Sierra Health and Life
A UnitedHealthcare Company

Clark County School District (CCSD)
Support Staff
Group Certificate of Coverage

This plan may include a Calendar Year Deductible; please refer to the Attachment A Benefit Schedule.

Certificate of Coverage ("COC") contains the terms and conditions under which Sierra Health and Life Insurance Co., Inc. ("SHL") makes coverage available to Eligible Individuals of CCSD Support Staff and their Eligible Family Members under the Group Enrollment Agreement ("GEA") issued to the policyholder (hereinafter referred to as "Group") and makes benefit payments for certain healthcare services.

SHL and the Group have agreed to all of the terms of this COC, and the COC has been incorporated by reference into the GEA signed by the Group. The Plan (as defined herein) may be terminated by SHL or Group upon written notice in accordance with this COC and the GEA. This Plan is guaranteed renewable. The Group is responsible for giving Insureds notice of termination of this Plan.

This COC and your attached Attachment A Benefit Schedule tell you about your benefits, rights and duties as an SHL Insured. They also tell you about SHL's duties to you.

This Certificate and your attached Attachment A Benefit Schedule tell you about your benefits, rights and duties as an SHL Insured. They also tell you about SHL's duties to you.

This Certificate, including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, your Enrollment Form, health statements, Insured identification card and all other applications received by SHL are all part of your SHL membership package. Please read them carefully and keep them in a safe place. **Words that are capitalized are defined in Section 15. - Glossary.**

Please carefully review your Certificate and your Attachment B, Services Requiring Prior Authorization, to determine which services require Prior Authorization under the Plan. Failure of the Insured to comply with the requirements of SHL's Managed Care Program and the Prior Authorization process will result in a reduction of benefits.

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The Department of Business and Industry

State of Nevada

Division of Insurance

Telephone Numbers for Consumers of Healthcare

The Division of Insurance ("Division") has established a telephone service to receive inquiries and complaints from consumers of healthcare in Nevada concerning healthcare plans.

Hours of operation for the Division:

Monday through Friday from 8 a.m. until 5 p.m., Pacific Time (PT)

The Division is closed during state holidays.

Contact information for the Division:

Carson City Office:
Phone: (775) 687-0700
Fax: (775) 687-0787
1818 East College Pkwy., Suite 103
Carson City, NV 89706

Las Vegas Office:
Phone: (702) 486-4009
Fax: (702) 486-4007
3300 West Sahara Ave., Suite 275
Las Vegas, NV 89102

The Division also provides a toll-free number for consumers residing outside of the above areas:

1-800-992-0900

Please listen to the greeting and select the appropriate prompt.

If you have any questions regarding your health care coverage, please contact SHL's Member Services Department at the following:

Address -

Sierra Health and Life Insurance Company, Inc.
Attn: Member Services Department
P.O. Box 15645
Las Vegas, NV 89114-5645

Phone -

1-800-888-2264

(Monday – Friday from 8:00 a.m. until 5:00 p.m., PT)

SECTION 1. Eligibility, Enrollment and Effective Date

Subscribers and Dependents who meet the following criteria are eligible for coverage under this COC.

1.1 Who Is Eligible

Subscriber. To be eligible to enroll as a Subscriber, an individual must be an Eligible Individual or Eligible Surviving Spouse as defined herein.

The active employment status requirement will not apply to individuals covered under Group's prior welfare benefit plan on the date of that plan's discontinuance, provided that this COC is initially effective no more than sixty (60) days after the prior plan's discontinuance.

Dependent. To be eligible to enroll as a Dependent, a person must be one (1) of the following:

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage, provided, however, that the Subscriber has enrolled for coverage under this Plan due to his status as an Eligible Individual rather than as an Eligible Surviving Spouse. An Eligible Surviving Spouse who elects to be covered as a Subscriber shall not be entitled, under any circumstances, to enroll his or her legal spouse as a Dependent.
- A child by birth. Adopted child. Stepchild. Minor child for whom a court has ordered coverage. Child being Placed for Adoption with the Subscriber. A child for whom a court has appointed the Subscriber or the Subscriber's spouse the legal guardian.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under the limiting age of 27.
- A Dependent includes a Dependent child who is incapable of self-sustaining employment due to mental or physical handicap, chiefly dependent upon the Subscriber for economic support and maintenance, and who has satisfied all of the requirements of (a) or (b) below:
  a. The child must be covered as a Dependent under this Plan before reaching the limiting age, and proof of incapacity and dependency must be given to SHL by the Subscriber within thirty-one (31) days of the child reaching the limiting age; or
  b. The handicap started before the child reached the limiting age, but the Subscriber was covered by another health insurance carrier that covered the child as a handicapped Dependent prior to the Subscriber applying for coverage with SHL.

SHL may require proof of continuing incapacity and dependency when the child reaches the limiting age. SHL's determination of eligibility is final.

Evidence of any court order needed to prove eligibility must be given to SHL.

1.2 Who Is Not Eligible

Eligible Dependents do not include:

- A foster child.
- A child placed in the Subscriber's home other than for adoption.
- A grandchild.
- Any other person not defined in Section 1.1.

1.3 Changes In Eligibility Status

It is the Subscriber's responsibility to give SHL written notice within thirty-one (31) days of changes, which affect his Dependents' eligibility. Changes include:

- Reaching the limiting age.
- Death.
- Divorce.
- The Eligible Person and/or Dependent loses eligibility under Medicaid or the Children's Health Insurance Program (CHIP). Coverage will begin only if SHL receives the completed enrollment form and any required Premium within 60 days of the date coverage ended.

If the Subscriber fails to give notice which would have resulted in termination of coverage, SHL shall have the right to terminate coverage in accordance with the Group Enrollment Agreement.

1.4 Enrollment

Eligible Employees and Eligible Family Members must enroll during one of the Enrollment Periods described below or within thirty-one (31) days of first becoming eligible in order to have coverage under this Plan.

1. **Initial Enrollment Period**. An Initial Enrollment Period is the period of time during which an Eligible Employee and Eligible Family Member may enroll under this Plan, as shown in the GEA signed by the Group.

2. **Group Open Enrollment Period**. An Open Enrollment Period of at least thirty-one (31) days may be held at least once a year allowing Eligible Employees and Eligible Family Members to enroll under this Plan.

3. **Special Enrollment Period**. A Special Enrollment Period allows a Special Enrollee to enroll for coverage under this Plan upon a Special Enrollment Event as defined herein during a period of at least thirty-one (31) days following the Special Enrollment Event.

4. **Right to Deny Application**. SHL can deny membership to any person who:
   - Violates or has violated any provision of the SHL COC.
   - Fails to follow SHL rules.
   - Fails to make a premium payment.

5. **Right to Deny Application for Renewal**. As a condition of Group's renewal under this Plan, SHL may require Group to exclude a Subscriber and/or Dependent who committed fraud upon SHL or misrepresented a material fact which affected his coverage under this Plan.

1.5 Effective Date of Coverage

Before coverage can become effective, SHL must receive and accept premium payments and an Enrollment Form for the person applying to become an Insured. When a person applies to become an Insured on or before the date he is eligible, coverage starts as shown in the GEA signed by Group.

1. If a person applies to become an Insured within thirty-one (31) days of the date he is first eligible to apply, coverage starts the first day of the month following the last day of the required waiting period as stated in the Group's GEA.

2. Subscriber's newborn natural child is covered for the first thirty-one (31) days from birth. Coverage continues after thirty-one (31) days only if the Subscriber enrolls the child as a Dependent and pays any premium within thirty-one (31) days of the date of birth.

3. An adopted child is covered for the first thirty-one (31) days from birth only if the adoption has been legally completed before the child's birth. A child Placed for Adoption at any other age is covered for the first thirty-one (31) days after the Placement for Adoption.

   Coverage continues after the applicable thirty-one (31) day period only if the Subscriber enrolls the child as a Dependent and pays any premium within thirty-one (31) days following the placement of the child in the Subscriber's home. In the event adoption proceedings are terminated, coverage of a child Placed for Adoption ends on the date the adoption proceedings are terminated.

4. If a court has ordered Subscriber to cover his or her legal spouse or unmarried minor child, that person will be covered for the first thirty-one (31) days following the date of the court order. Coverage continues after thirty-one (31) days if the Subscriber enrolls the Dependent and pays the Dependent's premium. A copy of the court order must be given to SHL.

5. For a Special Enrollee, an Enrollment Form must be received during the Special Enrollment Period. The Effective Date of Coverage will be the date of action of the event, unless otherwise specified in the GEA.

SECTION 2. Termination

This section tells you under what conditions your coverage under this Plan will terminate and the date that the coverage will end. In the event an Insured's coverage terminates pursuant to Sections 2.1 and 2.2 below, the coverage of his Dependents will also terminate.

2.1 Termination by SHL

SHL may terminate coverage under this Plan at the times shown for any one or more of the following reasons:
- Failure to maintain eligibility requirements as set forth in Section 1.
- On the first day of the month that a payment was due and was not received by SHL.

- With thirty (30) days written notice, if the Insured allows his, or any other Insured's, SHL ID Card to be used by any other person, or uses another person's SHL ID Card. The Insured will be liable to SHL for all costs incurred as a result of the misuse of the SHL ID Card.
- If the Insured performs an act or practice that constitutes fraud, or makes any intentional misrepresentation of material fact, as prohibited by the terms of coverage, SHL has the right to rescind coverage and declare coverage under the Plan null and void as follows:
  - For a material breach that occurred in the application process, rescission of coverage back to the original Effective Date of Coverage, with a refund any applicable premium; or
  - For any other act of fraud, termination effective no earlier than the date that the fraud had taken place.

  Thirty (30) days written notice shall be provided to the Insured prior to any rescission of coverage. An Insured has the right to appeal any such rescission.

- Subject to Section 3., Continuation of Coverage, on the last day of the calendar month (or sooner, if provided in the GEA) when an Insured no longer meets the requirements of Section 1. this paragraph also applies to Dependents who become ineligible for coverage under this Plan for any reason other than the death of the Subscriber. A Dependent spouse's coverage shall not terminate solely due to the death of the Subscriber. Specifically, coverage under this Plan for the surviving spouse and the children of the deceased employee continues, subject to the terms and conditions of the Plan, if they are otherwise eligible for coverage.
- On the 61st day after a change in residence if an Insured moves his primary residence outside SHL's Service Area. A Subscriber may continue coverage after a change in residence as long as his place of work is within SHL's Service Area. During the sixty (60) consecutive day period after the change in residence, the only Covered Services that SHL will provide outside SHL's Service Area are Emergency Services and Urgently Needed Services.
- On the date the GEA terminates for any reason, including but not limited to:
  1. Nonpayment of premiums.
  2. Failure to meet minimum enrollment requirements.
  3. SHL amends this COC and the Group does not accept the amendment.

2.2 Termination by the Subscriber

Subscriber has the right to terminate his coverage under this Plan by written notice to SHL. Such termination is effective on the last day of the month in which the notice is received by SHL, unless stated otherwise in the GEA.

2.3 Reinstatement

Coverage for any Subscriber that has been terminated in any manner may be reinstated by SHL at its sole discretion in consultation with the CCSD Support Staff.

2.4 Retroactive Termination

A request for retroactive termination by Group may be granted as shown in the GEA.

2.5 Effect of Termination

No benefits will be paid under this Plan by SHL for services provided after termination of an Insured's coverage under this Plan.

SECTION 3. Continuation of Coverage

This section tells you under what conditions your coverage can continue at Group rates in certain instances for a limited period of time when coverage under the Group Health Benefit Plan ends.

3.1 COBRA

The following rules apply only to Groups with twenty (20) or more employees on 50% of the workdays in the previous Calendar Year. For the purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Omnibus Budget Reconciliation Act of 1989 (OBRA), Group shall be considered the Plan Administrator.

Important Note: This Certificate does not, and cannot, contain all of the information that is required under the COBRA continuation coverage regulations. Federal laws and regulations regarding COBRA are publicly available.

a) A Subscriber and any enrolled Dependent who would lose coverage under this Plan because of:
   1) A reduction in the Subscriber's regularly scheduled work hours, or

2) Because of termination of the Subscriber's employment with the Group for any reason, other than gross misconduct, has the right to elect COBRA continuation coverage. Such coverage may continue for up to eighteen (18) months.

The premium for this COBRA continuation coverage may be increased to 102% of the premium for providing coverage to other Subscribers under this Plan. COBRA continuation coverage will not take effect until the Subscriber or Dependent elects COBRA and makes the required payment. The Subscriber or Dependent will have an initial grace period of forty-five (45) days from the date of COBRA election to make the first premium payment.

If the qualifying event is:
1) A reduction in the Subscriber's regularly scheduled work hours, or
2) Because of termination of the Subscriber's employment with the Group for any reason other than gross misconduct and the Subscriber became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, then COBRA continuation coverage for Dependents may continue for up to thirty-six (36) months after the initially determined date of Medicare entitlement.

b) A Dependent who would lose coverage under this Plan due to any of the qualifying events shown below has the right to elect COBRA continuation coverage. Such coverage may continue for up to thirty-six (36) months.

1. The Subscriber's death.
2. The Subscriber's divorce or legal separation.
3. The Subscriber becomes entitled to Medicare benefits under Part A, Part B, or both.
4. A Dependent no longer qualifies as a Dependent child as provided in Section 1. of this Certificate.

The premium for continuation coverage may be increased to 102% of the premium for providing coverage to other individuals under this Plan.

c) **Election of COBRA Continuation Coverage**. A Subscriber or Dependent identified in 3.1(a) or (b) above must elect to continue coverage within sixty (60) days of the election notice which qualifies him to continue coverage. If the election is not made within sixty (60) days, the Subscriber or Dependent is not eligible to continue coverage under this Plan.

Each Subscriber or Dependent will have an independent right to elect COBRA continuation coverage. Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Plans Offered Under COBRA Continuation Coverage. Subscribers and Dependents who qualify and elect COBRA continuation coverage must be offered the same Plan as similarly situated employees for whom a qualifying event has not occurred.

For purposes of COBRA continuation coverage, "similarly situated employees" means the group of covered employees, spouses of covered employees, or Dependent children of covered employees receiving coverage under a Group Health Benefit Plan maintained by the employer. Similarly situated employees receive healthcare coverage for a reason other than under COBRA continuation coverage and who, based on all of the facts and circumstances are most similarly situated to the circumstances of the qualified Subscriber immediately before the qualifying event.

For the purposes of determining the cost of COBRA continuation coverage, the Plan is entitled to take into account the Plan under which COBRA continuation coverage is provided.

d) **Notice from Plan Administrator (Group)**. The Plan Administrator will have up to forty-four (44) days from the qualifying event to provide the Subscriber or Dependent with the COBRA election notice which contains information concerning the actions required to elect COBRA continuation coverage and the premium to be paid. The Plan Administrator has the sole obligation to provide the Subscriber or Dependent with a notice of unavailability in the event that the Plan Administrator determines that such Subscriber or Dependent is not entitled to COBRA continuation coverage. SHL assumes no responsibility for the Plan Administrator's failure to provide COBRA notifications to the eligible Insureds.

e) SHL assumes no further obligation to provide COBRA continuation coverage if:
- The Plan Administrator does not notify the Insured within forty-four (44) days of the qualifying event; or
- The Insured does not make a timely election; or
- The Plan Administrator fails to notify SHL of the election within thirty (30) days of the election; or
- Timely premium payments are not made as described in 3.1(f).

There are two (2) ways in which the eighteen (18)-month period of COBRA continuation coverage identified in 3.1(a) can be extended:

1. **Disability Extension**. If a Subscriber or Dependent covered under the Plan is disabled as determined under Title II (OASDI) or Title XVI (SSI) of the Social Security Act (SSA), COBRA continuation coverage will be extended from eighteen (18) months up to a total maximum of twenty-nine (29) months, provided the disability started at some time before the sixtieth (60th) day of COBRA continuation coverage, continues until the end of the eighteen (18)-month period of COBRA continuation coverage, and notice is received by Group before the initial eighteen (18)-month period expires.

   The premium for the extension period of COBRA continuation coverage will be increased to 150% of the applicable Group premium for providing coverage to other Subscribers under this Plan. During the extended period, a disabled individual's coverage will be terminated automatically as of the first day of the month that is more than thirty (30) days after a final determination that the Subscriber or Dependent is no longer disabled.

   The individual is required to notify the Group within thirty (30) days of such determination. Disabled individuals are also subject to termination as set forth in 3.1(f).

2. **Second Qualifying Event Extension**. If a second qualifying event occurs while receiving eighteen (18) months of COBRA continuation coverage, an enrolled spouse and Dependent children can qualify for eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan.

   This extension may be available to the spouse and any Dependent children receiving COBRA continuation coverage if the Subscriber or former Subscriber:
   - Dies;
   - Becomes entitled to Medicare benefits (under Part A, Part B, or both);
   - Gets divorced or legally separated; or
   - If the Dependent child no longer qualifies as a Dependent child as provided in Section 1. of this Certificate.

f) **Required Notification**. The Subscriber or Dependent must notify Group and Group must notify SHL within sixty (60) days beginning from the latest of:
1. The date on which the relevant qualifying event occurs;
2. The date on which there is a loss of coverage under the Plan as a result of the qualifying event; or
3. The date on which the Subscriber or Dependent is informed through the Plan's Certificate or the general COBRA notice of their obligation to provide notice and the procedures for providing such notice.

The Subscriber or Dependent must provide notice to Group of any of the following qualifying events:

- A Subscriber's divorce.
- A Subscriber's legal separation.
- A Dependent no longer meets SHL's eligibility rules.
- A second qualifying event after a Subscriber or Dependent has become entitled to COBRA continuation coverage with a maximum duration of eighteen (18) or twenty-nine (29) months.
- A Subscriber or Dependent entitled to receive COBRA continuation coverage with a maximum duration of eighteen (18) months has been determined by the Social Security Administration under Title II or XVI of SSA to be disabled at any time during the first sixty (60) days of COBRA continuation coverage.

The Insured who seeks the disability extension must notify the Plan Administrator and SHL of the Social Security Administration disability determination no later than sixty (60) days after the latest of:
1) The date of Social Security Administration determination;
2) The date on which the qualifying event occurs;
3) The date on which the Subscriber or Dependent loses coverage under the Plan as a result of a qualifying event;
4) The date on which the Subscriber or Dependent is informed through the Plan's Certificate or the general COBRA notice of their obligation to provide notice.

- A disabled Subscriber or Dependent, who has subsequently been determined by the Social Security Administration under Title II or XVI of the SSA to no longer be disabled.

  If an Insured is determined by the Social Security Administration to no longer be disabled, the Insured must notify the Plan of that fact within thirty (30) days after the Social Security Administration's determination.

Any Subscriber, Dependent or any representative designated or authorized to act on behalf of the Subscriber or Dependent may provide the notice and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of the Subscriber and all Dependents with respect to the qualifying event.

g) **Non-Eligibility and Termination**. In addition to SHL's other rights to terminate this coverage as shown in Section 2., COBRA continuation coverage will not be allowed or shall be terminated prior to the end of the applicable eighteen (18)-month period, the nineteen (19) to twenty-nine (29) month extension period for the disability extension, or thirty-six (36)-month period for Dependents, if any of the following occur:

- The GEA is terminated in its entirety.

- The Subscriber, spouse or Dependent fails to pay premiums in full when due.

  The Subscriber or Dependent will have a one-time only initial grace period of forty-five (45) days from the date of COBRA election to make the first premium payment. Thereafter, payments for COBRA continuation coverage are due by the first day of each monthly period to which the payment applies (payments must be postmarked on or before the thirty (30)-day grace period).

  If you do not make payments on a timely basis, COBRA continuation coverage will terminate as of the last day of the period for which timely payment was made.

- The Subscriber or Dependent becomes eligible for coverage under another Group Health Benefit Plan.

- The divorced spouse remarries and becomes eligible for coverage under another Group Health Benefit Plan.

- The Subscriber or Dependent becomes entitled to Medicare benefits (under Part A, Part B or both) after electing COBRA continuation coverage.

- A disabled Subscriber is found to be no longer disabled.

The Plan Administrator has the sole obligation to provide the Subscriber or Dependent with a notice of termination in the event that COBRA continuation coverage is terminated prior to the end of the maximum period. SHL assumes no responsibility for the Plan Administrator's failure to provide such notification to the eligible Insureds.

h) **Address Changes**. The Insured shall be responsible for notifying Group of any changes in the addresses of enrolled Dependents.

i) **Plan Contact Information**. For additional information about the Plan or your rights under COBRA continuation coverage, contact SHL's Member Services Department by calling 1-800-888-2264.

j) **COBRA and FMLA**. If the Subscriber has taken a leave of absence under the Family Medical Leave Act of 1993 (FMLA) and does not return to work at the end of the FMLA leave, the Subscriber and Dependents may elect COBRA continuation coverage for up to eighteen (18) months from the earliest to occur of the following:
- The date that the Subscriber states that they will not be returning to work at the end of the leave;
- The end of the approved leave, assuming that the Subscriber does not return; or
- The date that the FMLA entitlement ends.

For purposes of an FMLA leave, the Subscriber and Dependents will be eligible for COBRA continuation coverage only if:
- The Subscriber and Dependents are covered by the Group Health Benefit Plan on the day before the leave begins (or become covered during the FMLA leave);
- The Subscriber does not return to employment at the end of the FMLA leave; and
- The Subscriber or Dependents lose coverage under SHL's Group Health Benefit Plan before the end of what would be the maximum COBRA continuation coverage period.

