of Fluoride, under the age of 19 (limited to once per Calendar Year)	0% of EDE	20% of EDE
Sealant – per tooth, limited to molars (allowed once in any three Calendar Years, under the age of 19)	0% of EDE	20% of EDE
Space Maintenance Appliance **Note:``Coverage for Space Maintainers is limited to Insureds under the age of nineteen (19) and includes all adjustments within six (6) months after installation. Allowed for the purposes of maintaining spaces created by extraction of primary teeth or unerupted teeth.**	0% of EDE	20% of EDE
Recementation of Space Maintainer	0% of EDE	20% of EDE

COVERED SERVICES	IN-PLAN COINSURANCE **Plan Dentist** After Calendar Year Deductible **Insured pays**	NON-PLAN COINSURANCE **Non-Plan Dentist** After Calendar Year Deductible **Insured pays**
TYPE II SERVICES **RESTORATIVE** (Includes local anesthesia and routine postoperative care)		
Restoration/Amalgam – per tooth (anterior & posterior teeth)	20% of EDE	40% of EDE
Restoration/Composite – per tooth (anterior & posterior teeth)	20% of EDE	40% of EDE
Recementation of Inlay, Crown or Bridge	20% of EDE	40% of EDE
Sedative Filling	20% of EDE	40% of EDE
Pin Retention – per tooth, in addition to restoration	20% of EDE	40% of EDE
Post Removal (not in conjunction with endodontic therapy)	20% of EDE	40% of EDE
Prefabricated Crown, per tooth (limited to under age 19)	20% of EDE	40% of EDE
TYPE II SERVICES **ENDODONTICS** (Includes local anesthesia and routine postoperative care)		
Pulp Cap – excluding final restoration	20% of EDE	40% of EDE
Therapeutic Pulpotomy, excluding final restoration	20% of EDE	40% of EDE
Pulpal Therapy, per primary tooth	20% of EDE	40% of EDE
Root Canal Therapy – initial or re-treatment, per tooth **Note: Root Canals include intra-operative radiographs; excludes final restoration.**	20% of EDE	40% of EDE
Apexification/Recalcification – per visit	20% of EDE	40% of EDE
Apicoectomy/Periradicular surgery – one or first root	20% of EDE	40% of EDE
Apicoectomy/Periradicular surgery – each additional root	20% of EDE	40% of EDE
Retrograde Filling – per root	20% of EDE	40% of EDE
Root Amputation – per root	20% of EDE	40% of EDE
Hemisection (including root removal) not including root canal therapy	20% of EDE	40% of EDE

COVERED SERVICES	IN-PLAN COINSURANCE **Plan Dentist** After Calendar Year Deductible **Insured pays**	NON-PLAN COINSURANCE **Non-Plan Dentist** After Calendar Year Deductible **Insured pays**
TYPE II SERVICES **PERIODONTICS** (Includes local anesthesia and routine postoperative care)		
Gingivectomy or Gingivoplasty – per quadrant	20% of EDE	40% of EDE
Gingivectomy or Gingivoplasty – per tooth	20% of EDE	40% of EDE
Gingival Curettage, surgical – per quadrant	20% of EDE	40% of EDE
Gingival Flap Procedure (including Root Planing) – per quadrant	20% of EDE	40% of EDE
Clinical Crown Lengthening	20% of EDE	40% of EDE
Osseous Surgery – (including flap entry and closure) – per quadrant	20% of EDE	40% of EDE
Free Soft Tissue Graft Procedure (including donor site surgery)	20% of EDE	40% of EDE
Periodontal Scaling/Root Planing – per quadrant (limited to once per quadrant per Calendar Year)	20% of EDE	40% of EDE
Full Mouth Debridement (limited to once in 3 Calendar Years)	20% of EDE	40% of EDE
Periodontal Maintenance Procedure – following Active Therapy (limited to once in any three month period)	20% of EDE	40% of EDE
TYPE II SERVICES **ORAL SURGERY** (Includes local anesthesia and routine postoperative care)		
Simple Extraction – per tooth	20% of EDE	40% of EDE
Surgical Extraction – per tooth	20% of EDE	40% of EDE
Surgical Exposure of impacted or unerupted tooth – per tooth	20% of EDE	40% of EDE
Alveoloplasty – per quadrant	20% of EDE	40% of EDE
Removal of Exostosis – per site	20% of EDE	40% of EDE
Incision and Drainage of Abscess	20% of EDE	40% of EDE
Frenulectomy	20% of EDE	40% of EDE

