



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

MySHL Solutions *Agreement of Coverage*

This Agreement of Coverage contains a Deductible.

This Agreement of Coverage (“AOC”) describes your healthcare plan.

Sierra Health and Life Insurance Company, Inc. (“SHL”) and the Subscriber have agreed to all of the terms of this AOC. It is part of the contract between SHL and the Subscriber. This plan is guaranteed renewable. It may be terminated by SHL or the Subscriber with written notice.

This AOC tells you about your benefits, rights and duties as an SHL Insured. It also tells you about SHL’s duties to you. This AOC including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, your application form, health statements, Member 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 14 – Glossary.**

NOTICE: If upon examination of this Agreement of Coverage you are not satisfied, for any reason, you may return the Agreement of Coverage materials, within ten (10) days of its delivery, and request a full refund of the premium paid.

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The Department of Business and Industry

State of Nevada

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 Standard Time (PST)
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
2501 East Sahara Ave., Suite 302
Las Vegas, NV 89104

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., Pacific Standard Time):

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SECTION 1. Eligibility, Enrollment and Effective Date

Subscribers and Eligible Family Members who meet the following criteria are eligible for healthcare coverage under this Plan.

1.1 Who Is Eligible

Subscriber. To be eligible to enroll as a Subscriber, an Individual must:

- Meet the guidelines established in the SHL Individual PPO Enrollment Application.
- Complete and submit to SHL such applications, or forms that SHL may reasonably request.
- Live in Nevada.

Dependent. To be eligible to enroll as a Dependent, an individual must be one of the following:

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage.
- A registered domestic partner.
- 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 26.
- A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.
- 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, but not more often than once a year after the first two (2) years beyond the date when the child reaches the limiting age.

Evidence of any Court Order needed to prove eligibility must be given to SHL.

1.2 Who Is Not Eligible

The following individuals are not eligible for coverage:

- An individual who is eligible and/or enrolled for coverage under Medicare Part A and/or B at the time of application.
- A foster child of the applicant or Subscriber.
- A child placed in the applicant's or Subscriber's home other than for adoption.
- A grandchild of the applicant or Subscriber.
- Any other individual 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 under this Plan. Changes include:

- Reaching the limiting age.
- Death.
- Divorce.
- Ceasing to satisfy the mental or physical handicap requirements.
- The Eligible Person and/or Dependent loses eligibility under Medicaid or 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.

- Any other event which affects a Dependent's eligibility.

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

A Dependent's coverage terminates on the same day as the Subscriber.

Continuation of Coverage Due to Specific Change in Eligibility Status

An Insured that becomes ineligible for coverage under this Plan due to specific changes in eligibility status may qualify for the same coverage under their current SHL benefit Plan and rates in the following circumstances:

- Death of the Subscriber;
- Divorce between Subscriber and spouse;
- Termination of a domestic partnership; or
- When a child involuntarily fails to meet the eligibility rules outlined in Section 1.1.

In order to qualify for continuation of coverage under the above circumstances, the affected Insured must contact SHL within thirty-one (31) days of the date of loss of eligibility to request continued coverage. Any and all waiting periods satisfied under the current Plan will be credited to the Insured under the continued Plan coverage.

1.4 Application

Eligible Individuals and Eligible Family Members must make application to SHL in order to have coverage under this Plan.

1. **Newly Eligible Family Members.** Any individual becoming a newly Eligible Family Member may apply for coverage under SHL by submitting to SHL the Application Form (or Membership Change Form) within thirty-one (31) days of the date on which the individual becomes eligible. An individual may become a newly Eligible Family Member as the result of:
 - A change in the Subscriber's marital or domestic partnership status.
 - A birth or adoption of a child by the Subscriber.
 - Loss of eligibility under other healthcare coverage.
2. **Right to Deny Application.** SHL can deny membership to any person who:
 - At application, does not meet eligibility guidelines.
 - Fails to make a premium payment.
3. **Right to Deny Application for Renewal.** As a condition of renewal under this Plan, SHL may terminate a Subscriber and/or Dependent(s) who committed fraud upon SHL or misrepresented a material fact which affected his coverage under this Plan.
4. **Annual Open Enrollment Periods.** An Insured is eligible to enroll during the Federally Required Open Enrollment Period.

1.5 Effective Date of Coverage

Before coverage can become effective, SHL must receive and accept premium payments and an SHL Individual PPO Application Form for the person applying to be an Insured.

When the Enrollment Application Form is received, approved and applicable premium payments have been accepted by SHL the Effective Date is as follows:

1. **Open Enrollment (2017)** -The annual open enrollment period is November 1, 2016 through January 31, 2017.
 - Applications received between November 1, 2016 and December 31, 2016 will be effective January 1, 2017.
 - Applications received between January 1, 2017 and January 31, 2017 will be effective February 1, 2017.
 - **Subsequent Open Enrollments (2017 and beyond)** – Applications received during the Federally Required Open Enrollment will be reviewed for an effective date of the 1st of the month following the date the application is received.
 - **Outside of Open Enrollment or of a Qualifying Event** – A waiting period of 90 (ninety) days is applied from the date the Application is received by SHL. The Effective Date will be the first of the month immediately following the month in which the waiting period expires.
2. A Subscriber's newborn natural child is covered for the first thirty-one (31) days following birth. Coverage continues after thirty-one (31) days only if the Subscriber makes application for 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, unless the adopted child is placed with the Subscriber during the first thirty-one (31) days of the child's life. A child

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Placed for Adoption 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 makes application for the child as a Dependent and pays any premium within thirty-one (31) days after the placement of the child in the Subscriber's home or the child's birth. The 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 makes application for the Dependent and pays any required premium. A copy of the court order must be given to SHL.

Subscriber must give SHL a copy of the certified birth certificate, decree of adoption, or certificate of placement for adoption for coverage to continue after thirty-one (31) days for newborn and adopted children.

Subscriber must give SHL a copy of the certified marriage certificate or any other required documents before coverage can be effective for other Eligible Family Members.

SECTION 2. Termination

SHL may terminate coverage under this Plan at the times shown for any one (1) or more of the following reasons:

2.1 Termination by SHL

- If a Subscriber fails to make full premium payments within thirty-one (31) days of the premium due date, coverage will be terminated on the first (1st) day of the month for which a premium was due and not received by SHL.
- With thirty (30) days written notice, if the Insured allows his or any other Insured's SHL Identification (ID) card to be used by any other person, or uses another person's card. The Insured will be liable to SHL for all costs incurred as a result of the misuse of the Insured's SHL ID card.
- Failure to maintain eligibility requirements as set forth in Section 1.
- 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 of the original Effective Date of Coverage and refund any applicable premium. Thirty (30) days written notice shall be provided to the Insured prior to any rescission of coverage. The Insured has the right to appeal any such rescission.
- Except as specifically provided in Section 1.3, on the last day of the calendar month in which an Insured no longer meets the requirements of Section 1
- If the Insured fails to give written notice within thirty-one (31) days of the loss of eligibility, SHL will terminate coverage retroactively and refund any corresponding premium.
- When information provided to SHL in the application form is determined to be untrue, inaccurate, or incomplete, in lieu of termination of coverage. SHL shall have the right to retroactively increase past premium payments to the maximum rate allowed that would have been billed if such untrue, inaccurate, or incomplete information had not been provided. If the revised premium rate is not received by SHL within thirty (30) days of the letter of notification, coverage will be terminated as of the paid-to date.