3.2 Federal Continuation of Coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

For Groups of any size, the Subscriber or any Dependents shall have the right to continue Group coverage as follows:

(a) **Eligibility**. In the event that Subscriber and any Dependent would lose coverage under the Plan because of Subscriber's absence from work due to Subscriber's service in the uniformed services, Subscriber may elect to continue coverage under the Plan on behalf of Subscriber and any Dependents.

(b) **Duration of COBRA Continuation Coverage**. The maximum period of COBRA continuation coverage under this section shall be the lesser of:

1. The 24-month period beginning on the date on which the Subscriber's absence from work begins; or

2. The day after the date on which the Subscriber fails to apply for or return to work with the Group as follows:
   a. If the Subscriber served in the uniformed services and is absent from work for less than thirty-one (31) days:

      (1) COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment which must not be later than the beginning of the first full regularly scheduled work period on the first full calendar day following completion of the period of service and the expiration of eight (8) hours after a period allowing for the Subscriber's transportation from the place of that service to the Subscriber's residence; or

      (2) As soon as possible after the expiration of the eight (8) hour period referred to in (1) if reporting within the period under (1) is impossible or unreasonable through no fault of the Subscriber.

   b. If the Subscriber is absent from work for any period for purposes of determining the Subscriber's fitness to perform service in the uniformed service, not later than the period described in (1) above.

   c. If the Subscriber served in the uniformed services and is absent from work for more than thirty (30) days but less than 181 days, COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment, which must not be later than fourteen (14) days after completion of the period of service. If applying within that period is impossible or unreasonable through no fault of the Subscriber, then the application for reemployment must be made by the next first full calendar day when applying becomes possible.

   d. If the Subscriber served in the uniformed services and is absent from work for more than 180 days, COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment which must not be later than ninety (90) days after completion of such period of service.

(c) **Premium for COBRA Continuation Coverage**. A Subscriber electing COBRA continuation coverage under this section shall be responsible for paying the applicable premium for such coverage. The premium for COBRA continuation coverage shall not exceed 102% of the applicable premium for providing coverage to other Subscribers of the Group. However, if the Subscriber performs service in the uniformed services for less than thirty-one (31) days, the Subscriber shall be liable only for the premium contribution (if any) that the Subscriber was paying for coverage under the Plan immediately prior to serving in the uniformed services.

3.3 Total Disability of Subscriber

For Groups of any size, continuation of coverage shall be offered to each Subscriber and their Dependents who are otherwise covered by this Plan while the Subscriber is on leave without pay (as defined by the GEA), as a result of Total Disability. This coverage is for any Injury or Illness suffered by the Subscriber, which is not related to the Total Disability or for any Injury or Illness suffered by a Dependent. This coverage will continue, subject to the payment of the applicable premium, until the earliest to occur of:

- The date Subscriber's employment is terminated.
- The date Subscriber obtains other healthcare coverage on an insured or self-insured basis.
- The date the GEA is terminated.
- After a period of twelve (12) months during which benefits for such coverage are provided to the Subscriber.

NOTE: In this Section 3., "Totally Disabled" or "Total Disability" refers to the continuing inability of the Subscriber to substantially perform duties related to his employment. Coverage is equal to coverage provided in this Plan.

3.4 Non-Election

For Groups of any size, if a Subscriber and/or Dependent does not elect to continue coverage under the Group Plan, or does not qualify for continuation of coverage, coverage under this Plan shall terminate on the date provided for in this Certificate.

3.5 State Law

In the event that applicable state law requires different continuation of coverage provisions for any size Group, the provisions required by such state law will apply.

SECTION 4. Managed Care Program

This section tells you about SHL's Managed Care Program and which Covered Services require Prior Authorization.

4.1 Managed Care Program

SHL's Managed Care Program, using the services of professional medical peer review committees, Utilization Review Committees, and/or the Medical Director, determines whether services and supplies are Medically Necessary. The Managed Care Program helps direct care to the most appropriate setting to provide healthcare in a cost-effective manner. Benefits payable for expenses incurred in connection with Covered Services, which are not Prior Authorized by the Managed Care Program, will be reduced as shown in the Attachment A Benefit Schedule.

4.2 Managed Care Program Requirements

SHL's Managed Care Program requires the Insured, Plan Providers and SHL to work together. All Plan Providers have agreed to participate in SHL's Managed Care Program. Plan Providers have agreed to accept SHL's Reimbursement Schedule amount as payment in full for Covered Services, less the Insured's payment of any applicable Calendar Year Deductible, Copayment or Coinsurance amount, whereas Non-Plan Providers have not. In no event will SHL pay more than the maximum payment allowance established in the SHL Reimbursement Schedule.

It is the Insured's responsibility to verify that the Provider selected is a Plan Provider before receiving any non-Emergency Services and to comply with all other rules of SHL's Managed Care Program.

Benefits payable for expenses incurred in connection with Covered Services which are not Prior Authorized by SHL's Managed Care Program will be reduced to 50% of what the Insured would have received if the services had been Prior Authorized.

4.3 Managed Care Process

The Medical Director and/or SHL's Utilization Review Committee will review proposed services and supplies to be received by an Insured to determine:

- If the services are Medically Necessary and/or appropriate.
- The appropriateness of the proposed setting.
- The required duration of treatment or admission.

Following review, SHL will complete the Prior Authorization written notification and send a copy to the Provider and the Insured. The Prior Authorization form will specify approved Covered Services and supplies. **Prior Authorization is not a guarantee of payment for Covered Services**.

The final decision as to whether any care should be received is between the Insured and the Provider. If SHL denies a request by an Insured and/or Provider for Prior Authorization of a service or supply, the Insured or Provider may appeal the denial (see the Appeals Procedures Section herein).

4.4 Services Requiring Prior Authorization

Please refer to Attachment B, Services Requiring Prior Authorization. The list represents services that are commonly reviewed and may require additional clinical information in order for a determination of Prior Authorization to be made.

SHL recommends that the Insured or the Insured's Physician or practitioner making a specific request for services verify benefits under this Plan and the Prior Authorization requirements prior to providing services. The Attachment B, Services Requiring Prior Authorization list is subject to change periodically and may be modified at any time without notification.

4.5 Emergency Admission Notification

The Insured must report all emergency admissions to the Member Services Department at 1-800-888-2264 within twenty-four (24) hours of admission, or as soon as reasonably possible, to authorize continued care.

All Emergency Services admissions are reviewed retrospectively to determine if the treatment received was Medically Necessary and appropriate and was for Emergency Services as defined in this COC. If such Emergency Services are provided by Non-Plan Providers, all Medically Necessary professional, Inpatient or outpatient Emergency Services will be Covered Services.

4.6 Failure to Comply

Failure of the Insured to comply with the requirements of SHL's Managed Care Program will result in a reduction of benefits. Benefits payable for Covered Services which are not Prior Authorized by SHL's Managed Care Program will be reduced to 50% of what the Insured would have received with Prior Authorization.

4.7 Appeals Rights

All decisions of SHL's Managed Care Program may be appealed by the Insured or his Authorized Representative through the Appeals Procedures. If an imminent and serious threat to the health of the Insured exists, the appeal will be directed to SHL's Medical Director.

SECTION 5. Obtaining Covered Services

This section tells you under what conditions services are available under this Plan and your obligations as an Insured. You should also carefully review the Exclusions and Limitations Sections (Section 7. and Section 8. respectively) prior to obtaining any healthcare services.

5.1 Availability of Covered Services

Insureds are entitled to receive benefits for the expenses incurred in connection with the Covered Services shown in Section 6 and the Attachment A Benefit Schedule subject to all terms and conditions of this Certificate, and payment of required premium. These Covered Services are available only if and to the extent that they are:

- Provided or Prescribed by a duly licensed Provider; and
- Specifically authorized through SHL's Managed Care Program as applicable; and
- Medically Necessary as defined in this Certificate.

To obtain maximum benefits, Prior Authorization must be received from SHL's Managed Care Program in order for full benefits to be payable for certain Covered Services. Please read the Certificate and the Attachment B, Services Requiring Prior Authorization, carefully to determine which services require Prior Authorization. This section does not apply to Emergency Services or Urgently Need Services as defined in this Certificate.

5.2 Designated Facilities and Other Providers

If an Insured has a medical condition that SHL determines to need special services, SHL may direct the Insured to a Designated Facility and/or a Designated Provider selected by SHL. If the Insured requires certain complex Covered Health Services for which expertise is limited, SHL may direct the Insured to a Network facility or provider that is outside the Insured's local geographic area. If the Insured is required to travel to obtain such Covered Health Services from a Designated Facility or Designated Provider, SHL may reimburse certain travel expenses at its discretion.

In both cases, Network Benefits will only be paid if the Insured's Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Provider or other provider chosen by SHL.

It is the responsibility of the Insured or of the Network Provider to notify SHL of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Provider. If the Insured does not notify SHL in advance, and if the Insured receives services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network benefits will not be paid. Non-Network Benefits may be available if the special needs services the Insured received are Covered Health Services for which Benefits are provided under the Policy.

Benefits payable for expenses incurred in connection with Covered Services which are not Prior Authorized by SHL's Managed Care Program will be reduced to 50% of what the Insured would have received if the services had been Prior Authorized.

5.3 Provider Selection

Subject to all conditions, exclusions and limitations, if the Insured uses the services of a Provider who is a licensed Practitioner in the state in which he is practicing and who is operating within the scope of his license, then such services shall be treated as though they had been performed by a Physician.

5.4 Continuity of Care from Plan Providers

Termination of a Plan Provider's contract will not release the Provider from treating an Insured, except for reasons of medical incompetence or professional misconduct as determined by SHL.

Coverage provided under this section is available until the latest of the following dates:

- The 120th day following the date the contract was terminated between the Provider and SHL; or
- If the medical condition is pregnancy, the 90th day after the date of delivery or if the pregnancy does not end in delivery the date of the end of the pregnancy.

The Insured or Plan Provider may submit a request for continuity of care to the following address. If the Plan agrees to the continued treatment, the Plan will pay for Covered Services at the Plan Provider level of benefits for a limited time, as outlined above. The Plan Provider may not seek payment from the Insured for any amounts for which the Insured would not be responsible if the Provider were still a Plan Provider.

Sierra Health and Life
PO Box 14856
Las Vegas, NV 89114-4856
Attention: Transition of Care/Continuity of Care
ProviderAdvocateTE@uhc.com

SECTION 6. Covered Services

This section tells you what services are covered under this Plan. Only services and supplies which meet SHL's definition of Medically Necessary will be considered to be Covered Services. The Attachment A Benefit Schedule shows, if applicable, the Calendar Year Deductible, Copayments, Coinsurance and benefit limitations for Covered Services. All Covered Services are subject to SHL's Managed Care Program.

Ambulance Services

Covered Services include Ambulance Services to the nearest appropriate Hospital. SHL will make direct payment to a Provider of Ambulance Services if the Provider does not receive payment from any other source. Ambulance Services will be reviewed on a Retrospective basis to determine Medical Necessity. The Insured will be fully liable for the cost of Ambulance Services that are not Medically Necessary.

Assistant Surgical Services

Covered Services include services performed by an assistant surgeon in connection with a covered surgical procedure but only to the extent that the surgical assistance is necessary due to the complexity of the procedure involved.

Autism Spectrum Disorder Services

Covered Services include Medically Necessary services that are generally recognized and accepted procedures for screening, diagnosing and treating Autism Spectrum Disorders. Covered Services must be provided by a duly licensed physician, psychologist or Behavior Analyst) or other provider that is supervised by the licensed physician, psychologist or behavior analyst and are subject to

SHL's Managed Care Program. With the exception of the specific limitation on benefits for Applied Behavior Analysis ("ABA") as outlined in Attachment A Benefit Schedule, benefits for all Covered Services for the treatment of Autism Spectrum Disorders are payable to the same extent as other Covered Services and Covered Drugs under the Plan.

Covered Services for the treatment of Autism Spectrum Disorder do not include services provided through school services.

Biomarker Testing

Covered Services include medically necessary biomarker testing for appropriate management and ongoing monitoring of a disease or condition.

Clinical Trial or Study

Covered Services include coverage for Prior Authorized medical treatment received as part of a clinical trial or study if the following provisions apply:

- The clinical trial or study is conducted in the state of Nevada and the medical treatment is provided:
  1. In a Phase I, Phase II, Phase III or Phase IV clinical trial or study for the treatment of cancer or other life-threatening disease or condition;
  2. In a Phase II, Phase III or Phase IV clinical trial or study for the treatment of chronic fatigue syndrome;
  3. For cardiovascular disease (cardiac/stroke) which is not life-threatening, for which, as SHL determines, a clinical trial meets the qualifying clinical trial criteria stated below.
  4. For surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which, as SHL determines, a clinical trial meets the qualifying clinical trial criteria stated below.
  5. Other diseases or disorders which are not life-threatening, for which, as SHL determines, a clinical trial meets the qualifying clinical trial criteria stated below
- The clinical trial or study is approved by one of the following entities:
  1. An agency of the National Institutes of Health (NIH) as set forth in 42 U.S.C. § 281 (b);
  2. The Centers for Disease Control and Prevention (CDC);
  3. The Agency for Healthcare Research and Quality (AHRQ);
  4. Centers for Medicare and Medicaid Services (CMS);
  5. A cooperative group;
  6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
  7. The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet the both of following criteria:
     - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
     - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. SHL may, at any time, request documentation about the trial;
- The medical treatment is provided by a duly licensed Provider of healthcare and the facility and personnel have the experience and training to provide the medical treatment in a capable manner;
- There is no medical treatment available which is considered a more appropriate alternative than the medical treatment provided in the clinical trial or study;
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment; and
- The Insured has signed a statement of consent before his participation in the clinical trial or study indicating that he has been informed of:
  1. The procedure to be undertaken;
  2. Alternative methods of treatment; and
  3. The risks associated with participation in the clinical trial or study.

Benefit coverage for medical treatment received during a clinical trial or study is limited to the following Covered Services:

- The initial consultation to determine whether the Insured is eligible to participate in the clinical trial or study;
- Any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the Insured, if the drug or device is not paid for by the manufacturer, distributor, or Provider:
- Services normally covered under this Plan that are required as a result of the medical treatment or related complications provided in the clinical trial or study when not provided by the sponsor of the clinical trial or study;
- Services required for the clinically appropriate monitoring of the Insured during the clinical trial or study when not provided by the sponsor of the clinical trial or study.

Benefits for Covered Services in connection with a clinical trial or study are payable under this Plan to the same extent as any other Illness or Injury.

Services must be provided by an SHL Plan Provider. In the event an SHL Plan Provider does not offer a clinical trial with the same protocol as the one the Insured's Plan Provider recommended, the Insured may select a Non-Plan Provider performing a clinical trial with that protocol within the State of Nevada. If there is no Provider offering the clinical trial with the same protocol as the one the Insured's Plan Provider recommended in Nevada, the Insured may select a clinical trial outside of Nevada but within the United States of America. In no event will SHL pay more than the maximum payment allowance established in the SHL Reimbursement Schedule.

SHL will require a copy of the clinical trial or study certification approval, the Insured's signed statement of consent, and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment.

Corrective Appliances

Corrective Appliances are devices that are designed to support a weakened body part and are manufactured or custom-fitted to an individual. Covered Services include custom-made or custom-fitted Medically Necessary Corrective Appliances when Prior Authorized by SHL's Managed Care Program, to include the following:

- Rigid Cervical Collars;
- Abdominal Binder/Corsets;
- Shoes when prescribed for a diabetic condition, otherwise only when an integral part of a lower body brace;
- Helmets when prescribed in connection with cranial orthosis.

Corrective Appliances do not include:

- Bionic, myoelectric, microprocessor-controlled, and computerized prosthetics; or
- Deluxe upgrades determined not to be Medically Necessary.

Replacements, repairs and adjustments to Corrective Appliances are Covered Services when required by normal wear and tear or by a significant change in the Insured's condition when ordered by a duly-licensed Provider.

Dental Anesthesia Services

Covered Services include general anesthesia when rendered in a Plan Hospital, Plan outpatient surgical facility, or other duly licensed Plan facility for an enrolled Dependent child, when such child, in the treating dentist's opinion and as Prior Authorized by the Plan, satisfies one or more of the following criteria:

- Has a physical, mental or medically compromising condition;
- Has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy;
- Is extremely uncooperative, unmanageable or anxious; or
- Has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

Coverage for dental anesthesia pursuant to this section is limited to services provided by a Plan anesthesia Provider. Coverage is provided only during procedures performed by:

- An educationally qualified Specialist in pediatric dentistry; or
- Another dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted; or
- Who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

Durable Medical Equipment

All benefits for Durable Medical Equipment ("DME") includes administration, maintenance and operating costs of such equipment, if the equipment is Medically Necessary or Prior Authorized. DME includes, but is not limited to:

- Braces;
- Canes;
- Crutches;
- Hospital beds;
- Intermittent positive pressure breathing machine;
- Standard outpatient oxygen delivery systems;
- Traction equipment;
- Walkers;
- Wheelchairs; or
- Any other items that are determined to be Medically Necessary by SHL's Managed Care Program.

Replacements, repairs and adjustments to DME are limited to normal wear and tear or because of significant change in the Insured's physical condition.

SHL will not be responsible for the following:

- Non-Medically Necessary optional attachments and modifications to DME for the comfort or convenience of the Insured;
- Accessories for portability or travel;
- A second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment;
- Home and car remodeling; and
- Replacement of lost or stolen equipment.

Emergency or Urgently Needed Services

Emergency Services obtained from Non-Plan providers will be payable at the same benefit level as would be applied to care received from Plan Providers.

Benefits are limited to Eligible Medical Expenses or the Recognized Amount, when applicable, for Non-Plan Provider Emergency Services as defined under "SHL Reimbursement Schedule". You are responsible for any Non-Plan Provider Emergency Service charges that exceed payments made by SHL. Benefits for Emergency Services are subject to any limit shown in the Attachment A Benefit Schedule.

If Emergency Services are required during an emergency as defined in this Certificate, all Covered Services which are Medically Necessary and appropriate will be paid for within the limit, if any, established in Attachment A Benefit Schedule.

IMPORTANT NOTE: If Medically Necessary treatment is received by an Insured in a Hospital emergency room or other emergency facility for a condition which does not require Emergency Services, a reduced benefit will be payable toward the Covered Services included in such treatment.

Examples of conditions which require Medically Necessary treatment, but **are not Emergency Services**, include:

- Earaches.
- Flu or fever.
- Medication refills.
- Routine dental services.
- Sore or stiff muscles.
- Sore throats.
- Sprains, strains or minor cuts.
- Suture removal.

24/7 Advice Nurse. If you are feeling ill and are not sure about where you should go to obtain care or do not know whom to call, you may call the 24/7 Advice Nurse for help. A nurse is available twenty-four (24) hours a day, seven (7) days a week at (702) 242-7330, or for the hearing-impaired through Relay Nevada's TDD/TYY at 1-800-326-6888. You may call toll free for assistance at 1-800-288-2264.

Free Standing Emergency Room Facilities

These facilities are licensed to provide emergency medical care and are physically separate from hospitals. However, unlike hospital-based emergency rooms, these facilities often do not provide services for critical conditions such as trauma, stroke or heart attacks; most do not receive ambulances or have an operating room on site. Please contact the 24/7 Advice Nurse if you have questions on where to go to obtain the appropriate level of service.

Gastric Restrictive Surgical Services

Covered Services include Prior Authorized Medically Necessary Gastric Restrictive Surgical Services for extreme obesity under the following circumstances:

- Have a body mass index (BMI) of greater than or equal to 40kg/m2; or
- Have a BMI between 35.1- 39.9 kg/m2 with significant co-morbidities; and
- Can provide documented evidence that dietary attempts at weight control are ineffective; and
- Must be at least 18 years old.

Documentation supporting the reasonableness and necessity of a Gastric Restrictive Surgical Service is required, including compliant attendance at a medically supervised weight loss program (within the last twenty-four (24) months) for at least six (6) consecutive months with documented failure of weight loss. Significant clinical evidence that weight is affecting overall health and is a threat to life will also be required.

SHL requires that an initial psychological/ psychiatric evaluation resulting in a recommendation for Gastric Restrictive Surgical Services is performed prior to review consideration by SHL's Managed Care Program. SHL may also require participation in a post-operative group therapy program.

Treatment for complications resulting from Gastric Restrictive Surgical Services will be covered the same as any other illness.

Gender Dysphoria

Covered Services for Gender Dysphoria, a disorder characterized by diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Health* published by *the American Psychiatric Association,* are provided if Prior Authorized and if the following diagnostic criteria are met:

For Adults and Adolescents:

- A marked incongruence between the Insured's experienced/expressed gender and the Insured's assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

For Children:

- A marked incongruence between the Insured's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender) and at least five of the following:
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

The following are Gender Dysphoria Covered Services:

- **Psychotherapy** for Gender Dysphoria and associated co-morbid psychiatric diagnoses.

- **Cross-sex hormone therapy** is available as follows:
  - Oral and injectable therapy, administered by a provider, during an office visit or in an outpatient or inpatient setting.
  - Oral and injectable therapy dispensed from a pharmacy as prescribed by a provider.

  Puberty suppressing medication is not cross-sex hormone therapy.

- **Laboratory Testing:** Benefit coverage includes laboratory testing to monitor continuous hormone replacement therapy provided as any other outpatient diagnostic service under the Plan.