COVERED SERVICES	IN-PLAN COINSURANCE **Plan Dentist** After Calendar Year Deductible **Insured pays**	NON-PLAN COINSURANCE **Non-Plan Dentist** After Calendar Year Deductible **Insured pays**
TYPE II SERVICES ADJUNCTIVE GENERAL SERVICES		
Excision of hyperplastic tissue – per arch	20% of EDE	40% of EDE
Sectioning of a bridge, to enable extraction of an abutment tooth	20% of EDE	40% of EDE
Adjustment to Denture or Partial, per appliance, per visit	20% of EDE	40% of EDE
Repair to Denture or Partial Denture, per repair, per appliance	20% of EDE	40% of EDE
Palliative (Emergency) treatment of dental pain – minor procedures	20% of EDE	40% of EDE
General Anesthesia or Intravenous Sedation when administered by the dentist in the office (when in connection with a surgical extraction or surgical procedure, or when Medically Necessary).	20% of EDE	40% of EDE
Analgesia, anxiolysis, inhalation of nitrous oxide (limited to a child under the age of 8, when Medically Necessary.)	20% of EDE	40% of EDE
Professional Consultation (diagnostic service provided by dentist other than dentist providing treatment)	20% of EDE	40% of EDE
Office Visit after Regularly Scheduled Office Hours	20% of EDE	40% of EDE
Therapeutic Drug Injection	20% of EDE	40% of EDE
Other Drugs and/or Medicaments, by report	20% of EDE	40% of EDE
Application of Desensitizing Medicaments	20% of EDE	40% of EDE
Behavior management (limited to a child under the age of 8)	20% of EDE	40% of EDE
Treatment of Complications (post-surgical), unusual circumstances	20% of EDE	40% of EDE
TYPE III SERVICES (SUBJECT TO 12 MONTH WAITING PERIOD) PROSTHODONTICS – REMOVABLE (Includes local anesthesia and routine postoperative care)		
Denture or Partial Denture, per appliance	50% of EDE	50% of EDE

COVERED SERVICES	IN-PLAN COINSURANCE **Plan Dentist** After Calendar Year Deductible **Insured pays**	NON-PLAN COINSURANCE **Non-Plan Dentist** After Calendar Year Deductible **Insured pays**
Rebase Denture or Partial Denture (limited to once per 3 Calendar Years, per appliance)	50% of EDE	50% of EDE
Reline Denture or Partial Denture, chairside process (limited to twice per Calendar Year, per appliance)	50% of EDE	50% of EDE
Reline Denture or Partial Denture, laboratory process (limited to twice per Calendar Year, per appliance)	50% of EDE	50% of EDE
Interim Partial Denture, replacing anterior teeth (temporary stayplate/flipper)	50% of EDE	50% of EDE
Tissue Conditioning (limited to twice per Calendar Year per appliance)	50% of EDE	50% of EDE
Note: Adjustments are included in the cost of full and immediate dentures, partial dentures, relines and tissues conditionings within the first six (6) months after installation. Relines are allowed twice in a Calendar Year. Precision attachments, overdentures, specialized techniques and characterizations are considered optional and the additional expense shall be borne by the insured. All partials include conventional clasps and rests.		
TYPE III SERVICES (SUBJECT TO 12 MONTH WAITING PERIOD) RESTORATIVE AND PROSTHODONTICS - FIXED (Includes local anesthesia and routine postoperative care)		
Inlay or Onlay, each	50% of EDE	50% of EDE
Crown – per tooth	50% of EDE	50% of EDE
Core Buildup, including pins	50% of EDE	50% of EDE
Post and Core, in addition to crown	50% of EDE	50% of EDE
Temporary Crown, fractured tooth	50% of EDE	50% of EDE
Crown or Bridge Repair (by report)	50% of EDE	50% of EDE
Pontic – per tooth	50% of EDE	50% of EDE

COVERED SERVICES	IN-PLAN COINSURANCE **Plan Dentist** After Calendar Year Deductible **Insured pays**	NON-PLAN COINSURANCE **Non-Plan Dentist** After Calendar Year Deductible **Insured pays**
Retainer (inlay/onlay) – per tooth	50% of EDE	50% of EDE
Retainer (crown/abutment) – per tooth	50% of EDE	50% of EDE

NOTE: REFER TO THE CERTIFICATE OF COVERAGE FOR LIMITATIONS, EXCLUSIONS, MANAGED CARE REQUIREMENTS AND ADDITIONAL INFORMATION ABOUT THE COVERED SERVICES.