2.2 Termination by the Subscriber

Subscriber has the right to terminate his coverage under the 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 coverage is terminated prior to such date by SHL.

2.3 Reinstatement

Any Individual PPO Plan, which has been terminated in any manner, may be reinstated by SHL at its sole discretion.

2.4 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. You will be responsible for payment of medical services and supplies incurred after the Effective Date of the termination of this Plan.

SECTION 3. Managed Care

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

3.1 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.

3.2 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 Copayment, Deductible 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 Prior Authorization has been obtained for any Covered Services requiring Prior Authorization and to comply with all other rules of SHL's Managed Care Program.

3.3 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 form and send a copy to the Provider and the Insured. This form will specify approved 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, the Insured or his Authorized Representative may appeal the denial to the Grievance Review Committee (see the Appeals Procedures Section).

3.4 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.

3.5 Emergency Admission Notification

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

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 AOC. If such Emergency Services are provided by Non-Plan Providers, all Medically Necessary professional, Inpatient or outpatient Emergency Services will be Covered Services.

3.6 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.

3.7 Independent Medical Review; Appeals Rights

SHL may require an Insured to have an Independent Medical Review prior to issuing Prior Authorization for any medical benefits. In that case, only a Physician or chiropractor who is certified to practice in the same field of practice as the primary treating Physician or chiropractor or who is formally educated in that field will conduct the review.

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The Independent Medical Review may include a physical exam of the Insured, unless he is deceased, and a personal review of all x-rays and reports made by the primary treating Physician or chiropractor. A certified copy of all reports of findings will be sent to the primary treating Physician or chiropractor and the Insured within ten (10) working days after the Independent Medical Review.

If the Insured disagrees with the findings of the Independent Medical Review, he may submit an appeal for binding arbitration to SHL within thirty (30) days after he receives the report. Please refer to the Appeals Procedures section in this AOC for more information.

3.8 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 4. 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 prior to obtaining any healthcare services.

4.1 Availability of Covered Services

Insureds are entitled to receive benefits for the expenses incurred in connection with the Covered Services shown in Section 5 and the Attachment A Benefit Schedule subject to all terms and conditions of this AOC, 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 AOC.

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 this AOC 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 Needed Services as defined in this AOC.

4.2 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 certified by SHL's Managed Care Program will be reduced to 50% of what the Insured would have received if the services had been certified.

4.3 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.

4.4 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:

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- The 120th day following the date the contract was terminated between the Provider and SHL; or
- If the medical condition is Complication of Pregnancy, the 45th 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 address shown below. 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 Insurance Co., Inc.
Attn: Provider Services Department
PO Box 15645
Las Vegas, NV 89114-5645
Phone: 1-800-888-2264

SECTION 5. Covered Services

This section tells you what services are covered under this Plan. Only Medically Necessary services are considered to be Covered Services. The Attachment A Benefit Schedule shows the applicable Deductible amount as well as Copayments and/or Coinsurance amounts and benefit limitations for Plan and Non-Plan Provider Covered Services.

5.1 Health Care Facility Services

Covered Services include the following accommodations, services and supplies when 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.
- 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.
- Nursery charges for routine care of newborn children regardless of whether or not an Injury or Illness exists.

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);
- 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;
- 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.

5.2 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;

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- 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;
- Treatment of the temporomandibular joint including Medically Necessary dental procedures, such as dental splints, subject to the maximum benefit limitation;
- Anesthesia services;
- Manual Manipulation (except for reductions of fractures or dislocations); and
- Family planning services including sterilization procedures; and
- Limited diagnostic and therapeutic infertility services determined to be Medically Necessary and Prior Authorized by SHL's Managed Care Program. Covered Services do not include those services specifically excluded herein, but do include limited:
 - Laboratory studies;
 - Diagnostic procedures; and
 - Artificial insemination services, up to six (6) cycles per Insured per lifetime.

5.3 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 SHL's Medical Director for further evaluation of an Illness or Injury on an Inpatient or outpatient basis.

Subject to all terms and conditions of this Plan, Covered Services shall include:

- **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 Insured may request a Third Opinion from a Physician qualified to diagnose and treat the specific Illness or Injury.
- Payment will be made whether or not the Elective Surgery or Inpatient care is performed. Payment will be subject to all terms of the AOC, except as otherwise provided in this Section.
- **Limitations.** No payment will be made for expenses incurred for Second or Third Opinions and Consultations in connection with:
 1. Any services not covered under the 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 the Managed Care Program.

5.4 Preventive Healthcare Services

Covered Preventive Healthcare Services will be paid at 100% of Eligible Medical Expenses, without application of any Copayment, Calendar Year Deductible 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 www.myshlonline.com.

- 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");
- Immunizations 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.

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

5.5 Laboratory Services

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

5.6 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 prescribed by an Insured's Physician and authorized by 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.

5.7 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 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 AOC, all Covered Services which are Medically Necessary and appropriate will be paid for within the limit, if any, established in the Attachment A Benefit Schedule.

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

Examples of conditions which require Medically Necessary treatment, but **not emergency** treatment, include:

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

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.

Telephone 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 Telephone 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.

5.8 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.

5.9 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.

5.10 Assistant Surgical Services

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

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5.11 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 40kg/m²; or
- Have a BMI greater than 35kg/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.

5.12 Mastectomy Reconstructive Surgery

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.

5.13 Oral Physician Surgical Services

Although dental services are not Covered Services, except as otherwise provide in the Attachment A Benefit Schedule, 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 is 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. 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's 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.

5.14 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.

Covered Services include services provided by on an Inpatient basis to an Insured who is the recipient of an organ or tissue transplant only in the following situations:

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.
- 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 EME incurred during the Transplant Benefit Period.

5.15 Home Health Care Services

Covered Services include services given to an Insured in his home by a licensed Home Health Care Provider or an approved Hospital program for Home Health Care. Benefits are payable for such services when an Insured is homebound for medical reasons, physically not able to obtain Medically Necessary care on an outpatient basis, under the care of a Physician and such care is given in place of Inpatient Hospital or Skilled Nursing Facility care.

Covered Services and supplies provided by a Home Health Care 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 Health Care agency or program for its patients.
- Prescribed drugs furnished and charged for by the Home Health Care Provider or program. Prescribed Drugs under this provision do not include Specialty Prescription 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.

5.16 Short-Term Rehabilitation Services

Short-Term Rehabilitation therapy Covered Services include:

- Speech therapy.
- Occupational therapy.
- Physical therapy on an Inpatient or outpatient basis when ordered by the Insured's Physician 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 Physician 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 mental retardation.

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5.17 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 (presymptomatic); and
- The result of the test will directly impact the treatment being delivered to the Insured.