- **Genital Surgery and Surgery to Change Secondary Sex Characteristics:** Provided as any other Medically Necessary service under this Plan (as appropriate to each patient) including:

  Male to Female:
  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:
  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)

The Insured must meet all of the following eligibility qualifications for genital surgery, surgery to change secondary sex characteristics and bilateral mastectomy or breast reduction surgery (in addition to the overall eligibility requirements in the COC).

Breast Surgery:
The Insured must provide documentation in the form of a written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Insured meets all of the following criteria:
- Has persistent, well-documented Gender Dysphoria;
- Has the capacity to make a fully informed decision and to consent for treatment;
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

Genital Surgery:
The Insured must provide documentation in the form of a written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Insured. The assessment must document that the Insured meets all of the following criteria:
- Has persistent, well-documented Gender Dysphoria;
- Has the Capacity to make a fully informed decision and to consent for treatment;
- If significant medical or mental health concerns are present, they must be reasonably well controlled;
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender; and
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

SHL may direct you to a plan provider or facility that is outside your service area. If you are required to travel to obtain such Gender Dysphoria Covered Services from a plan provider, SHL may reimburse certain reasonable and necessary travel expenses.

SHL makes no representation or warranty as to the medical competence or ability of any Gender Dysphoria Treatment Center/Facility or its respective staff or Physicians. SHL shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, or any actions or inactions, whether negligent or otherwise, on the part of any Gender Dysphoria Treatment Center/Facility or its respective staff or Physicians.

Genetic Disease Testing Services

Covered Services include Prior Authorized Medically Necessary Genetic Disease testing, when:
- Such testing is prescribed following the Insured's history, physical examination and pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, and a definitive diagnosis remains uncertain and a genetic disease diagnosis is suspected, and;
- The Insured displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); and
- The result of the test will directly impact the treatment being delivered to the Insured.

Healthcare Facility Services

Covered Services include the following accommodations, services and supplies received during an admission to a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility, Residential Treatment Center or Hospice Care Facility.

Accommodations:

- Semiprivate (or multibed unit) room, including bed, board and general nursing care.
- Private room including bed, board, and general nursing care, but only when treatment of the Insured's condition requires a private room. The semiprivate room rate will be allowed toward the private room rate when an Insured receives private room accommodations for any reason other than Medical Necessity.
- Inpatient accommodations provided in connection with the birth of a child shall be provided for a minimum of forty-eight (48) hours following an uncomplicated vaginal delivery or a minimum of ninety-six (96) hours following an uncomplicated delivery by cesarean section. This provision does not require an Insured to deliver in a Hospital or other healthcare facility or to remain therein for the minimum number of hours following delivery.
- Intensive care unit (including Cardiac Care Unit), including bed, board, general and special nursing care, and ICU equipment.
- Observation unit, including bed, board, and general nursing care not to exceed twenty-three (23) hours per day.
- Nursery charges for newborns.

Services and Supplies. Covered Services and supplies provided by a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility, Residential Treatment Center or Hospice Care Facility include:

- Non-surgical Provider visits;
- Operating, recovery, and treatment rooms and equipment (Hospital and Ambulatory Surgical Facility only);
- Delivery and labor rooms and equipment (Hospital and Ambulatory Surgical Facility only);
- Anesthesia materials and anesthesia administration by Hospital staff (Hospital and Ambulatory Surgical Facility only);
- Clinical pathology and laboratory services and supplies;
- Services and supplies for diagnostic tests required to diagnose Insured's Illness, Injury or other conditions but only when charges for the services and/or supplies are made by the facility (Hospital, Skilled Nursing Facility and Ambulatory Surgical Facility only);
- Drugs consumed at the time and place dispensed which have been approved for general marketing in the United States by the Food and Drug Administration (FDA);
- Dressings, splints, casts and other supplies for medical treatment provided by the Hospital from a central sterile supply department;
- Oxygen and its administration;
- Non-replaced blood, blood plasma, blood derivatives, and their administration and processing;
- Intravenous injections and solutions;
- Private duty nursing subject to the benefit limitation for such services;
- Supportive services for a Hospice patient's family, including care for the patient which provides a respite from the stresses and responsibilities that result from the daily care of the patient and bereavement services provided to the family after the death of the patient (Hospice Care Facility only); and
- Sterilization procedures.

Hearing Aids

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) and purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Service for which benefits are available under the applicable medical/surgical Covered Services categories in the SHL Certificate, only for an Insured:

- Who is not a candidate for an air-conduction hearing aid; and
- Which is used according to U.S. Food and Drug Administration (FDA) approved indications.

Benefits for bilateral bone anchored hearing aids are available to Insureds who meet the SHL Managed Care Program criteria.

Home Healthcare Services

Covered Services include services given to an Insured in his home by a licensed Home Healthcare Provider or an approved Hospital program for Home Healthcare. Such services are covered when:

- Such care is given in place of Inpatient Hospital or Skilled Nursing Facility care and/or;
- The Insured is not physically able to obtain Medically Necessary care on an outpatient basis; and/or
- The Insured is under the care of a Physician; and/or
- The Insured is homebound for medical reasons.

NOTE: The Insured is responsible for one cost-share per day per Home Healthcare agency.

Covered Services and supplies provided by a Home Healthcare agency include:

- Professional services of a registered nurse, licensed practical nurse or a licensed vocational nurse on an intermittent basis.
- Physical therapy, speech therapy and occupational therapy by a licensed therapist.
- Medical and surgical supplies that are customarily furnished by the Home Healthcare agency or program for its patients.
- Prescribed drugs furnished and charged for by the Home Healthcare agency or program. Prescribed drugs under this provision do not include Specialty Prescription Drugs. Please refer to the optional SHL Prescription Drug Benefit Rider, if applicable to your Plan, for information on benefits available for Specialty covered drugs.
- One (1) medical social service consultation per course of treatment.
- One (1) nutrition consultation by a certified registered dietitian.
- Health aide services furnished to Insured only when receiving nursing services or therapy.

Laboratory Services

Covered Services include prescribed diagnostic clinical and anatomic pathological laboratory services and materials when authorized by an Insured's Provider and SHL's Managed Care Program.

Mastectomy Reconstructive Surgical Services

Covered Services are provided in the same manner and at the same level as those for any other Covered Health Service, and also as required by the *Women's Health and Cancer Rights Act of 1998*, as follows:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy, including lymphedema, in a manner determined in consultation with the attending provider and the patient.

Medical – Physician Services

Covered Services include services which are generally recognized and accepted non-surgical procedures for diagnosing or treating an Illness or Injury, performed by a Physician in his office, the patient's home, or a licensed healthcare facility. Medical Services include:

- Direct physical examination of the patient;
- Examination of some aspect of the patient by means of pathology laboratory or electronic monitoring procedure which is a generally recognized and accepted procedure for diagnostic or therapeutic purposes in the treatment of an Illness or Injury;
- Procedures for prescribing or administering medical treatment;
- Manual Manipulation (except for reductions of fractures or dislocations);
- Treatment of the temporomandibular joint including Medically Necessary dental procedures, such as dental splints;
- Anesthesia services;
- Family planning services including sterilization procedures; and
- Limited diagnostic and therapeutic infertility services determined to be Medically Necessary by SHL and Prior Authorized by SHL's Managed Care Program. In order for the Insured to be eligible for infertility benefits, all of the following criteria must be met. The Insured:
  - Is not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
    - One year, if a female under age 35; or
    - Six months, if a female age 35 or older.
  - Has infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

  For the purposes of this benefit, "therapeutic donor insemination" means using a donor sperm sample to enable a female to become pregnant.

Covered Services do not include those services specifically excluded in the Exclusions section herein, but do include limited:

- Laboratory studies.
- Diagnostic procedures.
- Artificial insemination services, up to six (6) cycles per Insured per lifetime.

Medical Supplies

Medical Supplies are routine expendable supplies that are essential to carry out the course of treatment for an Illness or Injury or are necessary for the effective use of Durable Medical Equipment. Medical Supplies include, but are not limited to the following:

- Catheter and catheter supplies – urinary catheters, drainage bags, irrigation trays;
- Colostomy bags (and other ostomy supplies);
- Dressing/wound care-sterile dressings, ace bandages, sterile gauze and toppers, Kling and Kerlix rolls, Telfa pads, eye pads, incontinent pads, lamb's wool pads;
- Elastic stockings; and
- Splints and slings.

Mental Health Services and Severe Mental Illness Services

All benefits are subject to the Utilization Management process through Behavioral Healthcare. Services must be offered in a treatment setting that is appropriate for the Medically Necessary level of care, as determined by staffing, ability to provide patient safety, treatment intensity, the diagnostic and therapeutic modalities available, the extent of supportive services and access to general medical care. All non-routine, outpatient Mental Health or Severe Mental Illness Services require Prior Authorization.

Inpatient: A structured hospital-based program which provides twenty-four (24) hours a day, seven (7) days a week nursing care, medical monitoring, and physician availability; assessment and diagnostic services, daily physician visits, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the Insured or others.

Partial Hospitalization Program (PHP): A structured ambulatory program that may be freestanding or Hospital-based and provides services for at least twenty (20) hours per week.

Intensive Outpatient Program (IOP): A structured program that maintains hours of service for at least nine (9) hours per week for adults and six (6) hours per week for children or adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided.

Outpatient: Assessment, diagnosis and active behavioral health treatment that are provided in an ambulatory setting, including individual and group counseling services.

Residential Treatment Center Services (RTC): A sub-acute facility or acute care facility which delivers twenty-four (24) hours/ seven (7) days a week assessment, diagnostic services and active behavioral health treatment to Insureds. The level of care and length of stay, in a facility with the appropriate licensure level, is authorized through the SHL Managed Care program. NOTE: Transitional Living services are not covered under RTC and are not a covered benefit.

No benefits are available for psychosocial rehabilitation or care received as a custodial Inpatient.

All inpatient Mental Health or Severe Mental Illness Services require Prior Authorization. Network facilities must provide notification of all inpatient admissions to the Plan. When these services are provided out of network, the Insured is responsible for providing the notification and relevant information to the Plan. The Insured should provide notice of emergent admissions within twenty-four (24) hours of admission or as soon as reasonably possible given the circumstances. Insured may delegate their responsibility to provide notification to the non-network facility but it is the Insured's responsibility to ensure that the Plan receives notification. Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.

All admissions for Emergency Services are reviewed retrospectively to determine if the treatment received was Medically Necessary and appropriate. If the Insured receives services other than Emergency Services in a Mental Health or Severe Mental Illness facility without obtaining Prior Authorization from SHL, benefits will be reduced to 50% of what the Insured would have received if the services had been Prior Authorized, provided however, that the benefits paid will not be less than 50% of the Eligible Medical Expenses, or the Recognized Amount when applicable. If the treatment received is not a Covered Service or if treatment is received for a condition which is not Medically Necessary, no benefit is payable.

Oral Physician Surgical Services

Although dental services are not Covered Services, the following Oral Surgical Services are Covered Services:

- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Removal of teeth which are necessary in order to perform radiation therapy.
- Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an Injury (not to include injuries caused by chewing) when the treatment starts within the first ten (10) days after the Injury and ends within sixty (60) days from the date of injury. Examples of Covered Services, in such instances, include:
  a) Root canal therapy, post and build up.
  b) Temporary crowns.
  c) Temporary partial bridges.
  d) Temporary and permanent fillings.
  e) Pulpotomy.
  f) Extraction of broken teeth.
  g) Incision and drainage.
  h) Tooth stabilization through splinting.

No benefits are provided for removable dental prosthetics, dentures (partial or complete) or subsequent restoration of teeth, including permanent crowns.

Organ and Tissue Transplant Surgical Services

All Covered Transplant Procedures are subject to the provisions of SHL's Managed Care Program and all other terms and provisions of the Plan, including the following:

1. SHL will determine if the Insured satisfies SHL's Medically Necessary criteria before receiving benefits for transplant services.
2. SHL will provide a written Referral for care to a Transplant Facility.
3. If, after Referral, either SHL or the medical staff of the Transplant Facility determines that the Insured does not satisfy the Medically Necessary criteria for the service involved, benefits will be limited to Covered Services provided up to such determination.

Covered Transplant Procedures include the following services for human-to-human organ or tissue transplants received during a Transplant Benefit Period on an Inpatient basis due to an Injury or Illness as follows:

- Hospital room and board and medical supplies.
- Diagnosis, treatment, surgery and other Covered Services provided by a Physician.
- Organ and tissue retrieval which includes removing and preserving the donated part.
- Organ Procurement.
- Rental of wheel chairs, Hospital-type beds and mechanical equipment required to treat respiratory impairment.
- Ambulance services.
- Medication, x-rays and other diagnostic services.
- Laboratory tests.
- Oxygen.
- Surgical dressings and supplies.
- Immunosuppressive drugs.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- Transportation of the Insured and a companion to and from the site of the transplant. If the Insured is a minor, transportation of two (2) persons who travel with the minor is included. Reasonable and necessary lodging and meal costs incurred by such companions are included. Itemized receipts for these expenses are required. Daily lodging and meal costs will be paid up to the limit shown in the Attachment A Benefit Schedule. Benefits for all transportation, lodging and meal costs shall not exceed the maximum shown in the Attachment A Benefit Schedule for transportation, lodging and meals.

SHL makes no representation or warranty as to the medical competence or ability of any Transplant Facility or its respective staff or Physicians. SHL shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, for any actions or inaction, whether negligent or otherwise, on the part of any Transplant Facility or its respective staff or Physicians.

SHL shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, in the event a transplant patient is injured or dies, by whatever cause, while enroute to a Transplant Facility.

If a Covered Transplant Procedure is not performed as scheduled due to a change in the Insured's medical condition or death, benefits will be paid for Prior Authorized Eligible Medical Expenses or the Recognized Amount, when applicable, incurred during the Transplant Benefit Period.

Other Diagnostic and Therapeutic Services

Diagnostic and Therapeutic Covered Services when authorized by an Insured's Provider and SHL's Managed Care Program include the following:

- Therapeutic radiology services;
- Complex diagnostic imaging services including nuclear medicine, computerized axial tomography (CT scan), cardiac ultrasonography, magnetic resonance imaging (MRI) and arthrography;
- Complex vascular diagnostic and therapeutic services including Holter monitoring, treadmill or stress testing and impedance venous plethysmography;
- Complex neurological diagnostic services including electroencephalograms (EEG), electromyogram (EMG) and evoked potential;
- Complex psychological diagnostic testing;
- Complex pulmonary diagnostic services including pulmonary function testing and apnea monitoring;
- Anti-cancer drug therapy;
- Hemodialysis and peritoneal renal dialysis;
- Complex allergy diagnostic services including RAST and allergoimmuno therapy;
- Otologic evaluations only for the purpose of obtaining information necessary for evaluation of the need for or appropriate type of medical or surgical treatment for a hearing deficit or a related medical problem;
- Treatment of temporomandibular joint disorder;
- Other Medically Necessary intravenous therapeutic services as approved by SHL, including but not limited to, non-cancer related intravenous injection therapy; and
- Positron Emission Tomography (PET) Scans.

Different Copayment and/or Coinsurance amounts may apply to these Covered Services. Please refer to your Attachment A Benefit Schedule.

Physician Surgical Services – Inpatient and Outpatient

Covered Services include surgical services that are generally recognized and accepted procedures for diagnosing or treating an Illness or Injury.

Post-Cataract Surgical Services

Covered Services include Medically Necessary services provided for the initial prescription for corrective lenses (eyeglasses or contact lenses) and frames or intra-ocular lens implants for Post-Cataract Surgical Services.

Contact lenses will be covered if an Insured's visual acuity cannot be corrected to 20/70 in the better eye except for the use of contact lenses.

Preventive Healthcare Services

Covered Preventive Healthcare Services will be paid at 100% of Eligible Medical Expenses or the Recognized Amount, when applicable, without application of any Calendar Year Deductible, Copayment and/or Coinsurance when such services are provided by a Plan Provider**.**

Covered Services include the following Preventive Healthcare Services in accordance with the recommended schedule outlined in the SHL Preventive Guidelines included in your Member kit or you may access the most current version of these guidelines at any time by visiting SHL's web site at Preventive Services - Member - Sierra Health and Life.

- Evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") including:
  - Benefits for lung cancer screening for adults 50 to 80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years.
- Immunizations[(1)] that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, as long as they are not otherwise addressed by the recommendations of the USPSTF. Benefits include:
  - Prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization are provided without the requirement of prior authorization.

- Rapid point-of-contact test for syphilis screening of pregnant women.
- Contraceptive coverage includes the insertion of implantable rods, copper-based intrauterine devices and progesterone-based intrauterine devices at a hospital immediately after an Insured gives birth.

- With respect to all Insureds, condoms.
- Zero Cost Share Preventive Care Medications - The medications that are obtained at a Plan Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Calendar Year Deductible, Copayment and/or Coinsurance) as required by applicable law.

You may find out if a drug is a Zero Cost Share Preventive Care Medication via web at Prescription Drug Lists - Prescription Drug Coverage - Member - Sierra Health and Life or by calling the Member Services Department at the telephone number on your ID card.

If your health care provider determines you need a contraception medication that is not on the Zero Cost Share Preventive Care Medication list, they can let us know your medication is Medically Necessary and provide information about your diagnosis and medication history. If you are using your medication for an appropriate condition and it is approved, it will be covered at no cost to you. If you are using it to treat another medical condition, a cost share may apply. The health care reform copay waiver request form is available via web at https://sierrahealthandlife.com/member/contraception-exception-request.

For a complete list of Preventive Services, including all FDA approved contraceptives, go to http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/.

Group sponsored Covered Services also include the following Preventive Healthcare Services:

- Hearing and vision screening performed by the Provider to determine the need for hearing correction or eye refractions for children under the age of 18 years.

(1)Certain immunizations may be administered in a Plan pharmacy.

Prosthetic and Orthotic Devices

Covered Services include the following devices when received in connection with an Illness or Injury and authorized by SHL's Managed Care Program:

- Cardiac pacemakers.
- Breast prostheses for post-mastectomy patients.
- Terminal devices (example: hand or hook) and artificial eyes.
- Braces which include only rigid and semi-rigid devices used for supporting a weak or deformed body Insured or restricting or eliminating motion in a diseased or injured part of the body.
- Adjustment of an initial Prosthetic or Orthotic Device required by wear or by change in the patient's condition when ordered by a Plan Provider.

Routine Radiological and Non-Radiological Diagnostic Imaging Services

Covered Services include prescribed routine diagnostic radiological and non-radiological diagnostic imaging services and materials, including general radiography, fluoroscopy, mammography, and sonography, when authorized by an Insured's Provider and SHL's Managed Care Program, but only when no charges are made for the same services and/or supplies by a Hospital, Skilled Nursing Facility or an Ambulatory Surgery Center.

Self-Management and Treatment of Diabetes

Coverage includes medication, equipment, supplies and appliances for the treatment of diabetes. Diabetes includes type I, type II and gestational diabetes. Covered Services include:

- Medically Necessary training and education provided to an Insured for the care and management of diabetes, after he is initially diagnosed with diabetes, to include counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
- Medically Necessary training and education which is a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the Insured and which requires modification of his program of self-management of diabetes; and
- Medically Necessary training and education because of the development of new techniques and treatment for diabetes.

Short-Term Habilitation Services– Inpatient and Outpatient

Covered Services are provided for Short-Term Habilitation Services provided for Insureds with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist and
- The initial or continued treatment must be proven and not Experimental, Investigational or Unproven.

SHL will cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Coverage for Short-Term Habilitation Services does not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Short-Term Habilitation Services. A service that does not help the Insured to meet functional goals in a treatment plan within a prescribed timeframe is not a habilitative service. When the Insured reaches his maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

SHL may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Insured's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Insured to achieve demonstrable progress, SHL may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Short-Term Habilitation Services that are provided in the home by a licensed Home Healthcare Provider are covered as described under the Home Healthcare Services section.

Short-Term Rehabilitation Services – Inpatient and Outpatient

Short-Term Rehabilitation therapy Covered Services include:

- Speech therapy, including unlimited treatment of stuttering for Insureds under 26 years of age.
- Occupational therapy.
- Physical therapy on an Inpatient or outpatient basis when ordered by the Insured's Provider and authorized by SHL's Managed Care Program.

Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that, in the judgment of the Insured's Provider and SHL's Managed Care Program, are subject to significant improvement through Short-Term therapy.

Covered Services do not include cardiac rehabilitation services provided on a non-monitored basis nor do they include treatment for intellectual disability.

Special Food Product / Enteral Formulas

Covered Services include enteral formulas and special food product when prescribed by a Physician and authorized by SHL's Managed Care Program for treatment of an inherited metabolic disease.

- "Inherited Metabolic Disease" means a disease caused by an inherited abnormality of the body chemistry of a person characterized by congenital defects or defects arising shortly after birth resulting in deficient metabolism or malabsorption of amino acid, organic acid, carbohydrate or fat.
- "Special Food Product" means a food product specially formulated to have less than one gram of protein per serving intended to be consumed under the direction of a Physician. The term does not include food that is naturally low in protein.

Specialty Services, Second and Third Opinions and Consultations

Covered Services include medical services rendered by a Specialist or other duly licensed Provider whose opinion or advice is requested by an Insured's treating Physician or the Medical Director for further evaluation of an Illness or Injury on an Inpatient or outpatient basis.

- **Second Opinions.** When, as a result of an Illness or Injury, a procedure is recommended by a Physician, SHL or the Insured may request a Second Opinion from a Physician qualified to diagnose and treat the specific Illness or Injury.

- **Third Opinions.** In the event a first and Second Opinion for a Covered Service are in conflict, SHL or the Insured may request a Third Opinion from a Physician qualified to diagnose and treat the specific Illness or Injury.