5.18 Other Diagnostic and Therapeutic Services

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

- Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services as approved by SHL;
- Hemodialysis and peritoneal renal dialysis;
- Therapeutic radiology services;
- Complex allergy diagnostic services including RAST and allergeoimmuno 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;
- 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;
- Treatment of temporomandibular joint disorder; and
- Positron Emission Tomography (PET) Scans.

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

5.19 Prosthetic and Orthotic Devices

Benefits payable for expenses for the following devices when received in connection with an Illness or Injury for which benefits are payable 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 (only rigid and semi-rigid devices used for supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body);
- Adjustment of an initial Prosthetic Device required by wear or by change in the patient's condition when ordered by a Physician.

5.20 Self-Management and Treatment of Diabetes

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

- Supplies, 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;
- Supplies, training and education which is necessary as 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
- Supplies, training and education which is necessary because of the development of new techniques and treatment of diabetes.

5.21 Special Food Product/Enteral Formulas

Covered Services include enteral formulas and special food products when prescribed by a Physician and authorized by the 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 (1) 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.

5.22 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;
- Intermittent positive pressure breathing machine;
- Hospital beds;
- 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.

5.23 Mental Health Services and Severe Mental Illness Services

All benefits are subject to the Utilization Management process through Behavioral Healthcare Options (BHO). 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.

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, 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 Programs (PHP): A structured program that maintains hours of service for at least twenty (20) hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided.

Intensive Outpatient Programs (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.

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

5.24 Substance Abuse (Substance Use Disorder) Services

All benefits for Substance Abuse (Substance Use Disorder) Services are subject to the Utilization Management process through Behavioral Healthcare Options (BHO). 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.

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

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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: A hospital-based program which provides twenty-four (24) hours a day, seven (7) days nursing care, medical monitoring, and physician availability; 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 Programs (PHP): A structured program that maintains hours of service for at least twenty (20) hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided.

Intensive Outpatient Programs (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.

NOTE: All non-routine, outpatient Mental Health, Severe Mental Illness or Substance Abuse (Substance Use Disorder) Services require Prior Authorization. Insureds must contact BHO at (702) 364-1484 or 1-800-873-2246 for assistance in scheduling their first appointment in order to verify that any requested Mental Health, Severe Mental Illness or Substance Abuse (Substance Use Disorder) Services are Covered Services under the Plan, and that such Covered Services will be obtained at the appropriate level of care in order to be eligible for full benefit payment. A BHO coordinator will either assist in scheduling the appointment or will make a referral to the appropriate Plan Provider based on the service requested and the associated level of acuity.

All inpatient Mental Health, Severe Mental Illness and Substance Abuse (Substance Use Disorder) services require Plan notification. 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 Mental Health 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. 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.

5.25 Dental Anesthesia Services

Benefits are payable to the same extent as any other Illness or Injury. Covered Services include general anesthesia, when rendered in a Hospital, Outpatient Surgical Facility, or other duly licensed facility for an enrolled Dependent child, when such child, in the treating dentist's opinion and as Prior Authorized by SHL's Managed Care Program, 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 an anesthesia Provider only during procedures performed by an educationally qualified Specialist in pediatric dentistry, or other 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.

5.26 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:

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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 (AHRO);
 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 the State 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.

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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.

5.27 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, lambs wool pads;
- Elastic stockings; and
- Splints and slings.

5.28 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.

5.29 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 AOC, 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 Members who meet the SHL Managed Care Program criteria.

5.30 Autism Spectrum Disorders

Covered Services include Medically Necessary services that are generally recognized and accepted procedures for screening, diagnosing and treating Autism Spectrum Disorders for Insureds under the age of 18 or, if enrolled in high school, until such Insured reaches the age of 22. Covered Services must be provided by a duly licensed physician, psychologist or Behavior Analyst (including an Assistant Behavior Analyst and/or Autism Behavior Interventionist) 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 by:

- an early intervention agency or school for services delivered through early intervention, or
- school services.

5.31 Pediatric Dental and Vision Services

Covered Services are available to enrolled children up to age (19) when authorized by SHL's Managed Care Program.

Pediatric Vision coverage includes services for:

- Vision Examination;
- Lenses Frames;
- Contact Lenses;
- Low Vision Exam; and
- Optional Lenses and Treatments.

Pediatric Dental coverage includes:

- Diagnostic and Preventive Services;
- Restorative Services;
- Endodontic Services;
- Periodontic Services;
- Prosthodontic Services;
- Orthodontic Services; and
- Oral Surgery Services.

(For a complete listing of Pediatric Dental Services and the associated limitations, please refer to the Nevada Division of Insurance website located at <http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Essential-Health-Benefits/>.)

Please refer to the SHL Attachment A Benefit Schedule for the associated Insured cost share and limitations for Pediatric Dental and Vision Covered Services.

5.32 Habilitative Services

Covered Services are provided for Habilitative 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 Habilitative 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 Habilitative Services. A service that does not help the Insured to meet functional goals in a treatment plan within a prescribed time frame 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.

5.33 Telemedicine Services

Covered Services received through a Telemedicine Provider 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 delivering Telemedicine Services to demonstrate the necessity to provide services through Telemedicine or to receive additional certifications or licenses to provide Telemedicine Services.

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 Covered Services. SHL will not require Covered Services to be provided through Telemedicine as a condition of coverage.

5.33 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 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:

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- 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 one's 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:

1. **Psychotherapy** for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
2. **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.
3. **Laboratory Testing:** Benefit coverage includes laboratory testing to monitor continuous hormone replacement therapy provided as any other outpatient diagnostic service under the Plan.
4. **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 AOC).

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:

1. Has persistent, well-documented Gender Dysphoria;
2. Has the capacity to make a fully informed decision and to consent for treatment;
3. Must be 18 years or older; and
4. 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:

1. Has persistent, well-documented Gender Dysphoria;
2. Has the Capacity to make a fully informed decision and to consent for treatment;
3. Must 18 years or older;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled;
5. Complete at least 12 months of successful continuous full-time real-life experience in the desired gender; and
6. Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

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.

SECTION 6. Exclusions

This section tells you what services or supplies are excluded from coverage under this Plan. The following services and any resulting complications are excluded from coverage.

- 6.1** Services for which coverage is not specifically provided in this AOC, complications resulting from non-Covered Services, or services which are not Medically Necessary, whether or not recommended or provided by a Provider.
- 6.2** Any charges for non-Emergency Services provided outside the United States.
- 6.3** 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

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or disabilities.