Benefits are payable for expenses incurred in connection with an authorized Second or Third Opinion whether or not the elective surgery or Inpatient care is performed. Payment will be subject to all terms of the Certificate, except as otherwise provided in this section.

Limitations. No payment will be made for expenses incurred for Second or Third Opinions/Consultations in connection with:
1. Any services not covered under this Plan, including cosmetic and dental procedures;
2. Minor surgical procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions; or
3. Diagnostic tests ordered in connection with Second and Third Opinions/Consultations, unless Prior Authorized by SHL's Managed Care Program.

Substance-Related and Addictive Disorder Services

All benefits for Substance-Related and Addictive Disorder Services are subject to the Utilization Management process through Behavioral Healthcare. Services must be offered in a treatment setting that is appropriate for the Medically Necessary level of care, as determined by staffing, ability to provide patient safety, treatment intensity, the diagnostic and therapeutic modalities available, the extent of supportive services and access to general medical care. All non-routine, outpatient Substance-Related and Addictive Disorder Services require Prior Authorization.

Inpatient Detoxification: A hospital-based program which provides twenty-four (24) hours a day, seven (7) days nursing care, medical monitoring, and physician availability; daily physician visits, assessment, diagnostic services, and active behavioral health treatment services for the purpose of completing a medically safe and appropriate withdrawal from alcohol or other substances.

Outpatient Detoxification: Outpatient Detoxification is comprised of services that are provided in an ambulatory setting for the purpose of completing a medically safe withdrawal from alcohol or drugs.

Inpatient Rehabilitation: A hospital-based program which provides twenty-four (24) hours a day, seven (7) days nursing care, medical monitoring, and physician availability; daily physician visits, assessment and diagnostic services, and active behavioral health treatment services for the purpose of initiating the process of assisting an Insured with gaining the knowledge and skills needed to prevent recurrence of a substance-related disorder.

Partial Hospitalization Program (PHP): A structured ambulatory program that may be freestanding or Hospital-based and provides services for at least twenty (20) hours per week.

Intensive Outpatient Program (IOP): A structured program that maintains hours of service for at least nine (9) hours per week for adults and six (6) hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided.

Outpatient: Assessment, diagnosis and active behavioral health treatment that are provided in an ambulatory setting, including individual, group, and family counseling services.

Residential Treatment Center Services (RTC): A sub-acute facility or acute care facility which delivers twenty-four (24) hours/ seven (7) days a week assessment, diagnostic services and active behavioral health treatment to Insureds. The level of care and length of stay, in a facility with the appropriate licensure level, is authorized through the SHL Managed Care program. NOTE: Transitional Living services are not covered under RTC and are not a covered benefit.

All inpatient Substance-Related and Addictive Disorder Services require Prior Authorization. Network facilities must provide notification of all inpatient admissions to the Plan. When these services are provided out of network, the Insured is responsible for providing the notification and relevant information to the Plan. Insureds should provide notice of emergent admissions within twenty-four (24) hours of admission or as soon as reasonably possible given the circumstances. Insureds may delegate their responsibility to provide notification to the non-network facility but it is the Insured's responsibility to ensure that the Plan receives notification. Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.

All admissions for Emergency Services are reviewed retrospectively to determine if the treatment received was Medically Necessary and appropriate. If the Insured receives services other than Emergency Services in a Substance-Related and Addictive Disorder facility without obtaining Prior Authorization from SHL, benefits will be reduced to 50% of what the Insured would have received if the services had been Prior Authorized, provided however, that the benefits paid will not be less than 50% of the Eligible Medical Expenses or the Recognized Amount, when applicable. If the treatment received is not a Covered Service or if treatment is received for a condition which is not Medically Necessary, no benefit is payable.

Telemedicine Services

Covered Services received through Telemedicine do not require Prior Authorization unless the Covered Service would require Prior Authorization if provided in person. The Insured does not have to establish a relationship with a Telemedicine Provider to receive services. SHL does not require the Provider to demonstrate the necessity to provide services through, or to receive additional certifications or licenses in, Telemedicine. Benefits are available for urgent, on-demand healthcare delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency needs. SHL will not refuse to provide coverage because of the distant site from which the contracted Telemedicine Provider provides Covered Services or the originating site at which the Insured receives Telemedicine Services. SHL will not require Covered Services to be provided through Telemedicine as a condition of coverage. Telemedicine Services received from any Provider will be subject to the applicable facility and professional Copayments and/or Coinsurance amount as set forth in the Attachment A Benefit Schedule.

Benefits are also provided for Remote Physiologic Monitoring.

NowClinic Urgent Care Virtual Visits: Covered Services received through virtual visits do not require Prior Authorization when provided through an SHL contracted Provider. Refer to the Attachment A Benefit Schedule for the Insured's Cost-share responsibility. Benefits are available for urgent, on-demand healthcare delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency needs.

SECTION 7. Exclusions

This section tells you what services or supplies are excluded from coverage under this Plan.

7.1 Services or supplies for which coverage is not specifically provided in this Certificate, complications resulting from non-Covered Services, or services which are not Medically Necessary, whether or not recommended or provided by a Provider.

7.2 Any charges for non-Emergency Services provided outside the United States.

7.3 Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

7.4 Any services provided before the Effective Date or after the termination of this Plan. This includes admission to an Inpatient facility when the admission began before the Effective Date or extended beyond the termination date of the Plan.

7.5 Services and supplies that are included in the basic hospital charges for room, board and nursing services. Housekeeping or meal services as part of Home Health Care. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.

7.6 Services for a private room when not Medically Necessary Services and charges in excess of the average semi-private room and board rate.

7.7 Dental or orthodontic splints or dental prostheses, or any treatment on or to teeth, gums, or jaws and other services customarily provided by a dentist. Treatment of pain or infection known or thought to be due to a dental condition and in close proximity to the teeth or jaw; surgical correction of malocclusion; maxillofacial orthognathic surgery, oral surgery (except as provided under the Covered Services Section), orthodontia treatment, pre-prosthetic surgery and any procedure involving osteotomy of the jaw, including outpatient Hospital or ambulatory surgical services, anesthesia and related costs when determined by SHL to relate to a dental condition.

Charges for dental services in connection with temporomandibular joint dysfunction are also not covered unless they are determined to be Medically Necessary. Such dental-related services are subject to the limitation shown in the Attachment A Benefit Schedule.

7.8 Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered cosmetic procedures. Cosmetic procedures include:

- Surgery for sagging or extra skin;
- Any augmentation or reduction procedures;
- Rhinoplasty and associated surgery; and
- Any procedures utilizing an implant which does not alter physiologic functions unless Medically Necessary.

Psychological factors (example: for self-image, difficult social or peer relations) do not constitute restoring a physical bodily function and are not relevant to such determinations.

7.9 The following infertility services and supplies are excluded, in addition to any other infertility services or supplies determined by SHL not to be Medically Necessary:

- Advanced reproductive techniques such as embryo transplants, in vitro fertilization, ZIFT procedures, assisted hatching, intracytoplasmic sperm injection, egg retrieval via laparoscope or needle aspiration, sperm preparation, specialized sperm retrieval techniques, sperm washing except prior to artificial insemination if required;
- Home pregnancy or ovulation tests;
- Monitoring of ovarian response to stimulants;
- CT or MRI of sella turcica unless elevated prolactin level;
- Evaluation for sterilization reversal;
- Removal of fibroids, uterine septae and polyps;
- Open or laparoscopic resection, fulguration, or removal of endometrial implants; and
- Surgical tube reconstruction.

7.10 Powered and non-powered exoskeleton devices.

7.11 Any separate charges for anesthesia services associated with pain management procedures.

7.12 Services for the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and, except as provided in the Covered Services Gender Dysphoria section, implantation of a penile prosthesis.

7.13 Reversal of surgically performed sterilization or reversal of subsequent resterilization.

7.14 Amniocentesis, except when Medically Necessary under the guidelines of the American College of Obstetrics and Gynecology.

7.15 Third-party physical exams and/or medical services for employment, licensing, insurance, school, camp or adoption purposes. Immunizations related to foreign travel unless otherwise provided as a required preventive immunization identified by the USPSTF. Expenses for medical reports, including presentation and preparation. Exams or treatment ordered by a court, or in connection with legal proceedings are not covered.

7.16 Venipuncture (drawing of blood for laboratory tests).

7.17 Except as provided in the Covered Services Gastric Restrictive Surgical Services section, weight reduction procedures are excluded. Also excluded are any weight loss programs, whether or not recommended, provided or prescribed by a Physician or other medical Practitioner.

7.18 Except as provided in the Covered Services Organ and Tissue Transplant Surgical Services section, any human or animal transplant (organ, tissue, skin, blood, blood transfusions of bone marrow), whether human-to-human or involving a non-human device, artificial organs, or prostheses.

7.19 The following services when related to any excluded transplant service, procedure or treatment:

- Any and all services, supplies treatments, laboratory tests or x-rays received by the donor (including donor search, donor transportation, testing, registry and retrieval costs);
- Any and all treatment and costs related to cadaver or animal retrieval or maintenance of a donor for such retrieval; and/or
- Any and all Hospital, Physician, laboratory or x-rays services.

7.20 Institutional care which is determined by SHL's Managed Care Program to be for the primary purpose of controlling Insured's environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures.

7.21 Mental Health Services and Substance-Related and Addictive Disorder Services performed in connection with conditions not listed in the current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM)* or conditions listed as "Other Conditions" that may be of focus of clinical attention. This exclusion does not apply to conditions defined as *Medically Necessary* in Section 15: Glossary.

7.22 Outside of an initial assessment, Mental Health and Substance-Related and Addictive Disorder Services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. This exclusion does not apply to conditions defined as *Medically Necessary* in Section 15: Glossary.

7.23 Outside of an initial assessment, treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, personality disorders (with the exception of dialectical behavior therapy for borderline personality disorders) and paraphilic disorder.

7.24 Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

7.25 Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.

7.26 Outside of an initial assessment, unspecified disorders for which the provider is not obligated to provide the clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association, unless determined to be medically necessary.*

7.27 Neuropsychological testing when not required for the diagnosis of a Mental Illness, Substance-Related and Addictive Disorder, or developmental disability.

7.28 Vision exams to determine refractive errors of vision and eyeglasses or contact lenses other than as specifically covered in this Certificate. Coverage is provided for vision exams only when required to diagnose an Illness or Injury. Vision exams are not considered adult preventive care services.

7.29 Any prescription corrective lenses (eyeglasses or contact lenses) or frames following Post-Cataract Surgical Service which include, but are not limited to the following:

- Coated lenses;
- Cosmetic contact lenses;
- Costs for lenses and frames in excess of the Plan allowance;
- No-line bifocal or trifocal lenses;
- Oversize lenses;
- Plastic multi-focal lenses;
- Tinted or photochromic lenses;
- Two (2) pairs of lenses and frames in lieu of bifocal lenses and frames; or
- All prescription sunglasses.

7.30 Except as otherwise provided herein, Coverage is provided for hearing exams only when required to diagnose an Illness or Injury. Hearing exams are not considered adult preventive care services.

7.31 Bone anchored hearing aids are excluded except when both of the following applies:
- The Insured is not a candidate for an air-conduction hearing aid; and
- The bone-anchored hearing aid is used according to FDA approved indications.

Repairs and/or replacements for a bone anchored hearing aid, other than for malfunctions, are excluded for Insured's who meet the above coverage criteria.

7.32 Ecological or environmental medicine. Use of chelation, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile or gerovital.

7.33 Pain management invasive procedures as defined by SHL's protocols for chronic, intractable pain unless Prior Authorized by SHL and provided by a Plan Provider who is a pain management Specialist. Any Prior Authorized pain management procedures will be subject to the applicable facility and professional Copayments and/or Coinsurance amount as set forth in Attachment A, Benefit Schedule.

7.34 Acupuncture or Hypnosis.

7.35 Treatment of an Illness or Injury caused by or arising out of a riot, declared or undeclared war or act of war, insurrection, rebellion, armed invasion or aggression.

7.36 Treatment of an occupational Illness or Injury which is any Illness or Injury arising out of or in the course of employment for pay or profit.

7.37 Travel and accommodations, whether or not recommended or prescribed by a Provider, other than as specifically covered in this Plan.

7.38 Care for conditions that federal, state or local law requires to be treated in a public facility for which a charge is not normally made.

7.39 Any equipment or supplies that condition the air. Arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace. Heating pads, hot water bottles, wigs and their care and other primarily nonmedical equipment. Incontinence supplies (diapers, pads, adult briefs) and bath aids (rails, shower chairs, bath benches).

7.40 Any service or supply in connection with routine foot care, including the removal of warts, corns, or calluses, the cutting and trimming of toenails, or foot care for flat feet, fallen arches and chronic foot strain, in the absence of severe systemic disease.

7.41 Special formulas, orally administered formulas, nutritional supplements, food supplements other than as specifically covered in this Plan or special diets on an outpatient basis (except for the treatment of inherited metabolic disease).

7.42 Services, supplies or accommodations provided without cost to the Insured or for which the Insured is not legally required to pay.

7.43 Milieu therapy, biofeedback treatment, behavior modification, sensitivity training, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolffing, vocational rehabilitation and wilderness adventure, camping, outdoor or similar programs.

7.44 Experimental, Investigational or Unproven treatment or devices as determined by SHL.

7.45 Sports medicine treatment plans intended to primarily improve athletic ability.

7.46 Radial keratotomy or any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses.

7.47 Services requested or performed by a Provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the Provider may perform on him/herself. Services performed by a Provider with the same legal address as the Insured.

7.48 Ambulance services when an Insured could be safely transported by other means. Air Ambulance services when an Insured could be safely transported by ground Ambulance or other means.

7.49 Late discharge billing and charges resulting from a canceled appointment or procedure.

7.50 Telemetry readings, EKG interpretations when billed separately from the EKG procedure.

7.51 Arterial blood gas interpretations when billed separately from the procedure.

7.52 Services of more than one (1) assistant surgeon at one (1) operative session, unless approved in advance by SHL or its Medical Director. Service of an assistant surgeon when the Hospital provides or makes available qualified staff personnel (including Physicians in training status) as surgical assistants. Services of an assistant surgeon provided solely to meet a Hospital's institutional requirements when the complexity of the surgery does not warrant an assistant surgeon.

7.53 Covered services received in connection with a clinical trial or study, which includes the following:

- Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;
- Healthcare services that are specifically excluded from coverage under this Plan regardless of whether such services are provided under the clinical trial or study;
- Healthcare services that are customarily provided by the sponsors of the clinical trial or study free of charge to the Insured in the clinical trial or study;
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing and other expenses that an Insured may incur;
- Any expenses incurred by a person who accompanies the Insured during the clinical trial or study;
- Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the Insured; and
- Any cost for the management of research relating to the clinical trial or study.

7.54 Services or materials provided under Workers' Compensation or Employer's Liability laws.

7.55 Services provided or paid for by governmental agency or under any governmental program or law, except charges which the Insured is legally obligated to pay.

7.56 Services performed for cosmetic purposes or to correct congenital malformations.

7.57 Services received in connection with Gender Dysphoria, which includes the following:

- Abdominoplasty;
- Blepharoplasty;
- Body contouring, such as lipoplasty;
- Brow lift;
- Calf implants;
- Cheek, chin, and nose implants;
- Cryopreservation of fertilized embryos;
- Drugs for hair loss or growth;
- Face lift, forehead lift, or neck tightening;
- Facial bone remodeling for facial feminizations;
- Hair removal, except as part of a genital reconstruction procedure;
- Hair transplantation;
- Injection of fillers or neurotoxins;
- Lip augmentation;
- Lip reduction;
- Liposuction;
- Mastopexy;
- Pectoral implants for chest masculinization;

- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;
- Rhinoplasty;
- Skin resurfacing;
- Sperm preservation in advance of hormone treatment or gender surgery;
- Surgical treatment not Prior Authorized by SHL.

7.58 Non-Medical 24-Hour Withdrawal Management.

7.59 Nutritional supplements, vitamins, herbal medicines, appetite suppressants, and over-the-counter drugs, except as specifically covered herein. Drugs and medicines approved by the FDA for Experimental, Investigational or Unproven use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan.

7.60 Drugs and medicine approved by the FDA for experimental, investigational or unproven use or any drug that has been approved by the FDA for less than one (1) year, unless required by law.

7.61 Physician-assisted Suicide and any information, services or pharmaceuticals associated.

7.62 Healthcare services from a Non-Plan Provider for non-emergent, sub-acute inpatient or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Free Standing Facility, Residential Treatment Center, Inpatient Rehabilitation Facility or Skilled Nursing Facility received outside of the Insured's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Insured is a legal resident, plus any geographically bordering adjacent state or, for an Insured who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or when there is no Plan Provider who is reasonably accessible or available to provide Covered Services.

7.63 Any care or delivery at a birthing center.

7.64 Transitional Living.

7.65 Medical and surgical treatment of excessive sweating (hyperhidrosis).

7.66 High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria*, for an Insured with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment, unless determined to be medically necessary.

Pharmacy Specific Exclusions

7.67 Prescription Drug furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

7.68 Nutritional supplements, vitamins, herbal medicines, appetite suppressants, and over-the-counter drugs, except as specifically covered herein. Drugs and medicines approved by the FDA for Experimental, Investigational or Unproven use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan. Any drug that has been approved by the FDA for less than one (1) year.

7.69 Prescription Drugs for any condition, Injury, Illness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

7.70 Any product dispensed for the purpose of appetite suppression or weight loss.

7.71 Prescription Drugs used for cosmetic purposes.

7.72 Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

7.73 Certain Prescription Drugs that have not been prescribed by a Specialist.

7.74 Prescription Drug Products when prescribed to treat infertility.

7.75 Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

7.76 Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs.

7.77 Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the SHL COC.

7.78 Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members.

7.79 Drugs or supplies available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless SHL has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that SHL has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and SHL may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

7.80 General vitamins, except the following which require a prescription order or refill: prenatal vitamins; vitamins with fluoride; and single entity vitamins.

7.81 Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury except for Prescription Drug Products that are enteral formulas prescribed for the treatment of inherited metabolic diseases as defined by state law.

7.82 Certain Prescription Drugs that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug.

7.83 Any Prescription Drug for which the actual charge to the Insured is less than the amount due under this Plan.

7.84 Any refill dispensed more than one (1) year from the date of the latest prescription order or as permitted by applicable law of the jurisdiction in which the drug is dispensed.

7.85 Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.

7.86 Coverage for Prescription Drugs for the amount dispensed (days' supply, quantity limitation, dose, regimen, or frequency) which is less than or exceeds the supply limit.

7.87 Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to tier III or IV).

7.88 Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.

7.89 Experimental, Investigational or Unproven services and medications; medication used for experimental indications and/or dosage regimens determined by the Plan to be Experimental, Investigational or Unproven except when prescribed for the treatment of cancer or other life-threatening diseases or conditions, chronic fatigue syndrome, cardiovascular disease, surgical musculoskeletal disorder of the spine, hip and knees, and other diseases or disorders which are not life threatening or study approved by the Plan.

7.90 A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.

7.91 A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

7.92 Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Plan.

7.93 Prescription Drugs dispensed outside the United States, except as required for emergency treatment.

7.94 Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission.

7.95 Except as provided in the *Pharmacy Provisions* section, a Biosimilar Prescription Drug or Reference Product.

7.96 Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

7.97 Covered Drugs that are not FDA approved for a specific diagnosis.

7.98 Drugs and medicine approved by the FDA for Experimental, Investigational or Unproven use.

7.99 Drugs and medicine that have been approved by the FDA for less than one (1) year.

7.100 Drugs not approved by the FDA.

7.101 Certain Prescription Drugs that are repackaged, relabeled, or packaged as a unit dose.

7.102 Diagnostic kits and products, including associated services.

7.103 Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in your Attachment A Benefit Schedule. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.

7.104 Prescription Drugs prescribed by a provider who is on our list of excluded providers due to fraud, waste, and/or abuse findings.

SECTION 8. Limitations

This section tells you what services are limited under this Plan.

8.1 Calendar Year and Lifetime Maximum Benefit Limitations

Please see the Attachment A Benefit Schedule for Calendar Year maximums or lifetime maximums applicable to certain benefits.

8.2 Emergency Services

If treatment is received by an Insured in a Hospital emergency room or other emergency facility for a condition which may be Medically Necessary but which does not require Emergency Services as defined in this Certificate, a reduced benefit will be allowed toward expenses incurred in connection with Covered Services included in such treatment. Examples of treatment occurring in a Hospital emergency room or other emergency facility which may be Medically Necessary, but not of an emergency nature, include treatment for sore throats, flu/fever, earaches, sore or stiff muscles, sprains, strains, or convenience. If the treatment received was not for a Covered Service or if treatment was received which was not Medically Necessary, no benefit will be paid.

SECTION 9. Coordination of Benefits (COB)

This section describes how benefits under this policy will be coordinated with those of any other plan that provides benefits to the Insured. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits. NOTE: This plan is always secondary to a stand-alone dental plan for certain services pursuant to Nevada state regulations.

9.1 The Purpose of COB

This provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

Primary Plan. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.