- 6.4** Any services provided before the Effective Date or after the termination of coverage. This includes admission to an Inpatient facility when the admission began before the Effective Date or extended beyond the termination date of the Plan.
- 6.5** Services for a private room when not Medically Necessary Services and charges in excess of the average semi-private room and board rate.
- 6.6** Except as otherwise provided in the SHL Attachment A Benefit Schedule, 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. 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 limitations shown in the Attachment A Benefit Schedule.
- 6.7** Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function.
- 6.8** Third-party physical exams 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.
- 6.9** 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 or Prior Authorized by SHL's Managed Care Program:
- Advanced reproductive techniques such as embryo transplants, in vitro fertilization, ZIFT procedures, egg retrieval via laparoscope or needle aspiration, sperm preparation, 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.
- 6.10** Services for the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and implantation of a penile prosthesis.
- 6.11** Reversal of surgically performed sterilization or subsequent resterilizations.
- 6.12** Elective abortions.
- 6.13** Except as provided in the Covered Services Gastric Restrictive Surgical 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.
- 6.14** 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.
- Any and all services or supplies treatments, laboratory tests or x-rays received by the donor in connection with the transplant (including donor search, donor transportation, testing, registry and retrieval/harvesting costs) and costs related to cadaver or animal retrieval or maintenance of a donor for such retrieval.
 - Any and all Hospital, Physician, laboratory or x-ray services in any way related to any excluded transplant service, procedure or treatment.
- 6.15** Institutional care which is determined to be for the primary purpose of controlling an Insured's environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures.
- 6.16** Mental Health Services and Substance Abuse (Substance Use 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.

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- 6.17** Outside of an initial assessment, Mental Health and Substance Abuse (Substance Use 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*.
- 6.18** Outside of an initial assessment, treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, personality disorders (with the exception of dialectical behavior therapy for borderline personality disorders) and paraphilic disorder.
- 6.19** Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- 6.20** 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.
- 6.21** 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*.
- 6.22** Neuropsychological testing when not required for the diagnosis of a Mental Illness, substance use disorder, or developmental disability.
- 6.23** Except as otherwise provided in the SHL Attachment A Benefit Schedule, Vision exams to determine refractive errors of vision and eye glasses or contacts. Coverage is provided for vision exams only when required to diagnose an Illness or Injury.
- 6.24** 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.
- 6.25** Hearing exams to determine the need for or the appropriate type of hearing aid or similar devices, other than is specifically covered in this Plan. Coverage is provided for hearing exams only when required to diagnose an Illness or Injury. Hearing exams are not considered adult preventive services.
- 6.26** 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 in accordance with 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 criteria.
- 6.27** 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.
- 6.28** 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.
- 6.29** Acupuncture or hypnosis.
- 6.30** 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.

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- 6.31** 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.
- 6.32** Nutritional supplements, vitamins, herbal medicines, appetite suppressants, and over-the-counter drugs, except as specifically covered by this Plan. 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 unless Prior Authorized by SHL.
- 6.33** Drugs and medicines 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) unless Prior Authorized by SHL.
- 6.34** 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.
- 6.35** Medications used for cosmetic purposes.
- 6.36** Prescription Drug Products when prescribed to treat infertility.
- 6.37** Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
- 6.38** Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs.
- 6.39** Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the SHL AOC.
- 6.40** Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members.
- 6.41** 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.
- 6.42** General vitamins, except the following, which require a prescription order or refill: prenatal vitamins; vitamins with fluoride; and single entity vitamins.
- 6.43** 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.
- 6.44** Any Prescription Drug for which the actual charge to the Insured is less than the amount due under this Plan.
- 6.45** 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.
- 6.46** Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed. Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- 6.47** Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- 6.48** 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 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).
- 6.49** Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.

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- 6.50** Experimental or 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.
- 6.51** A Prescription Drug that contains an active ingredient(s) which is (are) a modified version of and/or Therapeutically Equivalent to a Covered Drug may be excluded as determined by the Plan.
- 6.52** Prescription Drugs dispensed outside the United States, except as required for emergency treatment.
- 6.53** Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission.
- 6.54** Covered Drugs that are not FDA approved for a specific diagnosis.
- 6.55** Biosimilar Prescription Drugs.
- 6.56** Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- 6.57** Unit dose packaging of Prescription Drugs.
- 6.58** Travel and accommodations, whether or not recommended or prescribed by a Provider.
- 6.59** Vitamins, herbal medicines, appetite suppressants, and other over-the-counter drugs. 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.
- 6.60** 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.
- 6.61** 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 non-medical equipment.
- 6.62** 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.
- 6.63** Special formulas, food supplements other than as specifically covered or special diets on an outpatient basis. (Except for the treatment of inherited metabolic disease.)
- 6.64** Services, supplies or accommodations provided without cost to the Insured or for which the Insured is not legally required to pay.
- 6.65** Milieu therapy, biofeedback treatment, behavior modification, sensitivity training, hypnosis, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolffing, vocational rehabilitation and wilderness programs.
- 6.66** Experimental, investigational or unproven treatment or devices as determined by SHL.
- 6.67** Sports medicine treatment plans intended to primarily improve athletic ability.
- 6.68** 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.
- 6.69** Any services given by a Provider to himself or to members of his family.
- 6.70** 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.
- 6.71** Late discharge billing and charges resulting from a canceled appointment or procedure.
- 6.72** Telemetry readings, EKG interpretations when billed separately from the EKG procedure. Arterial blood gas interpretations when billed separately from the procedure.
- 6.73** 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

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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.

- 6.74** Autologous blood donations.
- 6.75** 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.
- 6.76** If you are eligible for Medicare, any services covered by Medicare under Parts A and B are excluded to the extent actually paid for by Medicare.
- 6.77** Any services or supplies rendered in connection with the Insured acting as or utilizing the services of a surrogate mother.
- 6.78** Charges for services by a vision Plan Provider to his or her Dependents.
- 6.79** Visual therapy.
- 6.80** Replacement of lost or stolen eyewear.
- 6.81** Two pairs of eyeglasses in lieu of bifocals.
- 6.82** Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.
- 6.83** Any services and supplies not provided for in the Agreement of Coverage, not Medically Necessary as defined by the Agreement of Coverage or not required in accordance with the accepted standards of dental practice of the community, including:
- Charges for services by a dental Plan Provider to his or her Dependents.
 - Restorations using gold foil and any precious metal restoration when the tooth can be restored using other filling materials.
 - Bonding for cosmetic purposes.
 - Routine extractions for asymptomatic third (3rd) molar teeth.+
- 6.84** Routine extraction of loose deciduous teeth. Services and materials resulting from failure to comply with professionally prescribed treatment.
- 6.85** Services received in connection with Gender Dysphoria, which includes the following:
- Abdominoplasty;
 - Blepharoplasty;
 - Body contouring, such as lipoplasty;
 - Breast enlargement, including augmentation mammoplasty and breast implants;
 - 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;
 - 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 or hormone treatment on Insureds under eighteen (18) years of age;
- Surgical treatment not Prior Authorized by SHL;
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple);
- Transportation, meals, lodging or other similar expenses;
- Voice lessons and voice therapy; and
- Voice modification surgery.

SECTION 7. Limitations

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

7.1 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.

7.2 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 AOC, 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 8. Coordination of Benefits (COB)

This section tells you how other health insurance you may have affects your coverage under this Plan.

8.1 The Purpose of COB

Coordination of Benefits (COB) is intended to help contain the cost of providing healthcare coverage. When an individual person has dual coverage through SHL and another healthcare plan, the COB guidelines outlined in this section apply. The COB guidelines explain how, in a dual healthcare coverage situation, benefits are coordinated or shared by each plan.