Secondary Plan. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

For purposes of this section, terms are defined as follows:

A. **Plan.** A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: franchise insurance, hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; medical benefits under group or individual automobile contracts; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense.** Allowable Expense means Eligible Medical Expenses or the Recognized Amount, when applicable, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses or services that are not Allowable Expenses:
   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
   5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

9.2 Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:
1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, Insured, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Insured, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse or Domestic Partner does, that parent's spouse's or Domestic Partner plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
      3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
      4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         i. The Plan covering the Custodial Parent.
         ii. The Plan covering the Custodial Parent's spouse or Domestic Partner.
         iii. The Plan covering the non-Custodial Parent.
         iv. The Plan covering the non-Custodial Parent's spouse or Domestic Partner.

   c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph i) or ii) above as if those individuals were parents of the child.
   d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
   (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Insured, subscriber or retiree or covering the person as a dependent of an employee, Insured, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expense shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.
7. If an Insured is covered by a stand-alone dental benefit and a policy of health insurance, generally the stand-alone dental benefit is the primary policy and the claim must be first submitted to the health insurer that issued the stand-alone dental benefit.

9.3 Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

9.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply the COB provisions herein and to determine benefits payable under This Plan and other Plans. SHL may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and in determining benefits payable under This Plan and other Plans covering the person claiming benefits.

SHL need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give SHL any facts needed to apply these rules and determine benefits payable. If the Insured does not provide SHL the information needed to apply these rules and determine the benefits payable, the Insured's Claim for Benefits will be denied.

9.5 Payments Made and Right to Recover Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, SHL may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan and SHL will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

If the amount of the payments SHL made is more than should have paid under this COB provision, SHL may recover the excess from one or more of the persons SHL has paid or for whom has been paid; or any other person or organization that may be responsible for the benefits or services provided for the Insured. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If This Plan is secondary to Medicare, then benefits payable under This Plan will be based on Medicare's reduced benefits.

SECTION 10. Subrogation and Reimbursement

SHL has the right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.
Subrogation applies when SHL has paid benefits on your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that SHL is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that SHL has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to SHL one hundred percent (100%) of any benefits you receive for that Illness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer an Illness, Injury or damages, or who is legally responsible for the Illness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate in protecting SHLs legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying SHL, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
  - Providing any relevant information requested by SHL.
  - Signing and/or delivering such documents as SHL or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining SHLs or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with SHL is considered a breach of contract. As such, SHL will have the right to terminate or deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits we have paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with SHL. If SHL incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, SHL will have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- SHL has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, SHLs first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- SHLs subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. SHL is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from SHL's recovery without its express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, SHL may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which SHL may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by SHL may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of Illness or Injury, and SHL alleges some or all of those funds are due and owed to SHL, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of benefits provided on behalf of the Insured), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by SHL to enforce its reimbursement rights.
- SHL's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting benefits from SHL, you agree to assign to SHL any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the benefits we have paid for the Illness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize SHL's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- SHL may, at its option, take necessary and appropriate action to preserve SHL's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Illness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate SHL in any way to pay you part of any recovery SHL might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse SHL without SHL written approval.
- SHL has the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your Estate, the personal representative of your Estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse SHL is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse SHL for 100% of it's interest unless a written consent to the allocation is provided by SHL.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer an Illness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, SHL may terminate benefits to you, your dependents or the subscriber, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits we have paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by SHL due to your failure to abide by the terms of the Policy. If SHL incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, SHL has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to SHL.
- SHL and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to SHL.

10.1 Refund of Overpayments

If SHL pays benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to SHL if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount SHL paid in excess of the amount SHL should have paid under the Policy. If the refund is due from another person or organization, you agree to help SHL get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, SHL may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future benefits that are payable under the Policy. If the refund is due from a person or organization other than you, SHL may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part;

- Future benefits that are payable in connection with services provided to other Insureds under the Policy; or
- Future benefits that are payable in connection with services provided to persons under other plans for which SHL makes payment, pursuant to a transaction in which SHLs overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. SHL may have other rights in addition to the right to reduce future benefits.

10.2 Limitation of Action

You cannot bring any legal action against SHL to recover reimbursement until you have completed all the steps in the appeal process described in the Appeals Procedures section. After completing that process, if you want to bring a legal action against SHL you must do so within three years of the date SHL notified you of the final decision on your appeal or you lose any rights to bring such an action against SHL.

SECTION 11. General Provisions

11.1 Relationship of Parties

The relationship between SHL and Plan Providers is an independent contractor relationship. Plan Providers are not agents or employees of SHL, nor is SHL, or any employee of SHL, an employee or agent of a Plan Provider. SHL is not liable for any claim or demand on account of damages as a result of, or in any manner connected with, any Injury suffered by an Insured while receiving care from any Plan Provider. SHL is not bound by statements or promises made by its Plan Providers.

11.2 Entire Agreement

This Certificate, including the Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Insured's Enrollment Form, health statements, Insured Identification Card, and all other applications received by SHL constitutes the entire agreement between the Insured and SHL and as of its Effective Date, replaces all other agreements between the parties.

For the duration of time an Insured's coverage is continuously effective under SHL, regardless of the occurrence of any specific Plan or product changes during such time, all benefits paid by SHL under any and all such Plans on behalf of such Insured shall accumulate towards any applicable lifetime or other maximum benefit amounts as stated in the Insured's most current Plan Attachment A Benefit Schedule to the Certificate.

This policy, including the Endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

In the event SHL decides to discontinue offering and renewing health benefit plans delivered or issued for delivery in this state, SHL will provide notice of its intention to all persons covered by the discontinued insurance at least ninety (90) days before the nonrenewal of any health benefit plan by SHL.

11.3 Payment of Benefits

Payment of benefits by SHL shall be in cash or cash equivalents, or in a form of other consideration that SHL determines to be adequate. Where benefits are payable directly to a Provider, such adequate consideration includes the forgiveness in whole or in part of the amount the Provider owes to SHL, or to other Health Benefit Plans' for which SHL makes payments where SHL has taken an assignment of the other plans' recovery rights for value.

11.4 Contestability

No statement made by an Insured for the purpose of effecting any coverage or any increase in coverage under the Certificate for such Insured will be used in contesting the validity of the coverage with respect to which such statement was made after such coverage or increase in coverage has been in force prior to the contest for a period of two (2) consecutive years unless the statement is contained in a written instrument signed by the Insured.

11.5 Authority to Change the Form or Content of this Plan

No agent or employee of SHL is authorized to change the form or content of this Plan or waive any of its provisions. Such changes can be made only through an amendment authorized and signed by an officer of SHL.

11.6 Identification Card

Cards issued by SHL to Insureds are for identification only. Possession of an SHL identification card does not give the holder any right to services or other benefits under this Plan.
To be entitled to such services or benefits, the holder of the card must in fact be an Insured and all applicable premiums must actually have been paid. Any person not entitled to receive services or other benefits will be liable for the actual cost of such services or benefits.

11.7 Notice

Any notice under this Plan may be given by United States mail, first class, postage prepaid, addressed as follows:

Sierra Health and Life Insurance Company, Inc.
P. O. Box 15645
Las Vegas, Nevada 89114-5645

Notice to an Insured will be sent to the Insured's last known address.

11.8 Interpretation of the Certificate

The laws of the state of issue shall be applied to interpretation of this Certificate.

11.9 Assignment

This Plan is not assignable by Group without the written consent of SHL. The coverage and any benefits under this Plan are not assignable by any Insured without the written consent of SHL.

11.10 Modifications

By issuance of the Certificate and the GEA, the Group makes SHL coverage available under this Plan to individuals who are eligible under Section 1. However, the Certificate and the GEA shall be subject to amendment, modification or termination in accordance with any provision hereof or by mutual agreement between SHL and Group without the consent or concurrence of the Insureds. This Certificate will automatically be modified to conform with any applicable State and Federal law requirements.

11.11 Clerical Error

Clerical error in keeping any record pertaining to the coverage will not invalidate coverage in force or continue coverage terminated.

11.12 Policies and Procedures

SHL may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan with which Insureds shall comply. These policies and procedures are maintained by SHL at its offices. Such policies and procedures may have bearing on whether a medical service and/or supply is covered.

11.13 Choice of Facility of Provider

Nothing contained in the Certificate shall be deemed to restrict an Insured in exercising full freedom of choice in the selection of a Hospital, Skilled Nursing Facility, Physician or Provider for care or treatment of an Illness or Injury.

11.14 Overpayments

If SHL pays benefits for expenses incurred on account of an enrolled Insured, that Insured or any other person or organization that was paid, must make a refund to SHL if any of the following apply:

- If the refund is due from the Insured and the Insured does not promptly refund the full amount, SHL may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for the Insured that are payable under the policy. If the refund is due from a person or organization other than the Insured, SHL may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part;
  - Future benefits that are payable in connection with services provided to other Insureds under the policy; or
  - Future benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which SHLs overpayment recovery rights are assigned to such other Health Benefit Plan's in exchange for such Plans' remittance of the amount of the reallocated payment.

11.15 Cost Containment Features

This Plan contains a number of cost containment provisions including, but not limited to:
(a). Second surgical opinions;
(b). Preventive healthcare benefits;
(c). Plan Provider benefit incentives as described in Attachment A Benefit Schedule; and
(d). The Managed Care Program.

11.16 Release of Records

Each Insured authorizes the Physician, Hospital, Skilled Nursing Facility or any other Provider of healthcare to permit the examination and copying of the Insured's medical records, as requested by SHL.

11.17 Gender References

Whenever a masculine pronoun is used in this Certificate, it also includes the feminine pronoun.

11.18 Legal Proceedings

No action of law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of claim has been filed in accordance with the requirements of the Plan. No such action shall be brought at any time unless brought within the time limit allowed by the laws of the jurisdiction of issue. If the laws of the jurisdiction of issue do not designate the maximum length of time in which such action may be brought, no action may be brought after the expiration of three (3) years from the time proof of loss is required by the Plan.

11.19 Availability of Providers

SHL does not guarantee the continued availability of any specific Plan Provider or the availability of Plan Providers in all specialty fields.

11.20 Authorized Representative

An Insured may elect to designate an "Authorized Representative" to act on their behalf to pursue a Claim for Benefits or the appeal of an Adverse Benefit Determination. The term Insured also includes the Insured's Authorized Representative, where applicable and appropriate. To designate an Authorized Representative, a written notice, signed and dated by the Insured, is required. The notice must include the full name of the Authorized Representative and must indicate specifically for which Claim for Benefits or appeal the authorization is valid. The notice should be sent to:

Sierra Health and Life Insurance Company, Inc.
Attn: Customer Response and Resolution Dept.
P. O. Box 15645
Las Vegas, Nevada 89114-5645

Any correspondence from SHL regarding the specified Claim for Benefits or appeal will be provided to both the Insured and his Authorized Representative.

In case of an Urgent Care Claim, a healthcare professional with knowledge of the Insured's medical condition shall be permitted to act as an Authorized Representative of the Insured without designation by the Insured.

11.21 Failure to Obtain Prior Authorization

The Insured's Physician must initiate all requests for Prior Authorization. If a Physician or Insured fails to follow the Plan's procedures for filing a request for Prior Authorization (Pre-Service Claim), the Insured shall be notified of the failure and the proper procedures to be followed in order to obtain Prior Authorization. The Insured's request for Prior Authorization must be received by an employee or by the department of the Plan customarily responsible for handling benefit matters. The original request must specifically name the Insured, the specific medical condition or symptom and the specific treatment, service or product for which approval is requested. The Insured notification of correct Prior Authorization procedures from the Plan shall be provided as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of an Urgent Care Claim) following the Plan's receipt of the Insured's original request. Notification by SHL may be oral unless specifically requested in writing by the Insured.

11.22 Timing of Notification of Benefit Determination

Concurrent Care Decision: If SHL has approved an ongoing course of treatment to be provided over a period of time or number of treatments and reduces or terminates coverage of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, SHL will notify the Insured at the time sufficiently in advance of the reduction or termination to allow the Insured to appeal and obtain a determination before the benefit is reduced or terminated. Subject to the following paragraph, such request may be treated as a new Claim for Benefits and decided within the timeframes applicable to either a Pre-Service Claim or a Post-Service Claim, as appropriate. Provided, however, any appeal of such a determination must be made within a reasonable time and may not be afforded the full 180 day period as described in the Appeals Procedures Section herein.

Any request by an Insured to extend the course of treatment beyond the period of time or number of treatments for an Urgent Care Claim shall be decided as soon as possible. SHL shall notify the Insured within twenty-four (24) hours after receipt of the Claim for Benefits by the Plan, provided that the request is received at least twenty-four (24) hours prior to the expiration of the authorized period of time or number of treatments. If the request is not made at least twenty-four (24) hours prior to the expiration of the authorized period of time or number of treatments, the request will be treated as an Urgent Care Claim.

11.23 Notification of an Adverse Benefit Determination

If you receive an Adverse Benefit Determination, you will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the Claim for Benefits to be approved, modified or reversed, and an explanation of why such material or information is necessary;
- A description of the review procedures and the time limits applicable to such procedures;
- For Insured's whose coverage is subject to ERISA, a statement of the Insured's right to bring a civil action under ERISA Section 502(a) following an appeal of an Adverse Benefit Determination, if applicable;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Insured's request; and
- If the Adverse Benefit Determination is based on Medically Necessary or Experimental, Investigational or Unproven treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge.

11.24 Prior Healthcare Coverage

If the Insured has prior coverage that, as required by state law, extends benefits for a particular condition or a disability, benefits for that particular condition or disability are subject to your previous carrier's obligation under state law or contract.

11.25 Incentives Available to the Insured

Sometimes SHL may offer coupons, enhanced benefits, or other incentives to encourage an Insured to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-SHL entity. The Insured alone makes the decision about whether or not to take part in a program. However, SHL recommends discussion about taking part in such programs with your Provider. Questions can be directed to:

- Contact Us - Member - Sierra Health and Life; or
- The telephone number on the Inured ID card; or
- The Insured may be routed to a contact specific to the sponsoring company's program.

SECTION 12. Claims Provisions

This Section tells you how and when to file a claim under this Plan.

12.1 Notice and Proof of Claim

Written notice of each Illness or Injury for which benefits are claimed should be given to SHL within twenty (20) days of the date any healthcare services are received. Failure to furnish notice within twenty (20) days will not invalidate or reduce any claim if it is shown that notice was provided as soon as was reasonably possible.

SHL, upon receipt of such notice, will furnish to the Insured within fifteen (15) days, forms for filing the proof of claim. If such forms are not furnished within fifteen (15) days, the Insured shall be deemed to have complied with the requirements of this Certificate as to proof of loss upon submitting, within fifteen (15) days, written proof covering the occurrence, the character and the extent of the loss for which the claim is being made.

SHL agrees to:
(a). Provide claim forms to the Group for submitting claims to SHL;
(b). Receive claims and claims documentation;
(c). Correspond with Insureds and Providers of services if additional information is deemed by SHL to be necessary to complete the processing of claims;
(d). Coordinate benefits payable under the Plan with other benefit plans, if any;
(e). Determine the amount of benefits payable under the Plan; and
(f). Pay the amount of benefits determined to be payable under the Plan.

When seeking reimbursement from SHL for expenses incurred in connection with services received, the Insured must complete a claim form and submit it to the SHL Claims Department with copies of all of the medical records, bills and/or receipts from the Provider. Additional claim forms can be obtained by calling the Member Services Department at 1-800-888-2264.

If the Insured receives a bill for Covered Services, the Insured may request that SHL pay the Provider directly by sending the bill, with copies of all medical records and a signed completed claim form to the SHL Claims Department.

SHL shall approve or deny a claim within thirty (30) days after receipt of the claim. If the claim is approved, the claim shall be paid within thirty (30) days from the date it was approved.

If the approved claim is not paid within that thirty (30) day period, SHL shall pay interest on the claim at the rate set forth by applicable Nevada law. The interest will be calculated from thirty (30) days after the date on which the claim is approved until the date upon which the claim is paid.

SHL may request additional information to determine whether to approve or deny the claim. SHL shall notify the Provider of its request for additional information within twenty (20) days after receipt of the claim. SHL will notify the Provider of the healthcare services of all the specific reasons for the delay in approving or denying the claim. SHL shall approve or deny the claim within thirty (30) days after receiving the additional information. If the claim is approved, SHL shall pay the claim within thirty (30) days after it receives the additional information. If the approved claim is not paid within that time period, SHL shall pay interest on the claim in the manner set forth above.

If SHL denies the claim, notice to the Insured will include the reasons for the rejection and the Insured's right to file a written complaint as set forth in the Appeals Procedures Section herein.

12.2 Timely Filing Requirement

All claims must be submitted to SHL within sixty (60) days from the date expenses were incurred, unless it shall be shown not to have been reasonably possible to give notice within the time limit, and that notice was furnished as soon as was reasonably possible. If the Insured authorizes payment directly to the Provider, a check will be mailed to that Provider. A check will be mailed to the Insured directly if payment directly to the Provider is not authorized. The Insured will receive an explanation of how the payment was determined.

12.3 Late Claims Exclusion

No payments shall be made under this Plan with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by SHL within twelve (12) months after the date Covered Services were provided. In no event will SHL pay more than SHL's Eligible Medical Expenses or the Recognized Amount, when applicable, for such services.

12.4 Examination

SHL will have the right and opportunity at its own expense to examine the person or any individual whose Illness or Injury is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder. In the case of death, SHL will have the right at its own expense to request an autopsy where not prohibited by law.

SECTION 13. Pharmacy Provisions

13.1 Obtaining Covered Drugs

Benefits for Covered Drugs are payable subject to the following conditions:

- A **Designated** Plan Pharmacy must dispense the Covered Drug, except as otherwise specifically provided herein.
- A Generic Covered Drug will be dispensed when available, subject to the prescribing Provider's "Dispense as written" requirements.
- Benefits for Specialty Covered Drugs as defined herein are payable subject to the applicable tier Copayment and/or Coinsurance for up to a 30 day supply. If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, SHL may direct you to a Designated Plan Pharmacy with whom SHL has an arrangement to provide those Covered Drugs. If you choose not to use the Designated Plan Pharmacy and instead have the Specialty Covered Drugs dispensed by a non-Designated Plan Retail Pharmacy, you will be responsible for paying two times the amount of the Specialty Covered Drug tier as stated in the applicable plan Attachment A, Schedule of Benefits.
- When a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive thirty (30) day supply, the Cost-share that applies will reflect the number of days dispensed.

13.2 Designated Plan Pharmacy Benefit Payments

Benefits for Covered Drugs obtained at a Designated Plan Pharmacy are payable according to the applicable benefit tiers described below, subject to the Insured obtaining any required Prior Authorization or meeting any applicable Step Therapy requirement.

- **Tier I –** is the low Cost-share option for Covered Drugs.
- **Tier II –** is the midrange Cost-share option for Covered Drugs.
- **Tier III –** is the high Cost-share option for Covered Drugs.
- **Tier IV –** is the highest Cost-share option for Covered Drugs.
- **Mandatory Generic/Biosimilar benefit provision applies when:**
  - A Brand Name or Reference (originator) Covered Drug is dispensed and a Generic or Biosimilar Covered Drug equivalent is available. After satisfying any applicable CYD, the Insured will pay the applicable tier Copayment and/or Coinsurance plus the difference between the Eligible Medical Expenses, or the Recognized Amount when applicable, of the Generic or Biosimilar Covered Drug and of the Brand Name or Reference Covered Drug to the Designated Plan Pharmacy for each Therapeutic Supply. The difference in the amount between such Brand Name or Reference and Generic or Biosimilar Covered Drug paid by the Insured does not accumulate to any otherwise applicable plan Calendar Year Prescription Drug Deductible, overall plan CYD or annual Out of Pocket Maximum.

Your Calendar Year Deductible, Copayment and/or Coinsurance for insulin Prescription Drugs will not exceed $35 for a 30-day supply.

When a Drug is dispensed through the Mail Order Plan Pharmacy, benefits are subject to the applicable tier Copayment and/or Coinsurance per Mail Order Therapeutic Supply.

13.3 Non-Plan Pharmacy Benefit Payments

In order for claims for Covered Drugs obtained at a Non-Plan Pharmacy to be eligible for benefit payment, the Insured must complete and submit a Pharmacy Reimbursement Claim Form with the prescription label and register receipt to SHL or its designee.

Benefit payments are subject to the limitations and exclusions set forth in the SHL COC as follows:

1. When any Covered Drug is dispensed, the benefit payment will be subject to SHL's Eligible Medical Expenses or the Recognized Amount, when applicable, and any applicable tier Copayment and/or Coinsurance. The Insured is responsible for any amounts exceeding SHL's benefit payment.
2. The Mandatory Generic benefit provision applies when any Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The benefit payment is subject to SHL's Eligible Medical Expenses or the Recognized Amount, when applicable, of the Generic Covered Drug less the applicable tier copayment. The Insured is responsible for any amounts exceeding SHL's benefit payment.
3. No benefits are payable if SHL's Eligible Medical Expenses or the Recognized Amount, when applicable, of the Covered Drug is less than the applicable Copayment and/or Coinsurance.

13.4 90 Day Retail Plan Network [(1)] and Mail Order Plan Pharmacy Benefit Payments

Benefits for Covered Drugs are available when dispensed by an SHL Retail[(1)] and Mail Order Plan Pharmacy and are subject to the applicable tier Cost-share. Information on how to obtain Mail Order Drugs is provided in the Mail Order Brochure provided after enrollment with SHL.

[(1)] Applies to select retail pharmacies, please consult your Provider directory.

13.5 Maintenance Covered Drugs

Benefits for Maintenance Covered Drugs are available when dispensed by an SHL Retail[(1)] and Mail Order Plan Pharmacy subject to the applicable tier Copayment. Information on how to obtain Mail Order Drugs is provided in the Mail Order Brochure provided after enrollment with SHL.