8.2 Benefits Subject to COB

All of the healthcare benefits provided under this AOC are subject to this section. The Insured agrees to permit SHL to coordinate its obligations under this AOC with payment under any other Health Benefit Plan that covers the Insured.

8.3 Definitions

Some words in this section have a special meaning to meet the needs of this section. These words and their meaning when used are:

(a) "Plan" will mean an entity providing healthcare benefits or services by any of the following methods:

1. Insurance or any other arrangement for coverage for individuals whether on an insured or uninsured basis, including the following:
 - a. Hospital indemnity benefits with regard to the amount in excess of \$30 per day.
 - b. Hospital reimbursement type plans which permit the insured person to elect indemnity benefits at the time of claim.
2. Service plan contracts, group practice, individual practice and other prepayment coverage.
3. Any coverage for students that is sponsored by, or provided through, school or other educational institutions, other than accident coverage for grammar school or high school students that the parent pays the entire premium.
4. Any coverage under labor management trustee plans, union welfare plans, employer organization plans, employee benefit plans, or employee benefit organization plans.
5. Coverage under a governmental program, including Medicare and workers' compensation plans.

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The term "Plan" will be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

- (b) **“Allowable Expense”** means the Eligible Medical Expense for Medically Necessary Covered Services. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be an Allowable Expense and a benefit paid.
- (c) **“Claim Determination Period”** means the Calendar Year.
- (d) **“Primary Plan”** means a Plan that, in accordance with the rules regarding the order of benefits determination, provides benefits or benefit payments without considering any other Plan.
- (e) **“Secondary Plan”** means a Plan that in accordance with the rules regarding the order of benefit determination, may reduce its benefits or benefit payments and/or recover from the Primary Plan benefit payments.

8.4 When COB Applies

COB applies when an Insured covered under this Plan is also entitled to receive payment for or provision of some or all of the same Covered Services from another Plan.

8.5 Determination Rules

The rules establishing the order of benefit determination are:

- (a) **Non-Dependent or Dependent.** A Plan that covers the person as a Subscriber is primary to a Plan that covers the person as a Dependent.
- (b) **Dependent Child of Parents Not Separated or Divorced.** Except as stated in 10.5(c) below, when this Plan and another Plan cover the same child as a Dependent of different parents:
 - 1. The Plan of the parent whose birthday falls earlier in the Calendar Year is primary to the Plan of the parent whose birthday falls later in the year.
 - 2. If both parents have the same birthday, the Plan that has covered a parent for a longer period of time is primary.
 - 3. If the other Plan does not have the rule described in (1) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- (c) **Dependent Child of Separated or Divorced Parents.** If two (2) or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - 1. If there is a court decree that would establish financial responsibility for the medical, dental or other healthcare expenses with respect to the child, the benefits of a Plan that covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan that covers the child as a Dependent child;
 - 2. Second, the Plan of the parent with custody of the child;
 - 3. Third, the Plan of the spouse (stepparent) of the parent with custody of the child;
 - 4. Finally, the Plan of the parent not having custody of the child.
- (d) **Active/Inactive Subscriber.** A Plan that covers a person as a Subscriber who is neither laid-off nor retired (or that Subscriber's Dependents) is primary to a Plan that covers that person as a laid-off or retired Subscriber (or that Subscriber's Dependents). If the other Plan does not have this rule, and if as a result, the Plans do not agree on the order of benefits, this rule (d) is ignored.
- (e) **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Plan that covered the person for a longer period of time is primary to the Plan which covered that person for the shorter time period.

Two consecutive Plans shall be treated as one Plan if:

- 1. That person was eligible under the second Plan within 24 hours after the termination of the first Plan; and
 - 2. There was a change in the amount or scope of a Plan's benefits or there was a change in the entity paying, providing or administering Plan benefits; or
 - 3. There was a change from one type of Plan to another (e.g., single employer to multiple employer Plan).
- (f) **If No COB Provision.** If another Plan does not contain a provision coordinating its benefits with those of this Plan, the benefits of such other Plan will be considered primary.

8.6 How COB Works

Plans use COB to decide which healthcare coverage programs should be the Primary Plan for the Covered Service. If the Primary Plan payment is less than the charge for the Covered Service, then the Secondary Plan will apply its Allowable Expense to the unpaid balance. Benefits payable under another Plan include the benefits that would have been payable if the Insured had filed a claim for them.

8.7 Right to Receive and Release Information

In order to decide if this COB Section (or any other Plan's COB Section) applies to a claim, SHL (without the consent of or notice to any person) has the right to the following:

- (a) Release to any person, insurance company or organization, the necessary claim information.

- (b) Receive from any person, insurance company or organization, the necessary claim information.
- (c) Require any person claiming benefits under this Plan to give SHL any information needed by SHL to coordinate those benefits.

8.8 Facility of Payment

If another Plan makes a payment that should have been made by SHL, then SHL has the right to pay the other Plan any amount necessary to satisfy SHL's obligation. Any amount paid shall be deemed to be benefits paid under this Plan, and to the extent of such payments, SHL shall be fully discharged from liability under this Plan.

8.9 Right to Recover Payment

If the amount of benefit payment exceeds the amount needed to satisfy SHL's obligation under this section, SHL has the right to recover the excess amount from one or more of the following:

- (a) Any persons to or for whom such payments were made.
- (b) Any insurance companies or service plans.
- (c) Any other organizations.

8.10 Failure to Cooperate

If an Insured fails to cooperate with SHL's administration of this section, the Insured may be responsible for the expenses for the services rendered and if legal action is taken, a court could make the Insured responsible for any legal expense incurred by SHL to enforce its rights under this section.

Insured cooperation includes the completion of the necessary paperwork that would enable SHL to collect payment from the Primary Plan for services. Any benefits paid to the Insured in excess of actual expenses must be refunded to SHL.

SECTION 9. Premium Payments, Grace Period and Changes in Premium Rates

This section tells you when premium payments are due, what happens when payments are not received and when premium rates can change.

9.1 Monthly Payments

The Premium Due Date is the first (1st) day of the calendar month. On or before the Premium Due Date, the Subscriber will remit to SHL, on behalf of the Subscriber and his covered Dependents the premium amount specified by SHL.

9.2 Grace Period

Only Insureds for whom premium payment is actually received by SHL shall be entitled to Covered Services hereunder and then only for the period for which such payment is received. SHL shall not be liable for any healthcare services incurred by any Insured beyond the period for which the premium payment has been paid. SHL shall be entitled to receive reimbursement from the Subscriber for any claims paid by SHL for services provided after the date of termination.

9.3 Changes in Premium Payments

SHL reserves the right to establish a revised schedule of premium payments provided it gives the Subscriber thirty (30) day notice prior to the Annual Open Enrollment as established by Federal guidelines.

SECTION 10. General Provisions

10.1 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 Provider. SHL shall not be liable for any claims or demands on account of damages arising out 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.

10.2 Authority to Change the Form or Content of this AOC

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

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10.3 Identification Card

Cards issued by SHL to Insureds pursuant to this Plan are for identification only. Possession of an SHL identification card confers no 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 on whose behalf all applicable premiums under this Plan have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this AOC will be liable for the actual cost of such services or benefits.

10.4 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 Co., Inc.
P. O. Box 15645
Las Vegas, Nevada 89114-5645

Notice to an Insured will be sent to the last address known to SHL for the Insured.

10.5 Interpretations of the AOC

The laws of the state of issue shall be applied to interpretations of the Plan.

10.6 Modifications

By issuance of the Plan and the Agreement, the coverage available under this Plan becomes available to Insureds who are eligible under Section 1. However, the Plan shall be subject to amendment, modification or termination in accordance with any provision hereof or by mutual agreement between SHL and the Insured. This AOC will automatically be modified to conform with any applicable State and Federal law requirements. SHL reserves the right to establish a revised schedule of premium payments provided it gives the Subscriber thirty (30) day notice prior to the Annual Open Enrollment as established by Federal guidelines. By electing medical and hospital coverage through SHL or accepting any benefits under the Plan, all Insureds legally capable of contracting, and the legal representatives of all Insureds incapable of contracting, agree to all terms, conditions, and provisions hereof.

10.7 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.

10.8 Choice of Facility of Provider

Nothing contained in the AOC 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.

10.9 Overpayments

SHL has the right to correct payments for healthcare services made in error. Hospitals, Physicians, Providers, and/or Insureds have the responsibility to return any overpayments or incorrect payments to SHL. SHL has the right to offset any such overpayment against any future payments.

10.10 Cost Containment Features

The AOC contains a number of cost containment provisions including, but not limited to:

- (a) Second and Third Opinions/Consultations;
- (b) Preventive healthcare benefits;
- (c) Plan Provider benefit incentives as described in Attachment A Benefit schedule; and
- (d) SHL's Managed Care Program.

10.11 Entire Agreement

This AOC, 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 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 AOC.

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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 180 days before the nonrenewal of any health benefit plan by the SHL.

10.12 Contestability

No statement made by an Insured for the purpose of effecting any coverage or any increase in coverage under the Plan 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.

10.13 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.

10.14 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 AOC. No such action shall be brought at any time unless brought within the time 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 three (3) years from the time within which proof of loss is required by the AOC.

10.15 Gender References

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

10.16 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, 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 Co., Inc.
Attn: Customer Response and
Resolution Department
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.

10.17 Failure to Obtain Prior Authorization

If an 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 provided the Insured's request for Prior Authorization is received by an employee or department of the Plan customarily responsible for handling benefit matters and the original request specifically named the Insured, a specific medical condition or symptom, and a 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.

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10.18 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 a 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 paragraph below, 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 one-hundred eighty (180) day period as described in the Appeals Procedures section.

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.

10.19 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 Medical Necessity or experimental, investigational or unproventreatment 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.

SECTION 11. Claims Provisions

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

11.1 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 Plan 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 Insured 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 contacting 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.

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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 Insureds right to file an Informal Appeal as set forth in the Appeals Procedures section of this AOC.

11.2 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 directly to the Insured if direct payment to the Provider is not authorized. The Insured will receive an explanation of how the payment was determined.

11.3 Late Claims Exclusion

No payment shall be made under the 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 Expense for such services.

11.4 Examination

SHL will have the right and opportunity at its own expense to examine the person of 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 and in the case of death, to make an autopsy where not prohibited by law.

SECTION 12. Pharmacy Provisions

12.1 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 Cost-share 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 cost-share as stated in the applicable plan Attachment A, Schedule of Benefits.

12.2 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 benefit provision applies when:**
a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. After satisfying any applicable CYD, the Insured will pay the applicable tier Cost-share plus the difference between the Eligible Medical Expenses ("EME") of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Designated Plan Pharmacy for each Therapeutic Supply. The

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difference in the amount between such Brand Name and Generic 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.

12.3 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 AOC as follows:

1. When any Covered Drug is dispensed, the benefit payment will be subject to SHL's EME and any applicable Tier I, II, III or IV Cost-share. 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 EME 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 EME of the Covered Drug is less than the applicable Cost-share.

12.4 Limitations

- Prior Authorization or Step Therapy may be required for certain Covered Drugs.
- 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 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).

12.5 Coverage Policies and Guidelines

SHL's 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. 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 <http://www.uhcnevada.com/> which leads to SHL's portal www.myshlonline.com.

- Coupons: SHL may not permit certain coupons or offers from pharmaceutical manufacturers to apply to the Insured's annual CYD and/or Out of Pocket Maximum or to reduce the Insured's Copayments and/or Coinsurance. Costs defrayed for the Insured as a result of

pharmaceutical coupons are not Eligible Expenses. Questions regarding which coupons or offers are available can be addressed at myshlonline.com .

SECTION 13. 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 mandatory 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.

Please see the Glossary Terms Section herein for a description of the terms used in this section.

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.

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 Formal Appeal is resolved to the satisfaction of the Insured, the appeal is closed. The Formal Appeal is **mandatory** if the Insured is not satisfied with the initial determination and the Insured wishes to appeal such determination.

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

13.1 Formal Appeal

A 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. Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

A 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
- 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 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 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 the 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;

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- 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 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 unproventreatment 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.

13.2 Expedited 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 three (3) days of the oral notification.

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.

13.3 Arbitration of Disputes of an Independent Medical Review

If the Insured is dissatisfied with the findings of an Independent Medical Review, the Insured shall have the right to have the dispute submitted to binding arbitration before an arbiter under the commercial arbitration rules applied by the American Arbitration Association. This review is in place of SHL's Appeals Procedures.

The arbiter will be selected by mutual agreement of SHL and the Insured. The cost and expense of the arbitration shall be paid by SHL. The decision of the arbiter shall be binding upon the Insured and SHL.

13.4 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 Insured 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.

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Additionally, as per applicable law and regulations, the notice will provide the Insured the information outlined in Section 10.2 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 below and should include the signed HIPAA authorization form, authorizing the release of your medical records. The entire External Review process and any associated medical records are confidential.

Address

Office for Consumer Health Assistance
555 East Washington Avenue #4800
Las Vegas NV 89101

Telephone Numbers and website

(702) 486-3587
(888) 333-1597
Fax: (702)486-3586
www.dhhs.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. 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.

13.4.a 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 the 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 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 this 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.

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13.4.b Expedited External Review

A request for an Expedited External Review may be submitted to OCHA 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 with 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.

13.5 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.

13.5.a 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 the OCHA for an External Review.

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 according to Nevada law and regulations.

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 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.

13.5.b 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 that such service or treatment would be significantly less effective if not promptly initiated. Upon receipt of such request and proof, the 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 the 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.

13.6 Office for Consumer Health Assistance

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

SECTION 14. Glossary

14.1 “**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 or other 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.

14.2 “**Agreement of Coverage**” or “**AOC**” means this document including any Attachments or Endorsements thereto, the Insured’s Identification Card, health statements and all applications received by SHL.

14.3 “**Ambulance**” means a ground or air vehicle licensed to provide Ambulance services.

14.4 “**Ambulatory Surgical Facility**” means a facility that:

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- 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.