[(1)] Applies to select retail pharmacies, please consult your Provider directory.

13.6 Limitations

- Prior Authorization or Step Therapy may be required for certain Covered Drugs.
- Step Therapy does not apply when being treated with a Covered Drug, to treat a psychiatric condition if:
  - The Covered Drug has been approved by the FDA to treat a psychiatric condition or the use of the Covered Drug to treat a psychiatric condition is otherwise supported by medical or scientific evidence, and
  - When prescribed by a psychiatrist, a physician assistant under the supervision of psychiatrist, an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing, or a primary care provider that is providing care in consultation with one of the above, and
  - The practitioner who prescribed the drug knows, based on the medical history of the Insured, or reasonably expects each alternative drug that is required to be used earlier in the Step Therapy protocol to be ineffective at treating the psychiatric condition.
- Benefits are available for refills of Covered Drugs, including prescription eye drops and opioids, only when dispensed as ordered by a duly licensed health care provider. Refills are provided once a given amount of the Covered Drug is used through the course of therapy; amounts vary by the type of Covered Drug. Refill dates of Covered Drugs can be aligned so that drugs that are refilled at the same frequency can be refilled concurrently.
- A pharmacy may refuse to fill or refill a prescription order when in the professional judgment of the pharmacist the prescription should not be filled.
- Benefits for prescriptions for Mail Order Drugs submitted following SHL's receipt of notice of Insured's termination will be limited to the appropriate Therapeutic Supply from the date such notice of termination is received to the Effective Date of termination of the Insured.
- Benefits are not payable if the Insured is directed to a Designated Plan Pharmacy and chooses not to obtain the Covered Drug from that Designated Plan Pharmacy.
- If SHL determines that the Insured may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, the Insured's selection of Plan Pharmacies may be limited. If this happens, SHL may require the Insured to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if the Insured uses the assigned single Plan Pharmacy. If a selection is not made by the Insured within thirty-one (31) days of the date of notification, then SHL will select a single Plan Pharmacy for the Insured.
- Certain Specialty Prescription Drugs may be dispensed by the Designated Pharmacy in fifteen (15) day supplies up to ninety (90) days and at a pro-rated Copayment or Coinsurance. The Insured will receive a fifteen (15) day supply of the Specialty Prescription Drug Product to determine if the Insured will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Insured each time prior to dispensing the fifteen (15) day supply to confirm if the Insured is tolerating the Specialty Prescription Drug Product. The list of these certain Specialty Prescription Drugs is available through review of the SHL Prescription Drug List (PDL).
- If a Prescription Drug is excluded from coverage, the Insured or representative may request an exception to gain access to the excluded Prescription Drug. Exceptions do not apply to drugs that are considered benefit exclusions, such as drugs for sexual dysfunction, cosmetic products and infertility.
  - To make a request, contact SHL in writing or call the toll-free number on your ID card. Please note, if the request for an exception is approved by SHL, the Insured may incur the cost of the excepted Prescription Drug at the highest tier. If the request requires immediate action and a delay could significantly increase a health risk or the ability regain maximum function, call SHL as soon as possible. SHL will provide a written or electronic determination within seventy-two (72) hours. If the Insured is not satisfied with SHLs determination of the exclusion exception, they may request an External Review. Please refer to the *Appeals Procedure* section herein for further information.

- If a Prescription Drug requires step therapy, the Insured or representative may request an exception from the step therapy protocol to gain access to the Prescription Drug.
  - To make a request, contact SHL via web at https://sierrahealthandlife.com/Member/Step-Therapy-Exception-Request. The Insured will be informed of the determination within two (2) business days. If the Insureds provider requests an expedited review and a delay could significantly increase a health risk, SHL will provide a determination within twenty-four (24) hours.
- SHL may have certain programs in which the Insured may receive an enhanced benefit based on their actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. Questions about these programs can be directed to the Member Services telephone number on your ID card.
- Coverage for all drugs approved by the FDA for prevention and treatment of HIV, medication-assisted treatment for opioid use disorder or treatment of Hepatitis C, when prescribed by a participating provider acting within the scope of their license (includes Physicians, Physician Extender/Physician Assistant, and registered Pharmacists).
- Coverage for self-administered hormonal contraceptives, provided without a prescription, when a Pharmacist complies with the providing requirements protocols of the State Board of Pharmacy.

13.7 Coverage Policies and Guidelines

SHLs Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on SHL's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug to a certain tier by considering a number of factors including but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug's acquisition cost including, but not limited to, available rebates and assessments of the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others; therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed, or according to whether it was prescribed by a Specialist Physician.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding covered persons as a general population. Whether a particular Prescription Drug is appropriate for an individual covered person is a determination that is made by the covered person and the prescribing Physician.

NOTE: the tier status of a Prescription Drug may change periodically based on the process described above but only at times specified by NRS 687B.4095 . As a result of such changes, you may be required to pay more or less for that Prescription Drug.

Questions about SHL's PDL should be directed to the Member Services Department at 1-800-888-2264 or the PDL and the Pharmacy Reimbursement Claim Form is available at Prescription Reimbursement Request Form (sierrahealthandlife.com).

Coupons
At various times, SHL may send mailings or provide other communications that include a variety of messages, including information about prescription and non-prescription drugs. These communications may include offers that enable the Insured to purchase the described product at a discount. In some instances, non-SHL entities may support and/or provide content for these communications and offers. Only the Insured and the Provider can determine whether a change in prescription and/or non-prescription drug regimen is appropriate for the Insured's medical condition.

Variable Copayment Program
Certain Specialty Prescription Drugs are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for the Insured's Prescription Drug and SHL may help the Insured determine whether the Specialty Prescription Drug is eligible for this reduction. If the Insured redeems a coupon from a pharmaceutical manufacturer or affiliate, the Copayment and/or Coinsurance may vary. Please contact the telephone number on your ID card for an available list of Specialty Prescription Drugs. If the Insured chooses not to participate, they will pay the Copayment or Coinsurance as described in the Outpatient Prescription Drug Rider.

The amount of the coupon will not count toward any applicable Calendar Year Deductible or Out of Pocket Maximums, in cases where a coupon is used and a generic is available or if the U.S. Department of Health and Human Services provides additional guidance on the use of copayment accumulator programs.

Rebates and Other Payments
SHL may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that an Insured purchased prior to meeting any applicable deductible. As determined by SHL, a portion of any rebates may be passed on to the Insured and may be taken into account in determining any applicable Copayment and/or Cost-share.

SHL, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from the Outpatient Prescription Drug benefit. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug benefit and, therefore, such amounts do not pass on to the Insured.

SECTION 14. Appeals Procedures

The SHL Appeals Procedures are available to you in the event you are dissatisfied with some aspect of the Plan administration or you wish to appeal an Adverse Benefit Determination. This procedure does not apply to any problem of misunderstanding or misinformation that can be promptly resolved by the Plan supplying the Insured with the appropriate information.

If an Insured's Plan is governed by ERISA, the Insured must exhaust the mandatory level of appeal before bringing a claim in court for a Claim of Benefits.

Concerns about medical services are best handled at the medical service site level before being brought to SHL. If an Insured contacts SHL regarding an issue related to the medical service site and has not attempted to work with the site staff, the Insured may be directed to that site to try to solve the problem there, if the issue is not a Claim for Benefits.
The following Appeals Procedures will be followed if the medical service site matter cannot be resolved at the site or if the concern involves the Adverse Benefit Determination of a Claim for Benefits. All Appeals will be adjudicated in a manner designed to ensure independence and impartiality on the part of the persons making the decision.

Informal Review: An Adverse Benefit Determination or medical site service complaint/concern which is directed to the SHL Member Services Department via phone or in person. If an Informal Review is resolved to the satisfaction of the Insured, the matter ends. The Informal Review is **voluntary**.

1st Level Formal Appeal: An appeal of an Adverse Benefit Determination filed either orally or in writing which SHL's Customer Response and Resolution Department investigates. If a 1st Level Formal Appeal is resolved to the satisfaction of the Insured, the appeal is closed. The 1st Level Formal Appeal is **mandatory** if the Insured is not satisfied with the initial determination and the Insured wishes to appeal such determination.

2nd Level Formal Appeal: If a 1st Level Formal Appeal is not resolved to the Insured's satisfaction, an Insured may then file a 2nd Level Formal Appeal. A 2nd Level Formal Appeal is submitted either orally or in writing and reviewed by the Grievance Review Committee. The 2nd Level Formal Appeal is **voluntary** for Adverse Benefit Determinations. Appeals that meet expedite criteria are not eligible for 2nd Level Formal Appeal. These may be processed through the expedited external review process.

Grievance Review Committee: A committee in which the majority of those individuals who are voting members must be members of an SHL Health Benefit Plan.

Member Services Representative: An employee of SHL that is assigned to assist the Insured or the Insured's Authorized Representative in filing a grievance with SHL or appealing an Adverse Benefit Determination.

14.1 Informal Review

An Insured who has received an Adverse Benefit Determination of a Claim for Benefits may request an Informal Review. All Informal Reviews must be made to SHL's Member Services Department within 180 days of the Adverse Benefit Determination. Informal Reviews not filed in a timely manner will be deemed waived. The Informal Review is a **voluntary** level of appeal.

Upon the initiation of an Informal Review, an Insured must provide Member Services with at least the following information:

- The Insured's name (or name of Insured and Insured's Authorized representative), address, and telephone number;
- The Insured's SHL membership number and Group name; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Insured feels that the Adverse Benefit Determination was wrong.

The Member Services Representative will inform the Insured that upon review and investigation of the relevant information, SHL will make a determination of the Informal Review. The determination will be made as soon as reasonably possible but will not exceed thirty (30) days unless more time is required for fact-finding. If the determination of the Informal Review is not acceptable to the Insured and the Insured wishes to pursue the matter further, the Insured may file a 1st Level Formal Appeal.

14.2 1st Level Formal Appeal

When an Informal Review is not resolved in a manner that is satisfactory to the Insured or when the Insured chooses not to file an Informal Review and the Insured wishes to pursue the matter further, the Insured must file a 1st Level Formal Appeal. The 1st Level Formal Appeal must be submitted orally or in writing to SHL's Customer Response and Resolution Department within 180 days of an Adverse Benefit Determination. Such 180 days will run concurrently with the 180 day time period applicable to an Informal Review as set forth herein. NOTE: 1st Level Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

The 1st Level Formal Appeal shall contain at least the following information:

- The Insured's name (or name of Insured and Insured's Authorized Representative), address, and telephone number;
- The Insured's SHL membership number and Group name; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Insured feels that the Adverse Benefit Determination was wrong.

Additionally, the Insured may submit any supporting medical records, Physician's letters, or other information that explains why SHL should approve the Claim for Benefits. The Insured can request the assistance of a Member Services Representative at any time during this process.

The 1st Level Formal Appeals should be sent or faxed to the following:

Sierra Health and Life Insurance Co., Inc.
Attn: Customer Response and Resolution Department
PO Box 14865
Las Vegas, NV 89114
Fax: 1-702-266-8813

SHL will investigate the appeal. When the investigation is complete, the Insured will be informed in writing of the resolution within thirty (30) days of receipt of the request for the 1st Level Formal Appeal. This period may be extended one (1) time by SHL for up to fifteen (15) days, provided that the extension is necessary due to matters beyond the control of SHL and SHL notifies the Insured prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension and the date by which SHL expects to render a decision. If the extension is necessary due to a failure of the Insured to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Insured shall be afforded at least forty-five (45) days from receipt of the notice to provide the information.

If SHL is unable to resolve the Insureds appeal as additional information is required, SHL will contact the Insured to obtain their permission to withdraw the appeal. The Insured will receive written notification that the appeal has been withdrawn and advise of the ninety (90) day timeframe in which to reopen their appeal.

If the 1st Level Formal Appeal results in an Adverse Benefit Determination, the Insured will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the Insured is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Insured's Claim for Benefits;
- A statement describing any voluntary appeal procedures offered by SHL and the Insured's right to receive additional information describing such procedures;
- For Insured's whose coverage is subject to ERISA, a statement of the Insured's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination, if applicable;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Insured's request; and
- If the Adverse Benefit Determination is based on Medical Necessity or Experimental, Investigational or Unproven treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge as well as information regarding the Insured's right to request an External Review by the State of Nevada's Office for Consumer Health Assistance (OCHA).

Limited extensions may be required if additional information is required in order for SHL to reach a resolution.

If the resolution to the 1st Level Formal Appeal is not acceptable to the Insured and the Insured wishes to pursue the matter further, the Insured is entitled to file a 2nd Level Formal Appeal. The Insured will be informed of this right at the time the Insured is informed of the resolution of his 1st Level Formal Appeal.

14.3 Expedited Appeal – 1st Level Formal Appeal

The Insured can ask (either orally or in writing) for an Expedited Appeal of an Adverse Benefit Determination for a Pre-Service Claim that involves an Urgent Care Claim if the Insured or his Physician believe that the health of the Insured could be seriously harmed by waiting for a routine appeal decision. Expedited Appeals are not available for appeals regarding denied claims for benefit payment (Post-Service Claim) or for Pre-Service Claims that are not Urgent Care Claims. Expedited Appeals must be decided no later than seventy-two (72) hours after receipt of the appeal, provided all necessary information has been submitted to SHL. If the initial notification was oral, SHL shall provide a written or electronic explanation to the Insured within seventy-two (72) hours after the expedited appeal being filed.

If insufficient information is received, SHL shall notify the Insured as soon as possible, but no later than twenty-four (24) hours after receipt of the claim of the specific information necessary to complete the claim. The Insured will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. SHL shall notify the Insured of the benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

- SHL's receipt of the specified information, or
- The end of the period afforded the Insured to provide the specified information.

If the Insured's Physician

- Requests an Expedited Appeal, or
- Supports an Insured's request for an Expedited Appeal and indicates that waiting for a routine appeal could seriously harm the health of the Insured or subject the Insured to unmanageable severe pain that cannot be adequately managed without care or treatment that is the subject of the Claim for Benefits, SHL will automatically grant an Expedited Appeal.

If a request for an Expedited Appeal is submitted without support of the Insured's Physician, SHL shall decide whether the Insured's health requires an Expedited Appeal. If an Expedited Appeal is not granted, SHL will provide a decision within thirty (30) days, subject to the routine appeals process for Pre-Service Claims.

14.4 2nd Level Formal Appeal

When a 1st Level Formal Appeal is not resolved in a manner that is satisfactory to the Insured, the Insured may initiate a 2nd Level Formal Appeal. This appeal must be submitted orally or in writing within thirty (30) days after the Insured has been informed of the resolution of the 1st Level Formal Appeal.

Exhaustion of the 1st Level Formal Appeal procedure is a precondition to filing a 2nd Level Formal Appeal. A 2nd Level Formal Appeal not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which it relates. The 2nd Level Formal Appeal is **voluntary** for all Pre-Service and Post-Service Claims for Benefits.

Expedited appeals are not eligible for 2nd Level Formal Appeal. Expedited appeals may be processed through the Expedited External Review process. Please reference Expedited External Review of this plan document.

The notice to the Insured or the Insured's Authorized Representative will also include:

- A HIPAA compliant authorization for use by which the Insured or Insured's Authorized Representative can authorize SHL and the Insured's Physician to disclose protected health information ("PHI"), including medical records, that are pertinent to the 2nd Level Formal appeal and
- Any other forms as required by Nevada law or regulation.

The 2nd Level Formal Appeal review cannot be scheduled without the written authorization from the Insured or the Insured's Authorized Representative.

The Insured shall be entitled to the same reasonable access to copies of documents referenced above under the 1st Level Formal Appeal. Any new or additional information considered, relied upon or generated by the Plan will be provided to the Insured, free of charge and in advance of the date on which the notice of the final internal adverse determination is required, in order to give the Insured a reasonable opportunity to respond prior to this date.

The Insured can request the assistance of a Member Services Representative at any time during this process.

Upon request, the Insured is entitled to present telephonically and provide a formal presentation on a 2nd Level Formal Appeal. If such a hearing is requested, SHL shall make every reasonable effort to schedule a mutually convenient time for the parties involved. Repeated refusal on the part of the Insured to cooperate in the scheduling of the formal presentation shall relieve the Grievance Review Committee of the responsibility of hearing a formal presentation, but not of reviewing the 2nd Level Formal Appeal. If a formal presentation is held, the Insured will be permitted to provide documents to the Grievance Review Committee and to have assistance in presenting the matter to the Grievance Review Committee, including representation by counsel. However, SHL must be notified at least five (5) business days before the date of the scheduled formal presentation of the Insured's intent to be represented by counsel and/or to have others present during the formal presentation. Additionally, the Insured must provide SHL with copies of all documents the Insured may use at the formal presentation five (5) business days before the date of the scheduled formal presentation.

Upon SHL's receipt of the written request, the request will be forwarded to the Grievance Review Committee along with all available documentation relating to the appeal.

The Grievance Review Committee shall:

- Consider the 2nd Level of Appeal;
- Schedule and conduct a formal presentation if applicable;
- Obtain additional information from the Insured and/or staff as it deems appropriate; and
- Make a decision and communicate its decision to the Insured within thirty (30) days following SHL's receipt of the request for a 2nd Level Formal Appeal.

If the resolution of the 2nd Level Formal Appeal results in an Adverse Benefit Determination, the Insured will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement describing any additional voluntary levels of appeal; and
- A statement describing the Insured's External Appeals Rights, if applicable, or judicial review.

Limited extensions may be required if additional information is required or a formal presentation is requested and the Insured agrees to the extension of time.

14.5 External Review

SHL offers to the Insured or the Insured's Authorized Representative the right to an External Review of an adverse determination. For the purposes of this section, an Insured's Authorized Representative is a person to whom an Insured has given express written consent to represent the Insured in an External Review of an adverse determination; or a person authorized by law to provide substituted consent for an Insured; or a family member of an Insured or the Insured's treating provider only when the Insured is unable to provide consent.

Adverse determinations eligible for External Review set forth in this section are only those relating to Medical Necessity, appropriateness of service, healthcare service, healthcare setting, or level of care or effectiveness of a healthcare service. SHL will provide the Insured notice of such an adverse determination which will include the following statement:

> *SHL has denied your request for the provision or payment of a requested healthcare service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for External Review to the Office for Consumer Health Assistance (OCHA).*

Additionally, as per applicable law and regulations, the notice will provide the Insured the information outlined herein as well as the following:

- The telephone number for the Office for Consumer Health Assistance for the state of jurisdiction of the health carrier and the state in which the Insured resides.
- The right to receive correspondence in a culturally and linguistically appropriate manner.

The notice to the Insured or the Insured's Authorized Representative will also include:

- A HIPAA compliant authorization form by which the Insured or the Insured's Authorized Representative can authorize SHL and the Insured's Physician to disclose protected health information ("PHI"), including medical records, that are pertinent to the External Review and
- Any other forms as required by Nevada law or regulation.

The Insured or the Insured's Authorized Representative may submit a request directly to OCHA for an External Review of an adverse determination by an Independent Review Organization ("IRO") within four (4) months of the Insured or the Insured's Authorized Representative receiving notice of such determination. The IRO must be certified by the Nevada Division of Insurance. Requests for an External Review must be made in writing and submitted to OCHA at the address following and should include the signed HIPAA authorization form, authorizing the release of the Insured's medical records. The entire External Review process and any associated medical records are confidential.

Office of the Governor, Consumer Health Assistance
3320 W. Sahara Ave., Suite 100, Las Vegas, NV 89102
Telephone: 702-486-3587 Toll-free: 1-888-333-1597
Web: dhhs.nv.gov/Programs/CHA/
Email: cha@govcha.nv.gov

The determination of an IRO concerning an External Review in favor of the Insured of an adverse determination is final, conclusive and binding. If your plan is governed by Employee Retirement Income and Security Act (ERISA), you may have the right to file a civil action under ERISA if all required mandatory reviews of your claim have been completed. Upon receipt of the notice of a decision by the IRO reversing an adverse determination, SHL shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination. The cost of conducting an External Review of an adverse determination will be paid by SHL.

14.6 Standard External Review

The Insured may submit a request for an External Review of an adverse determination under this section only after

- The Insured has exhausted all applicable internal SHL Appeals Procedures provided under this Plan or
- If SHL fails to issue a written decision to the Insured within thirty (30) days after the date the Appeal was filed, and the Insured or Insured's Authorized Representative did not request or agree to a delay or,
- If SHL agrees to permit the Insured to submit the adverse determination to OCHA without requiring the Insured to exhaust all internal applicable SHL Appeals Procedures. In such event, the Insured shall be considered to have exhausted the internal SHL Appeals Process.

Within five (5) days after OCHA receives a request for External Review, OCHA shall notify the Insured, the Insured's Authorized Representative and SHL, that such request has been received and filed. As soon as practical, OCHA shall assign an IRO to review the case.

Within five (5) days after receiving notification specifying the assigned IRO from OCHA, SHL shall provide to the selected IRO all documents and materials relating to the adverse determination, including, without limitation:

- Any medical records of the Insured relating to the adverse determination;
- A copy of the provisions of the healthcare Plan upon which the adverse determination was based;
- Any documents used and the reason(s) given by SHL's Managed Care Program for the adverse determination; and
- If applicable, a list that specifies each Provider who provided healthcare to the Insured and the corresponding medical records from the Provider relating to the adverse determination.

Within five (5) days after the IRO receives the required documentation from SHL, they shall notify the Insured or the Insured's Authorized Representative, if any additional information is required to conduct the review. If additional information is required, it must be provided to the IRO within five (5) days after receiving the request. The IRO will forward a copy of the additional information to SHL within one (1) business day after receipt.