- 14.5** “**Application Review Period**” means the period of time that must pass before coverage for an individual or Eligible Family Member can become effective. The Application Review Period begins on the date the individual submits a substantially complete application for coverage and ends on the following:
- the date coverage begins if the application results in coverage; or
 - the date on which the application is denied by SHL if the application does not result in coverage; or
 - the date on which the offer for coverage lapses if the application does not result in coverage.
- 14.6** “**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.
- 14.7** “**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.
- 14.8** “**Autism Behavior Interventionist**” means a person who is registered as a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board, Inc., or its successor organization, and provides behavioral therapy under the supervision of: (1) A licensed psychologist; (2) A licensed behavior analyst; or (3) A licensed assistant behavior analyst.
- 14.9** “**Autism Spectrum Disorders**” means a neurobiological medical condition including, but not limited to, autistic disorder, Asperger’s Disorder and Pervasive Developmental Disorder not otherwise specified.
- 14.10** “**Benefit Schedule**” means the brief summary of benefits, limitations and Copayments given to the Subscriber by SHL. It is Attachment A to this AOC.
- 14.11** “**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.
- 14.12** “**Blended Lenses**” means bifocals which do not a visible dividing line.
- 14.13** “**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
- 14.14** “**Calendar Year**” means January 1 through December 31 of the same year.
- 14.15** “**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.
- 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;
 - 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.
- 14.16** “**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).
- 14.17** “**Coated Lenses**” means a substance which is added to a finished lens on one or both surfaces.

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- 14.18** “**Coinsurance**” means the percentage of the charges billed or the percentage of eligible Medical Expenses, 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.)
- 14.19** “**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.
- 14.20** “**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.
- 14.21** “**Contact Lenses**” means ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Plan Provider to be fitted directly to the patient’s eyes.
- 14.22** “**Convenient Care Facility**” means a facility that provides services for Medically Necessary, non-urgent or non-emergent injuries or illnesses. Examples of such conditions include:
1. diagnostic laboratory services;
 2. general health screenings;
 3. minor wound treatment and repair;
 4. minor illnesses (cold/flu);
 5. treatment of burns and sprains;
 6. blood pressure checks.
- 14.23** “**Copayment**” or “**Cost-share**” means the amount the Insured pays when a Covered Service is received.
- 14.24** “**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.
- 14.25** “**Covered Services**” means the health services, supplies and accommodations for which SHL pays benefits under this Plan.
- 14.26** “**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.
- 14.27** “**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.
 - Training or assistance in personal hygiene.
 - Other forms of self-care.
 - Supervisory care by a Physician in a custodial facility to meet regulatory requirements.
- 14.28** “**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.
- 14.29** “**Deductible**” means the portion of Eligible Medical Expenses, 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.)

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- 14.30** “**Dentist**” means anyone qualified and licensed to practice dentistry who has a degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.)
- 14.31** “**Dental Director**” means a Dentist designated by SHL to review the utilization of dental services by Insureds.
- 14.32** “**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 the AOC;
 - is enrolled under this Plan; and
 - for whom premiums have been received and accepted by SHL.
- 14.33** “**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.
- 14.34** “**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.
- 14.35** “**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.
- 14.36** “**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.
- 14.37** “**Effective Date**” means the initial date on which Insureds are covered for services under this Agreement of Coverage provided any applicable premiums have been received and accepted by SHL.
- 14.38** “**Eligible Dental Expenses**” (“**EDE**”) means the maximum amount SHL will pay for a particular Covered Service as determined by SHL in accordance with SHL Reimbursement Schedule. Dental Plan Providers have agreed to accept SHL’s reimbursement as payment in full for Covered Services, less any applicable Copayment. Deductible or Coinsurance. In no event will SHL pay more than the maximum payment allowance established in the SHL Reimbursement Schedule.
- 14.39** “**Eligible Family Member**” means a member of the Subscriber’s family that is eligible to enroll for coverage under this Plan as a Dependent.
- 14.40** “**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.
- 14.41** “**Eligible Vision Expenses**” (**EVE**) means the maximum allowable amount the Company will pay for a particular Covered Service as determined by the Company in accordance with the SHL Reimbursement Schedule. Vision Plan Providers have agreed to accept the SHL Reimbursement Schedule as payment in full for Covered Services, less any applicable Copayment. In no event will SHL pay more than the maximum payment allowance established in the SHL Reimbursement Schedule.
- 14.42** “**Emergency Services**” means Covered Services provided after the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention 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.
- 14.43** “**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.

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- 14.44** “**ERISA**” means Employee Retirement Income Security Act of 1974, as amended, including regulations implementing the Act.
- 14.45** “**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.
- 14.46** “**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.
- 14.47** “**External Review**” means an independent review of an Adverse Benefit Determination conducted by an Independent Review Organization.
- 14.48** “**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.
- 14.49** “**Frames**” mean standard eyeglass Frames adequate to hold two Lenses.
- 14.50** “**Free Standing Diagnostic Center**” means a licensed establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient diagnostic services.
- 14.51** “**Gender Dysphoria**” means there is a marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Gender Dysphoria is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one’s sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender.
- 14.52** “**Generic Drug**” means an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.
- 14.53** “**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.
- 14.54** “**Habilitative 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.
- 14.55** “**Health Benefit Plan**” means a policy, contract, certificate or agreement offered by a carrier or similar agreement offered by an employer or other legal entity, to provide for, arrange for payment of, pay for or reimburse any of the costs of healthcare services. This term includes Short-Term and 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;

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- Workers' compensation insurance;
- Coverage for medical payments under a policy of automobile insurance;
- Coverage for on-site medical clinics; or
- Medicare supplemental health insurance.

- 14.56** “**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.
- 14.57** “**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.
- 14.58** “**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.
- 14.59** “**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:
- health resorts;
 - nursing homes;
 - Christian Science sanatoria;
 - institutions for exceptional children;
 - Skilled Nursing Facilities, places that are primarily for the care of convalescents;
 - clinics;
 - Physician offices;
 - private homes; or
 - Ambulatory Surgical Facilities.
- 14.60** “**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 AOC, 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 AOC.
- 14.61** “**Independent Medical Review**” means an independent evaluation of the medical or chiropractic care of an Insured that must include a physical examination of the Insured unless he is deceased, and a personal review of all x-rays and reports by a certified Physician or Chiropractor who is formally educated in the applicable medical field.
- 14.62** “**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
- 14.63** “**Initial Enrollment Period**” means the period of time during which an eligible person may enroll under this Plan.
- 14.64** “**Injury**” means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.
- 14.65** “**Inpatient**” means being confined in a Hospital or Skilled Nursing Facility as a registered bed patient under a Physician's order.
- 14.66** “**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.
- 14.67** “**Lenses**” mean ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Vision Plan Provider to be fitted into frames.

- 14.68** “**Licensed Assistant Behavior Analyst**” means a person who holds current certification or meets the standards to be certified 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 Board of Psychological Examiners and who provides Behavioral Therapy under the supervision of a Licensed Behavior Analyst or psychologist.
- 14.69** “**Licensed Behavior Analyst**” means a person who holds current certification or meets the standards to be certified as a board certified Behavior Analyst or a board certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and whom the Board of Psychological Examiners licenses as a Behavior Analyst.
- 14.70** “**Low Vision**” means a significant loss of vision but not total blindness.
- 14.71** “**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.
- 14.72** “**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.