The IRO shall approve, modify, or reverse the adverse determination within fifteen (15) days after it receives the information required to make such a determination. The IRO shall submit a copy of its determination, including the basis thereof, to the:

- Insured;
- Insured's Physician;
- Insured's Authorized Representative, if any; and
- SHL.

14.7 Expedited External Review

A request for an Expedited External Review may be submitted to OCHA when the mandatory 1st Level Appeal has been exhausted and after it receives proof from the Insured's Provider that the adverse determination concerns:

- An inpatient admission;
- Availability of inpatient care;
- Continued stay or health care service for Emergency Services while still admitted to an inpatient facility; or
- Failure to proceed in an expedited manner may jeopardize the life or health of the Insured.

The OCHA shall approve or deny this request for Expedited External Review within seventy-two (72) hours after receipt of the above required proof. If OCHA approves the request, it shall assign the request to an IRO no later than one (1) business day after approving the request. SHL will supply all relevant medical documents and information used to establish the adverse determination to the IRO within twenty-four (24) hours after receiving notice from the OCHA.

The IRO shall complete its Expedited External Review within forty-eight (48) hours after initially being assigned the case unless the Insured or the Insured's Authorized Representative and SHL agree to a longer time period.

The IRO shall notify the following parties no later than twenty-four (24) hours after completing its Expedited External Review:

- Insured;
- Insured's Physician;
- Insured's Authorized Representative, if any; and
- SHL.

The IRO shall then submit a written copy of its determination within forty-eight (48) hours to the applicable parties listed above.

14.8 Request for an External Review Due to Denial of Experimental, Investigational or Unproven Healthcare Service or Treatment.

A Standard or Expedited External Review of an adverse determination due to a requested or recommended healthcare service or treatment being deemed Experimental, Investigational or Unproven is available in limited circumstances as outlined in the following sections.

14.9 Standard External Review

The Insured or Insured's Authorized Representative may within four (4) months after receiving notice of an adverse determination subject to this section, submit a request to OCHA for an External Review. All requests for standard external review must be made in writing to OCHA.

OCHA will notify SHL and/or any other interested parties within one (1) business day after the receipt of the request for External Review. Within five (5) business days after SHL receives such notice and, subject to applicable Nevada law and regulation and pursuant to this section, SHL will make a preliminary determination of whether the case is complete and eligible for External Review.

Within one (1) business day of making such a determination, SHL will notify in writing, the Insured or the Insured's Authorized Representative and OCHA, accordingly. If SHL determines that the case is incomplete and/or ineligible, SHL will notify the Insured in writing of such determination. Such notice shall include the required additional information or materials needed to make the request complete and, if applicable, state the reasons for ineligibility and also state that such determination may be appealed to OCHA. Upon appeal, OCHA may overturn SHL's determination that a request for External Review of an adverse determination is ineligible, and submit the request to External Review, subject to all of the terms and provisions of this Plan and applicable Nevada law and regulation.

Within one (1) business day after receiving the confirmation of eligibility for External Review from SHL, OCHA will assign the IRO accordingly and notify in writing the Insured or the Insured's Authorized Representative and SHL that the request is complete and eligible for External Review and provide the name of the assigned IRO. SHL, within five (5) days after receipt of such notice from the OCHA, will supply all relevant medical documents and information used to establish the adverse determination to the assigned IRO who will select and assign one or more clinical reviewers to the External Review.

The IRO shall approve, modify, or reverse the adverse determination pursuant to this section within twenty (20) days after it receives the information required to make such a determination.

The Independent Review Organization shall submit a copy of its determination, including the basis thereof, to the:
- Insured;
- Insured's Physician;
- Insured's Authorized Representative, if any; and
- SHL.

14.10 Expedited External Review

The Insured or the Insured's Authorized Representative may request in writing, an internal Expedited Appeal by SHL and an Expedited External Review from OCHA simultaneously
- If the adverse determination of the requested or recommended service or treatment is determined by SHL to be Experimental, Investigational or Unproven and,
- If the treating provider certifies, in writing, that such service or treatment would be less effective if not promptly initiated.

An oral request for an Expedited External Review may be submitted directly to the OCHA upon the written submission of proof from the Insured's Provider to OCHA. Upon receipt of such request and proof, OCHA shall immediately notify SHL accordingly.

SHL will immediately determine if the request meets the requirements for Expedited External Review pursuant to this section and notify the Insured or the Insured's Authorized Representative and OCHA of the determination. If SHL determines the request to be ineligible, the Insured will be notified that the request may be appealed to OCHA.

If OCHA approves the request for Expedited External Review, it shall immediately assign the request to an IRO and notify SHL. The IRO has one (1) business day to select one or more clinical reviewers. SHL must submit the documentation used to support the adverse determination to the IRO within five (5) business days. If SHL fails to provide the information within the specified time, the IRO may terminate the External Review and reverse the adverse determination.

The Insured or Insured's Authorized Representative may, within five (5) business days after receiving notice of the assigned IRO, submit any additional information in writing to the IRO. Any information submitted by the Insured or the Insured's Authorized Representative after five (5) business days to the IRO may be considered as well. Any information received by the Insured or the Insured's Authorized Representative must be submitted to SHL by the IRO within one (1) business day.

The clinical reviewers have no more than five (5) days to provide an opinion to the IRO. The IRO has forty-eight (48) hours to review the opinion of the clinical reviewers and make a determination.

The IRO shall notify the following parties no later than twenty-four (24) hours after completing its External Review:
- Insured;
- Insured's Physician;
- Insured's Authorized Representative, if any; and
- SHL.

The IRO shall then submit a written copy of its determination within forty-eight (48) hours to the applicable parties listed above.

14.11 No Surprises Act

The Policy complies with the applicable provisions of the *Consolidated Appropriations Act (the "Act") (P.L. 116-260).*

Balance Billing
The No Surprises Act prohibits balance billing by out-of-network providers in the following instances:
- When ancillary services are received at certain network facilities on a non-emergency basis from out-of-network Physicians.
- When non-ancillary services are received at certain network facilities on a non-emergency basis from out-of-network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described in the Act.
- When emergency health care services are provided by an out-of-network provider.
- When air ambulance services are provided by an out-of-network provider.

In these instances, the out-of-network provider may not bill you for amounts in excess of your applicable copayment, coinsurance or deductible (cost share). Your cost share will be provided at the same level as if provided by a plan provider and is determined based on the recognized amount.

For the purpose of this summary, "certain network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Determination of Our Payment to the Out-of-Network Provider:
When covered health care services are received from out-of-network providers for the instances as described above, the recognized amount, which are used to determine our payment to out-of-network providers, are based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state All Payer Model Agreement.
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-network provider and us.
- The amount determined by Independent Dispute Resolution (IDR).

Continuity of Care
The Act provides that if you are currently receiving treatment for covered health care services from a provider whose network status changes from network to out-of-network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, please call the telephone number on your ID card.

Provider Directories
The Act provides that if you receive a covered health care service from an out-of-network provider and were informed incorrectly by us prior to receipt of the covered health care service that the provider was a plan provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from a plan provider.

14.12 Office for Consumer Health Assistance

(702) 486-3587 in the Las Vegas area
1-888-333-1597 outside of the Las Vegas area (toll-free)

SECTION 15. Glossary

This section tells you meanings of some of the more important words in the Certificate of Coverage. Please read it carefully. It will help you to understand the rest of the Certificate of Coverage.

❖ **"Accidental Injury"** means physical damage to the body that is caused by an outside force; and is directly caused by an accident. Accidental Injury does not mean bodily injury caused by routine body movements such as stooping, twisting, bending, or chewing.

❖ "**Adverse Benefit Determination**" means a rescission of coverage; a decision by SHL to deny, reduce, terminate, fail to provide, or make payment for a benefit, including a denial, reduction termination, or failure to provide, or make a payment for a benefit that is based on:

- An individual's eligibility;
- A determination that a benefit is not a Covered Service;
- The imposition of a limitation on an otherwise Covered Service; or
- A determination that a benefit is Experimental, Investigational or Unproven or not Medically Necessary or appropriate.

External Review is only available for a Final Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service. An Adverse Benefit Determination is final if the Insured has exhausted all complaint and Appeal Procedures set forth herein for the review of such Adverse Benefit Determination.

❖ **"Air Ambulance"** means medical transport by rotary wing air ambulance or fixed wing air ambulance as defined in CFR 414.605.

❖ **"Alternate Facility**" means a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Illness or Substance-Related and Addictive Disorders Services on an Outpatient or Inpatient basis.

❖ "**Ambulance**" means a ground or air vehicle licensed to provide Ambulance services.

❖ "**Ambulatory Surgical Facility**" means a facility that:

- Is licensed by the state where it is located.
- Is equipped and operated mainly to provide for surgeries or obstetrical deliveries.
- Allows patients to leave the facility the same day the surgery or delivery occurs.

❖ "**Ancillary Services**" means items and services provided by a Non-Plan Provider at a Plan facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a Non-Plan Provider when no other Plan Provider is available.

❖ **"Applied Behavior Analysis"** or **"ABA"** means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

❖ "**Authorized Representative**" means a person designated by the Insured to act on his behalf in pursuing a Claim for Benefits, to file an appeal of an Adverse Benefit Determination, or in obtaining an External Review of an adverse determination. The designation must be in writing unless the claim or appeal involves an Urgent Care Claim and a healthcare professional with knowledge of the Insured's medical condition is seeking to act on the Insured's behalf as his Authorized Representative.

❖ **"Autism Spectrum Disorders"** means a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests, or activities and as listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.

❖ **"Benefit Schedule"** means the brief summary of benefits, limitations and Copayments, Deductibles and Coinsurance amount given to the Subscriber by SHL. It is Attachment A to this Certificate.

❖ **"Biomarker"** means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.

❖ "**Biosimilar Prescription Drug**" means a biological Prescription Drug approved based on showing that it is highly similar to a Reference Product and has no clinically meaningful differences in terms of safety and effectiveness from the Reference Product.

❖ **"Brand Name Drug"** means a Prescription Drug which is marketed under or protected by:

- A registered trademark; or
- A registered trade name; or
- A registered patent.

❖ "**Calendar Year**" means January 1 through December 31 of the same year.

❖ "**Calendar Year Out of Pocket Maximum"** means the maximum amount of Out of Pocket expenses an Insured is required to pay for Covered Services in a Calendar Year, as outlined in the Attachment A, Schedule of Benefits. Once the Calendar Year Out of Pocket Maximum is met, no further cost share is required for the remainder of the Calendar Year. For purposes of accumulating benefits paid toward any applicable benefit maximums under the Plan, the period of such accumulation will coincide with the time period of the Calendar Year applicable to the Group.

The Out of Pocket Maximum does not include any expenses:

- For reduction in benefits resulting from Insured's failure to comply with SHL's Managed Care Program, including the inappropriate use of an emergency room facility for a condition which does not require Emergency Services;
- In excess of Eligible Medical Expenses or the Recognized Amount, when applicable;
- For services that are not Covered Services under this Plan; or
- In excess of the Calendar Year, per Illness or any other benefit maximums as set forth in Attachment A Benefit Schedule.

❖ **"Certificate of Coverage"** or **"COC"** means this document, including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Insured's Enrollment Form, health statements, Insured Identification Card, and all other applications received by SHL.

❖ "**Claim for Benefits**" means a request for a Plan benefit or benefits made by an Insured in accordance with the Plan's Appeals Procedures, including any Pre-Service Claims (requests for Prior Authorization) and Post-Service Claims (requests for benefit payment).

❖ "**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended.

❖ **"Coinsurance"** means the percentage of the charges billed or the percentage of Eligible Medical Expenses or the Recognized Amount, when applicable, whichever is less, that an Insured must pay a Provider for Covered Services. Coinsurance amounts are to be paid by the Insured directly to the Provider who bills for the Covered Services. (See Attachment A Benefit Schedule.)

❖ **"Complications of Pregnancy"** means:

- Conditions with diagnoses which are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis; nephrosis, cardiac decompensation; hyperemesis gravidarum; puerperal infection; toxemia; eclampsia; and missed abortion;
- A nonelective cesarean section;
- Terminated ectopic pregnancy; or
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does NOT include (1) false or premature labor; (2) occasional spotting; (3) prescribed rest during the period of pregnancy; or (4) similar conditions associated with the management of a difficult or high risk pregnancy not constituting a distinct Complication of Pregnancy.

❖ **"Compound"** means to form or create a Medically Necessary customized composite product by combining two (2) or more different ingredients according to a Physician's specifications to meet an individual patient's need.

❖ **"Congenital Anomaly"** means a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

❖ "**Contract Year**" means the twelve (12) months beginning with and following the Effective Date of the Group Enrollment Agreement (GEA).

❖ **"Convenient Care"** means a facility that provides services for Medically Necessary, non-urgent or non-emergent injuries or illnesses. Examples of such conditions include:

- Blood pressure checks;
- Diagnostic laboratory services;
- General health screenings;
- Minor illnesses (cold/flu);
- Minor wound treatment and repair;
- Treatment of burns and sprains.

❖ **"Copayment"** or **"Cost-share"** means the amount the Insured pays at the time a Covered Service is received.

❖ **"Covered Drug"** means a Brand Name or Generic Prescription Drug or diabetic supply or equipment which:
- Can only be obtained with a prescription;
- Has been approved by the Food and Drug Administration ("FDA") for general marketing;
- Is dispensed by a licensed pharmacist;
- Is prescribed by a Plan Provider, except in the case of Emergency Services and Urgently Needed Services;
- Is a Prescription Drug that does not have an over-the-counter Therapeutic Equivalent available; and
- Is not specifically excluded herein.

❖ **"Covered Person"** means an Insured who meets the eligibility requirements of Section 1., who has enrolled under this Plan and for whom premiums have been received and accepted by SHL.

❖ "**Covered Services**" means the health services, supplies and accommodations for which SHL pays benefits under this Plan.

❖ "**Covered Transplant Procedure**" means any Medically Necessary, human-to-human, organ or tissue transplants performed upon an Insured who satisfies medical criteria developed by SHL for receiving transplant services.

❖ "**Custodial Care**" means care that mainly provides room and board (meals) for a physically or mentally disabled person. Such care does not reduce the disability so that the person can live outside a Hospital or nursing home. Examples of Custodial Care include:
- Non-Skilled Nursing Care.
- Supervisory care by a Physician in a custodial facility to meet regulatory requirements.
- Training or assistance in personal hygiene.
- Other forms of self-care.

❖ **"Date of Onset"** means the day the Insured first had a symptom or condition that a Provider could have used to identify the Illness or Injury or other condition with reasonable accuracy.

❖ **"Deductible"** means the portion of Eligible Medical Expenses or the Recognized Amount, when applicable, excluding Copayments, billed by Providers each Calendar Year that an Insured must pay, either in the aggregate or for a particular service, before SHL will make any benefit payments for Covered Services. (See Attachment A Benefit Schedule.)

❖ "**Dependent**" means an Eligible Family Member of the Subscriber's family who:
- Meets the eligibility requirements of the Plan as set forth in Section 1 of this Certificate;
- Is enrolled under this Plan; and
- For whom premiums have been received and accepted by SHL.

❖ "**Designated Facility"** means a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

❖ "**Designated Plan Pharmacy"** means a pharmacy that has entered into an agreement with SHL to provide specific Covered Drugs and/or supplies to Insureds. The fact that a pharmacy is a Plan Pharmacy does not mean that it is a Designated Plan Pharmacy. For the purposes of the Prescription Drug Benefit, please refer to the SHL PDL on the website or contact Member Services for the specific Designated Plan Pharmacy for your Covered Drug and/or supply/equipment.

❖ **"Dispensing Period"** as established by SHL means 1) a predetermined period of time; or 2) a period of time up to a predetermined age attained by the Insured that a specific Covered Drug is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition.

❖ "**Durable Medical Equipment**" or "**DME**" means medical equipment that:
- Can withstand repeated use;
- Is used primarily and customarily for a medical purpose rather than convenience or comfort;
- Generally is not useful to a person in the absence of an Illness or Injury;
- Is appropriate for use in the home; and
- Is prescribed by a Physician.

❖ "**Effective Date**" means the initial date on which Insureds are covered for services under the SHL Plan provided any applicable premiums have been received and accepted by SHL.

❖ "**Eligible Employee**" means a natural person that meets the following criteria:

- Is employed full-time;
- Is in an active employment status;
- Works at least the minimum number of hours per week indicated by the Group in the Attachment A to the GEA (typically 30 hours);
- Meets the applicable waiting period indicated by the Group in the Attachment A to the GEA;
- Enrolls during an enrollment period; and
- Works for an employer that meets the minimum employer contribution percentage for the applicable coverage as set forth in the Attachment A to the GEA.

❖ "**Eligible Family Member**" means a member of the Subscriber's family that is or becomes eligible to enroll for coverage under this Plan as a Dependent.

❖ "**Eligible Medical Expenses**" or "**EME**" means the maximum amount SHL will pay for a particular Covered Service as determined by SHL in accordance with SHL's Reimbursement Schedule or determined as required by law.

❖ "**Emergency Services**" means Covered Services provided for a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention at a Hospital or Emergency department could result in serious:

- Jeopardy to his health;
- Jeopardy to the health of an unborn child;
- Impairment of a bodily function; or
- Dysfunction of any bodily organ or part.

Emergency Services include items and services otherwise covered by SHL when provided by a Non-Plan Provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an inpatient or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

- The attending Emergency Physician or treating Provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network Provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
- The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
- The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
- The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
- Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

❖ "**Enrollment Date**" means the first day of coverage under this Plan or, if there is a Waiting Period, the first day of the Waiting Period. If an individual receiving benefits under the employer's Health Benefit Plan changes benefit packages, or if the employer changes Health Benefit Plan carriers, the individual's Enrollment Date does not change.

❖ "**ERISA**" means Employee Retirement Income Security Act of 1974, as amended, including regulations implementing the Act.

❖ **"Essential Benefits"** include the following: ambulatory services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services; including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

❖ "**Expedited Appeal**" means if an Insured appeals a decision regarding a denied request for Prior Authorization (Pre-Service Claim) for an Urgent Care Claim, the Insured or Insured's Authorized Representative can request an Expedited Appeal, either orally or in writing. Decisions regarding an Expedited Appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

❖ **"Experimental or Investigational"** means medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time SHL makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information* (*AHFS DI*) under the therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIA, or class IIb; or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A or 2B.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
  Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical trials for which benefits are available as described herein.
- SHL may, as we determine, consider an otherwise Experimental or Investigational service to be a covered healthcare service for that illness or condition if:
  - The Insured is not a participant in a qualifying clinical trial, as herein: and
  - The Insured has an illness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, SHL must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that illness or condition.

❖ "**External Review**" means an independent review of an Adverse Benefit Determination conducted by an Independent Review Organization.

❖ **"Final Adverse Benefit Determination"** means the upholding of an Adverse Benefit Determination at the conclusion of the internal appeals process or an Adverse Benefit Determination in which the internal appeals process has been deemed exhausted.

External Review is only available for a Final Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service.

❖ **"Free Standing Diagnostic Center"** means a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

❖ **"Free Standing Emergency Facility"** means a facility, structurally separate and distinct from a hospital, which provides limited services for the treatment of a medical emergency and licensed as ascribed in NAC 449.61032 – NAC 449.61384.

❖ **"Gender Dysphoria"** means a disorder characterized by diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Health* published by *the American Psychiatric Association.*

❖ **"Generic Drug"** means an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.

❖ "**Genetic Disease Testing**" means the analysis of human DNA, chromosomes, proteins or other gene products to determine the presence of disease related genotypes, mutations, phenotypes or karyotypes for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risks, identification of carriers, monitoring, diagnosis or prognosis, but do not include tests conducted purely for research.

❖ "**Group**" means an employer or legal entity that has completed and signed the Group Enrollment Agreement and the Attachment A to the Group Enrollment Agreement (Group Application) with SHL for SHL to provide Covered Services.

❖ "**Group Enrollment Agreement**" or "**GEA**" means the agreement signed by SHL and Group that states the conditions for coverage, eligibility and enrollment requirements and premiums.

❖ "**Health Benefit Plan**" means a policy, contract, certificate or agreement offered by a carrier to provide for, deliver payment for, arrange for the payment of, pay for or reimburse any of the costs of health care services. The term includes catastrophic health insurance policies and a policy that pays on a cost-incurred basis.

Health Benefit Plans do not include:

- Coverage for accident only, dental only, vision only, disability income insurance, long-term care only insurance, hospital indemnity coverage or other fixed indemnity coverage, limited benefit coverage, specific disease/Illness coverage, credit-only insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation insurance;
- Coverage for medical payments under a policy of automobile insurance;
- Coverage for on-site medical clinics; or
- Medicare supplemental health insurance.

❖ "**Home Healthcare**" means healthcare services given by a Home Healthcare agency under a Physician's orders in the person's home. It is care given to persons who are homebound for medical reasons and physically not able to obtain necessary medical care on an outpatient basis. A Home Healthcare agency must be licensed by the state where it is located.

❖ "**Hospice**" means an establishment licensed by the state where it is located that furnishes a centrally administered program of palliative and supportive services. Such services are provided by a team of healthcare Providers and directed by a Physician. Services include physical, psychological, custodial and spiritual care for patients who are terminally ill and their families. For the purposes of this benefit only, "family" includes the immediate family, the person who primarily cared for the patient and other persons with significant personal ties to the patient, whether or not related by blood.