- 14.73** “**Medical Director**” means a Physician named by SHL to review use of health services by Insureds.
- 14.74** “**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.**

- 14.75** “**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.

- 14.76** “**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.

- 14.77** “**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 AOC and otherwise covered under the Severe Mental Illness Covered Services section, or any of the following when they represent the primary need for therapy:
- Marital or family problems;

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- Social, occupational, or religious maladjustment;
- Behavior disorders;
- Impulse control disorders;
- Learning disabilities;
- Mental retardation;
- Chronic organic brain syndrome;
- Personality disorder; or

- 14.78** “**Mental Health Professional**” means any person qualified and licensed to provide assessments, diagnosis and therapy for mental health conditions or substance use disorders.
- 14.79** “**Non-Plan Pharmacy**” means a duly licensed pharmacy that does not have an independent contractor agreement with SHL to provide Covered Drugs to Insureds.
- 14.80** “**Non-Plan Provider**” means a Provider who does not have an independent contractor agreement with SHL.
- 14.81** “**Occupational Illness or Injury**” means any Illness or Injury arising out of or in the course of employment for pay or profit.
- 14.82** “**Orthoptics**” means the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.
- 14.83** “**Orthotic Devices**” means an apparatus used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.
- 14.84** “**Oversize Lenses**” means larger than standard lens blank, to accommodate prescriptions.
- 14.85** “**Photochromic Lenses**” means lenses which change color with intensity of sunlight.
- 14.86** “**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.
- 14.87** “**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 or physician assistant.
- 14.88** “**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.
- 14.89** “**Plan**” means this Agreement of Coverage (AOC), 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.
- 14.90** “**Plan Dentist**” means a Dentist who has an independent contractor agreement with SHL to provide Covered Services to Insureds.
- 14.91** “**Plan Pharmacy**” means a duly licensed pharmacy that has an independent contractor agreement with SHL to provide Covered Drugs to Insureds. Plan Pharmacy services are retail services only.
- 14.92** “**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.
- 14.93** “**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.
- 14.94** “**Plano Lenses**” means lenses which have no refractive power.
- 14.95** “**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.

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- 14.96** “**Practitioner**” means any person(s) qualified and licensed to practice the healing arts when they are acting within the scope of their license.
- 14.97** “**Predetermination**” means a system that requires a Plan Provider to get approval from SHL before providing non-emergent healthcare services to a Insured for those services to be considered Covered Services. Prior Authorization is not an agreement to pay for a service.
- 14.98** “**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.
- 14.99** “**Prescription Drug**” means a Federal legend drug or medicine that can only be obtained by a prescription order or that is restricted to prescription dispensing by state law. It also includes insulin and glucagon.
- 14.100** “**Prescription Drug List (PDL)**” means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by SHL.
- 14.101** “**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.
- 14.102** “**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.
- 14.103** “**Professional Vision Services**” means examination, material selection, fitting of glasses, related adjustments, etc.
- 14.104** “**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.
- 14.105** “**Provider**” means a:
- Hospital,
 - Skilled Nursing Facility,
 - Urgent Care Facility,
 - Ambulatory Surgical Facility,
 - Physician,
 - Practitioner,
 - dentist,
 - podiatrist, or
 - other person or organization licensed by the state where his practice is located to provide medical or surgical services, supplies, and accommodations acting within the scope of his license.
- 14.106** “**Referral**” means a recommendation for an Insured to receive a service or care from another Provider or facility.
- 14.107** “**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. .
- 14.108** “**Retransplant**” means the retransplantation of a previously transplanted organ or tissue.
- 14.109** “**Retrospective**” or “**Retrospectively**” means a review of an event after it has taken place.
- 14.110** “**Rider**” means a provision added to the Plan or the AOC to expand benefits or coverage.
- 14.111** “**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), published by the American Psychiatric Association:
- Schizophrenia
 - Schizoaffective disorder
 - Bipolar disorder

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- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder.

- 14.112** “**SHL Reimbursement Schedule**” means the schedule showing the amount SHL will pay for Eligible Medical Expenses (EME) to Providers. EME 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 Expense 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 Expense 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.

- 14.113** “**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.
- 14.114** “**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.
- 14.115** “**Skilled Nursing Care**” means services requiring the skill, training or supervision of licensed nursing personnel.
- 14.116** “**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.
- 14.117** “**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.
- 14.118** “**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.
- 14.119** “**Step Therapy**” is a program for Insureds who take Prescription Drugs for an ongoing medical condition, such as arthritis, asthma or high blood pressure, which ensures the Insured receives the most appropriate and cost-effective drug therapy for their condition. The Step Therapy program requires that before benefits are payable for a high cost Covered Drug that may have initially been prescribed, the Insured try a lower cost first-step Covered Drug. If the prescribing Physician has documented with SHL why the Insured’s condition cannot be stabilized with the first-step Covered Drug, SHL will review a request for Prior Authorization to move the Insured to a second-step drug, and so on, until it is determined by SHL that the prescribed Covered Drug is Medically Necessary and eligible for benefit payment.
- 14.120** “**Subscriber**” means an Individual who meets the eligibility requirements of this AOC and who has enrolled under this Plan, and for whom premiums have been received and accepted by SHL.
- 13.1** “**Substance Use Disorder**” as defined in the Diagnostic and Statistical Manual of Mental Disorder (DSM), fifth edition, is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. Substance Use 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.
- 14.121** “**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,

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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.

- 14.122 “Telemedicine”** means certain Covered Services for diagnosis and treatment of low acuity medical conditions delivered to SHL Insureds through the use of interactive audio, video, or other telecommunications or electronic technology by a contracted SHL Telemedicine Provider listed as such in the SHL Provider Directory at a site other than the site at which the patient is located. Telemedicine is available in all states where SHL contracted Telemedicine Providers offer telemedicine services. Telemedicine does not include the use of standard telephone calls, facsimile transactions or e-mail messaging and is only available through designated providers listed as Telemedicine Providers in the SHL Provider Directory.
- 14.123 “Therapeutic Equivalent”** means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.
- 14.124 “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.
- 14.125 “Tinted Lenses”** means lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc.).
- 14.126 “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.
- 14.127 “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:
- (a). the date 365 days after the date of the transplant; or
 - (b). the date when the Insured is no longer covered under this Plan, whichever is earlier.
- 14.128 “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 AOC. Non-Plan Hospitals do not have agreements with SHL to provide such services.
- 14.129 “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.
- 14.130 “Urgent Care Facility”** means a facility equipped and operated mainly to give immediate treatment for an acute Illness or Injury.
- 14.131 “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.
- 14.132 “Vision Plan Provider”** means a Provider who has an independent contractor agreement with SHL to provide certain Covered Services to Insureds.
- 14.133 “Waiting Period”** means a period of 90 (ninety) days applied from the date the Application is received by SHL. The Effective Date will be the first of the month immediately following the month in which the waiting period expires.