❖ "**Hospice Care Services**" means acute care provided by a Hospice if the Insured has less than six (6) months to live as certified by the treating Physician, and the Insured is not receiving or intending to receive any curative treatment. Care may be provided in the home, at a residential facility or at a medical facility at any time of the day or night. These services include bereavement care provided to the patient's family after the patient dies.

❖ "**Hospital**" means a facility that:

- Is licensed by the state where it is located and is Medicare-certified;
- Provides 24-hour nursing services by registered nurses (RNs) on duty or call; and
- Provides services under the supervision of a staff of one or more Physicians to diagnose and treat ill or injured bed patients hospitalized for surgical, medical or psychiatric conditions.

Hospital does not include:

- Ambulatory Surgical Facilities;
- Christian Science sanataria;
- Free Standing Emergency Facilities;
- Health resorts;
- Institutions for exceptional children;
- Nursing homes;
- Residential Treatment Centers;
- Physician offices;
- Private homes; or
- Skilled Nursing Facilities, places that are primarily for the care of convalescents.

- "**Illness**" means an abnormal state of health resulting from disease, sickness or malfunction of the body; or a congenital malformation, which causes functional impairment. For purposes of this Certificate, Illness also includes sterilization or circumcision. Illness does not include any state of mental health or mental disorder other than Mental Illness as it is defined in this Certificate.

- **"Independent Review Organization"** means an entity that:
  - Conducts an independent External Review of an adverse determination; and
  - Is certified by the Nevada Commissioner of Insurance.

- "**Initial Enrollment Period**" means the period of time during which an eligible person may enroll under this Plan, as shown in the GEA signed by the Group.

- "**Injury**" means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.

- "**Inpatient**" means being confined in a Hospital, Skilled Nursing Facility or Residential Treatment Center as a registered bed patient under a Physician's order.

- "**Insured**" means a person who meets the eligibility requirements of Section 1., who has enrolled under this Plan and for whom premiums have been received and accepted by SHL.

- **"Licensed Assistant Behavior Analyst"** means a person who holds current certification as a Board Certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

- **"Licensed Behavior Analyst"** means a person who holds current certification as a Board Certified Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and is licensed as a behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services.

- **"Mail Order Plan Pharmacy"** means a duly licensed pharmacy that has an independent contractor agreement with SHL to provide certain Covered Drugs to Insureds by mail.

- **"Maintenance Covered Drug"** means a Prescription Drug anticipated to be used for six months or more to treat or prevent a chronic condition.

- "**Managed Care Program**" means the process that determines Medical Necessity and directs care to the most appropriate setting to provide quality care in a cost-effective manner, including Prior Authorization of certain services.

- "**Manual Manipulation**" means the diagnosis, treatment or maintenance by a Practitioner for the treatment of:
  - Musculoskeletal strain surrounding vertebra, spine, broken neck; or
  - Subluxation of vertebra.

  Manual Manipulation does not include diagnosis or treatment requiring general anesthesia, surgery or Hospital confinement.

- "**Medical Director**" means a Physician named by SHL to review use of health services by Insureds.

- "**Medically Necessary**" means a service or supply needed to improve a specific health condition or to preserve the Insured's health and which, as determined by SHL is:
  - Consistent with the diagnosis and treatment of the Insured's Illness or Injury;
  - The most appropriate level of service which can be safely provided to the Insured; and
  - Not solely for the convenience of the Insured, the Provider(s) or Hospital.

In determining whether a service or supply is Medically Necessary, SHL may give consideration to any or all of the following:

- The likelihood of a certain service or supply producing a significant positive outcome;
- Reports in peer-review literature;
- Evidence based reports and guidelines published by nationally recognized professional organizations that include supporting scientific data;
- Professional standards of safety and effectiveness that are generally recognized in the United States for diagnosis, care or treatment;
- The opinions of independent expert Physicians in the health specialty involved when such opinions are based on broad professional consensus; or
- Other relevant information obtained by SHL.

When applied to Inpatient services, "Medically Necessary" further means that the Insured's condition requires treatment in a Hospital rather than in any other setting. **Services and accommodations will not automatically be considered Medically Necessary simply because they were prescribed by a Physician.**

❖ "**Medically Necessary for External Review**" means healthcare services or products that a prudent Physician would provide to a patient to prevent, diagnose or treat an Illness, Injury or disease or any symptoms thereof that are necessary and:

- Provided in accordance with generally accepted standards of medical practice;
- Clinically appropriate with regard to type, frequency, extent, location and duration;
- Not primarily provided for the convenience of the patient, Physician or other Provider of healthcare;
- Required to improve a specific health condition of an Insured or to preserve his existing state of health; and
- The most clinically appropriate level of healthcare that may be safely provided to the Insured.

❖ "**Medicare**" means Medicare Part A and Medicare Part B healthcare benefits that an Insured is receiving under Title XVIII of the Social Security Act of 1965 as amended.

❖ **"Mental Health Professional"** means any person qualified and licensed to provide assessments, diagnosis and therapy for mental health conditions or substance use disorders.

❖ "**Mental Illness**" means a pathological state of mind producing clinically significant psychological or physiological symptoms together with impairment in one or more major areas of functioning where improvement can reasonably be anticipated with therapy. Mental Illness does not include any Severe Mental Illness as defined in the COC and otherwise covered under the Severe Mental Illness Covered Services section, or any of the following when they represent the primary need for therapy:

- Behavior disorders;
- Chronic organic brain syndrome;
- Learning disabilities;
- Marital or family problems;
- Intellectual disability;
- Personality disorder; or
- Social, occupational, or religious maladjustment.

❖ **"Minimum Essential Coverage (MEC)"** means any insurance plan that meets the Affordable Care Act requirement for having health coverage. To avoid the penalty for not having insurance a person must be enrolled in a plan that qualifies as minimum essential coverage (sometimes called "qualifying health coverage"). Examples of plans that qualify include:

- Job-based plans;
- Marketplace plans;
- Medicare; and
- Medicaid & CHIP.

❖ "**Non-Medical 24-Hour Withdrawal Management**" means an organized residential service, including those defined in American Society of Addiction Medicine (ASAM) criteria, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

❖ **"Non-Plan Pharmacy"** means a duly licensed pharmacy that does not have an independent contractor agreement with SHL to provide Covered Drugs to Insureds.

❖ "**Non-Plan Provider**" means a Provider who does not have an independent contractor agreement with SHL.

- "**Occupational Illness or Injury**" means any Illness or Injury arising out of or in the course of employment for pay or profit.

- "**Open Enrollment Period**" means an annual thirty-one (31) day period of time during which Eligible Employees and their Eligible Family Members may enroll under this Plan without giving SHL evidence of good health.

- "**Orthotic Devices**" means an apparatus used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.

- **"Pharmaceutical Product(s)"** means U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with Covered Services by a Physician.

- "**Physician**" means anyone qualified and licensed to practice medicine and surgery by the state where the practice is located who has the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO). Physician also means Doctor of Dentistry, a Doctor of Podiatric Medicine or a Chiropractor when they are acting within the scope of their license.

- "**Physician-assisted Suicide**" means a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

- **"Physician Extender/Physician Assistant"** means a health care provider who is not a physician (MD/DO) but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner, physician assistant or pharmacist.

- "**Placed (or Placement) for Adoption**" means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person ends upon the termination of such legal obligation.

- "**Plan**" means this Certificate of Coverage (COC), including the Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Insured's Enrollment Form, health statements, the Insured Identification Card, and all other applications received by SHL.

- **"Plan Pharmacy"** means a duly licensed pharmacy that has an independent contractor agreement with SHL to provide Covered Drugs to Insureds. Unless otherwise specified as Mail Order Plan Pharmacy herein, Plan Pharmacy services are retail services only and do not include Mail Order services.

- "**Plan Physician**" means a Physician who has an independent contractor agreement with SHL to provide certain Covered Services to Insureds. A Plan Provider's agreement with SHL may terminate, and an Insured will be required to select another Plan Provider.

- "**Plan Provider**" means a Provider who has an independent contractor agreement with SHL to provide certain Covered Services to Insureds. A Plan Provider's agreement with SHL may terminate, and an Insured receiving care from that Provider may be required to select another Plan Provider.

- "**Post-Service Claim**" means any Claim for Benefits under a Health Benefit Plan regarding payment of benefits that is not considered a Pre-Service Claim or an Urgent Care Claim.

- "**Practitioner**" means any person(s) qualified and licensed to practice the healing arts when they are acting within the scope of their license.

- **"Predetermination"** means a system that requires a Plan Provider to get approval from SHL before providing non-emergent healthcare services to an Insured for those services to be considered Covered Services. Prior Authorization is not an agreement to pay for a service.

❖ "**Prescription Drug**" means a medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered in a Network Pharmacy.
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips - glucose;
  - Urine-testing strips - glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices; and
  - Glucose meters, including continuous glucose monitors.

❖ **"Prescription Drug List (PDL)"** means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by SHL.

❖ "**Pre-Service Claim**" means any Claim for Benefits under a Health Benefit Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

❖ "**Prior Authorization**" or "**Prior Authorized**" means a system that requires a Provider to get approval from SHL before providing non-emergency healthcare services to an Insured for those services to be considered Covered Services. Prior Authorization is not an agreement to pay for a service.

❖ "**Procurement**" means obtaining Medically Necessary human organs or tissue for a Covered Transplant Procedure as determined by SHL and includes donor search, testing, removal, preservation and transportation of the donated organ or tissue. Procurement will also apply to medically appropriate donor testing services including, but not limited to, HLA typing, subject to any maximum procurement benefit amount. Procurement does not include maintenance of a donor while the Insured is awaiting the transplant.

❖ "**Prosthetic Device**" means a non-experimental device that replaces all or part of an internal or external body organ or replaces all or part of the function of a permanently inoperative or malfunctioning internal or external organ.

❖ **"Provider"** means a:

- Ambulatory Surgical Facility;
- Dentist;
- Hospital;
- Physician;
- Practitioner;
- Podiatrist;
- Skilled Nursing Facility;
- Urgent Care Facility, or
- Other person or organization licensed by the state where his/the practice is located to provide medical or surgical services, supplies, and accommodations acting within the scope of his/the license.

❖ **"Qualified Late Enrollee"** means an Eligible Employee or his Eligible Family Members who:

- Enrolls under this Plan after the Initial or Open Enrollment Period; was insured under existing coverage at the time of the Initial or Open Enrollment Period and stated in writing that another source of coverage was the reason for the declination to enroll; whose existing coverage was canceled because of an unforeseen event; and requests enrollment under this Plan not more than thirty-one (31) days after such existing coverage is canceled.
- Enrolls in another Health Benefit Plan offered by the Group during the period of the Initial or Open Enrollment Period and then seeks to change to coverage under this Plan and submits a completed enrollment form for such enrollment no later than thirty (31) days after the close of such Initial or Open Enrollment Period.
- For whom a court has ordered coverage be provided and who requests to be enrolled under this Plan no later than thirty (31) days after the court order is issued.
- Was covered under COBRA, such COBRA coverage has been exhausted, and applies for enrollment under this Plan no later than thirty (30) days after the expiration of the COBRA coverage.

❖ **"Recognized Amount"** means the amount which the Copayment, Coinsurance and any applicable CYD, is based on for the below Covered Services when provided by Non-Plan Providers.

- Non-Plan Emergency Services.
- Non-Emergency Covered Services received at certain Network facilities by Non-Plan Providers, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

- An All Payer Model Agreement if adopted;
- State law; or
- The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a Non-Plan Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Services that use the Recognized Amount to determine the Insured cost sharing may be higher or lower than if cost sharing for these Covered Services were determined based upon the Eligible Medical Expenses.

❖ **"Reference Product"** means a biological Prescription Drug.

❖ "**Referral**" means a recommendation for an Insured to receive a service or care from another Provider or facility.

❖ **"Remote Physiologic Monitoring"** is the automatic collection and electronic transmission of patient physiological data that are analyzed and used by a licensed Physician or other qualified healthcare professional to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. The treatment plan will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiological Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiological Monitoring may not be used while the patient is Inpatient at a hospital or other facility. Use of multiple devices must be coordinated by one Physician.

❖ **"Residential Treatment Center"** means a sub-acute facility or acute care facility which delivers twenty-four (24) hours/ seven (7) days a week assessment, diagnostic services and active behavioral health treatment to Insureds. The level of care and length of stay, in a facility with the appropriate licensure level, is authorized through the SHL Managed Care program.

❖ "**Retrospective**" or "**Retrospectively**" means a review of an event after it has taken place.

❖ "**Rider**" means a provision added to the Agreement or the Certificate to expand benefits or coverage.

❖ "**Secretary**" means as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

❖ **"Severe Mental Illness"** means any of the following Mental Illnesses that are biologically based and for which diagnostic criteria are prescribed in the Diagnostic and Statistical Manual of Mental Disorder (DSM), current edition, published by the American Psychiatric Association:

- Bipolar disorder;
- Major depressive disorders;
- Obsessive-compulsive disorder;
- Panic disorder;
- Schizoaffective disorder; and
- Schizophrenia.

❖ "**SHL Reimbursement Schedule**" means the schedule showing the amount SHL will pay for Eligible Medical Expenses or the Recognized Amount, when applicable, to Providers. Eligible Medical Expenses or the Recognized Amount, when applicable, will be applicable to Non-Plan Providers including Non-Plan Facilities. SHL Reimbursement Schedule is based on:

- The amount most consistently paid to the Provider; or
- The amount paid to other Providers with the same or similar qualifications; or
- The relative value and worth of the service compared to other services which SHL determines to be similar in complexity and nature with reference to other industry and governmental sources, examples of these sources include published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar services within the geographic market, a gap methodology, or Eligible Medical Expenses or the Recognized Amount, when applicable, could be based on a percentage of the provider's billed charge.

For Non-Plan Provider Emergency Services, SHL will pay the greater of:

- The amount we have negotiated with Plan Providers for the Emergency Services received (and if there is more than one amount, the median of the amounts); or
- 100% of the Eligible Medical Expenses or the Recognized Amount, when applicable, for Emergency Services provided by a Non-Plan Provider under your Plan; or
- The amount that would be paid for the Emergency Services under Medicare.

❖ "**Short-Term**" means the time required for treatment of a condition that, in the judgment of the Insured's Physician and SHL, is subject to significant improvement within sixty (60) consecutive calendar days from the first day of treatment.

❖ **"Short-Term Habilitation Services"** means occupational therapy, physical therapy and speech therapy prescribed by the Insured's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by an Insured prior to that Insured developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

❖ "**Short-Term Rehabilitation**" means Inpatient or outpatient rehabilitation services which are provided within the applicable number of visits as set forth in the Plan's Attachment A Benefit Schedule. This includes speech therapy, occupational therapy and physical therapy.

❖ "**Skilled Nursing Care**" means services requiring the skill, training or supervision of licensed nursing personnel.

❖ "**Skilled Nursing Facility**" means a facility or distinct part of a facility that is licensed by the state where it is located to provide Skilled Nursing Care instead of Hospitalization and that has an attending medical staff consisting of one or more Physicians.

❖ **"Small Employer"** or small group means as ascribed in 42 U.S.C. § 18024(b)(2).

❖ "**Special Enrollee**" means an Eligible Employee or Eligible Family Member who applies for coverage during a Special Enrollment Period following a Special Enrollment Event.

❖ "**Special Enrollment Event**" means the occurrence of one of the events described below which allows an Eligible Employee and/or Eligible Family Member to enroll under this Plan during a Special Enrollment Period, as follows:

Special Enrollment Event Upon Loss of Coverage Under Another Health Benefit Plan. In the event of a loss of coverage under a Health Benefit Plan that is not COBRA continuation coverage, except where the loss of coverage is due to failure of the Eligible Employee or Eligible Family Member to pay premiums on a timely basis or termination of employment for cause. Loss of coverage under a Health Benefit Plan can be the result of:

- Legal separation, divorce, cessation of Dependent status, death, termination of employment (not for cause) or a reduction in hours of employment;
- Meeting or exceeding a lifetime Health Benefit Plan limit on all benefits under such coverage;
- Termination of employer contributions for the Eligible Employee or Eligible Family Member's coverage;
- Exhaustion of COBRA continuation coverage.

Note: Voluntary cancellation of healthcare coverage is not considered a Special Enrollment Event.

❖ "**Special Enrollment Period**" means the thirty-one (31)-day period following a Special Enrollment Event during which an Eligible Employee and/or any Eligible Family Members can enroll under this Plan.

❖ "**Specialist Physician**" or "**Specialist**" means a Physician who assumes responsibility for the delivery of specialty medical services to Insureds. These specialty medical services include any Physician services not related to the ongoing primary care of the Insured.

❖ **"Specialty Drugs"** are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by SHL's P&T Committee that are either self-administered or administered by a healthcare Provider and used or obtained in either an outpatient or home setting.

❖ **"Step Therapy"** means certain Prescription Drugs are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drugs and/or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first**.**

❖ "**Subrogation**" means SHL's right to bring a lawsuit in the Insured's name against any party whom the Insured could have sued for reimbursement of covered medical expenses.

❖ "**Subscriber**" means an employee of the Group who meets the eligibility requirements of this Certificate and who has enrolled under this Plan, and for whom premiums have been received and accepted by SHL.

❖ **"Substance-Related and Addictive Disorder"** as defined in the Diagnostic and Statistical Manual of Mental Disorder (DSM), current edition, is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. Substance-Related and Addictive Disorder treatment:

- Must be provided as a part of a treatment plan with clearly defined goals that are realistic and measurable. The plan must address significant impairment or deterioration in the Insured's occupational or scholastic function, social function, or ability to provide self-care.
- Must be provided by state licensed professionals who are practicing within the scope of this licensure.

❖ **"Summary of Benefits" ("SBC")** means a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. The SBC helps consumers better understand the coverage they have and allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions and coverage limitations and exceptions. Insureds will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year and within seven business days of requesting a copy from their insurance issuer or group health plan.

❖ **"Telemedicine"** means the delivery of Covered Services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including facsimile or electronic mail. The term includes, without limitation, the delivery of services from a provider of health care to a patient at a different location through the use of:

- Synchronous interaction or an asynchronous system of storing and forwarding information; and
- Audio-only interaction, whether synchronous or asynchronous.

❖ **"Therapeutic Equivalent"** means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.

❖ "**Therapeutic Supply**" is the maximum quantity of supplies for which benefits are available for a single applicable Copayment or Coinsurance amount, if applicable, and may be less than but shall not exceed a thirty (30)-day supply.

❖ "**Totally Disabled**" means:

- The continuing inability of a Subscriber to substantially perform duties related to his employment or to work for pay, profit or gain at any job for which he is suited by reason of education, training or experience because of Illness or Injury; or
- The inability of a Dependent to engage in his regular and usual activities.

❖ **"Transitional Living"** means Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide twenty-four (24) hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria*, and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help with recovery. Please note: These living arrangements are also known as supportive housing (including recovery residences).

❖ "**Transplant Benefit Period**" means the period beginning with the date the Insured receives a written Referral from SHL for care in a Transplant Facility and ending on the first of the following to occur:

- The date 365 days after the date of the transplant; or
- The date when the Insured is no longer covered under this Plan, whichever is earlier.

❖ "**Transplant Facility**" means a Hospital that has an independent contractor agreement or other contractual relationship with SHL to provide Covered Services related to a Covered Transplant Procedure as defined in this Certificate. Non-Plan Hospitals do not have agreements with SHL to provide such services.

❖ **"Unproven"** in the context of **"**Experimental, Investigational or Unproven", means services, including medications and devices, regardless *of U.S. Food and Drug Administration (FDA)* approval,, that are not determined to be effective for treatment of the medical or behavioral health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or observational studies in the prevailing published peer-reviewed medical literature.

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case-control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

SHL has a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, SHL will issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. The Insured can view these policies at https://healthplanofnevada.com/Provider/Medical-Policies.

NOTE: If the Insured has a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment) SHL may, as we determine, consider an otherwise Unproven service to be a covered healthcare service for that illness or condition. Prior to such a consideration, SHL must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that illness or condition.

❖ "**Urgent Care Claim**" means a Claim for Benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not Urgent Care Claims could seriously jeopardize the Insured's life, health or the ability to regain maximum function by waiting for a routine appeal decision. An Urgent Care Claim also means a Claim for Benefits that, in the opinion of a physician with knowledge of the Insured's medical conditions, would subject the Insured to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for Prior Authorization of an Urgent Care service was denied, the Insured could request an Expedited Appeal for the Urgent Care Claim.

❖ "**Urgent Care Facility**" means a facility equipped and operated mainly to give immediate treatment for an acute Illness or Injury.

❖ "**Urgently Needed Services**" means Covered Services needed to prevent a serious deterioration in an Insured's health. While not as immediate as Emergency Services, these services cannot be delayed until the Insured can see a Plan Provider.

- **"Utilization Review"** means a system for reviewing the appropriate and efficient allocation of Inpatient Hospital resources, Inpatient medical services and Outpatient surgery services that are being given or are proposed to be given to a patient, and of any medical, surgical and healthcare services or claims for services that may be covered by a healthcare insurer depending on determinable contingencies, including without limitation Outpatient services, in-office consultations with medical specialists, specialized diagnostic, testing, mental health services, emergency care and Inpatient and Outpatient hospital services excluding elective requests for the clarification of coverage.

- "**Waiting Period**" means the period of time established by the Group that must pass before coverage for an Eligible Employee or Eligible Family Member can become effective. If an Eligible Employee or Eligible Family Member enrolls as a Special Enrollee, any period before such Special Enrollment is not a Waiting Period.