P.O. Box 15645 • Las Vegas, Nevada 89114-5645

Small Business
Group Certificate Of Coverage

THIS CERTIFICATE CONTAINS A DEDUCTIBLE

This Small Business Group Health Insurance Certificate of Coverage ("Certificate") contains the terms under which Sierra Health and Life Insurance Company, Inc. ("SHL") agrees to insure Eligible Employees and their Eligible Family Members of the Policyholder ("Group") and to make benefit payments for certain healthcare services.

SHL and Group have agreed to all of the terms of this Certificate, and the Certificate has been incorporated by reference into the Group Enrollment Agreement ("GEA") entered into by SHL and Group.

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

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

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

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The Department of Business and Industry

State of Nevada

Division Of Insurance

Telephone Numbers for Consumers of Healthcare

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

(702) 242-7700 **or** 1-800-888-2264

SECTION 1. Eligibility, Enrollment and Effective Date

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

1.1 Who Is Eligible

Subscriber. To be eligible to enroll as a Subscriber, an employee must:
A. Be a bona fide employee of the Group; and
B. Meet the following criteria;

- Be employed full-time;
- Be actively at work;
- Work at least the minimum number of hours per week indicated by the Group in its Attachment A to the Group Enrollment Agreement (GEA);
- Meet the applicable waiting period indicated by the Group in its Attachment A to the GEA;
- Enroll during an enrollment period; and
- Work for an employer that meets the Minimum Employer Contribution Percentage for the applicable coverage as set forth in the Attachment A to the GEA.

The actively at work requirement will not apply to individuals covered under Group's prior welfare benefit plan on the date of that plan's discontinuance, provided that this Certificate is initially effective no more than sixty (60) days after the prior plan's discontinuance. All other requirements will apply to such individuals.

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 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. SHL's determination of eligibility is final.

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

1.2 Who Is Not Eligible

Eligible Dependent does not include:

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

1.3 Changes In Eligibility Status

It is the Subscriber's responsibility to give SHL written notice within thirty-one (31) days of changes which affect his Dependent's eligibility. Changes include, but are not limited to:

- Reaching the limiting age.
- Ceasing to satisfy the mental or physical handicap requirements.
- Death.
- Divorce.
- 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 in accordance with the Group Enrollment Agreement.

1.4 Enrollment

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

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

2. **Group Open Enrollment Period**. An Open Enrollment Period of at least thirty-one (31) days may be held at least once a year allowing Eligible Employees and Eligible Family Members to enroll under this Plan without giving evidence of good health.

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

4. **Right to Deny Application**. SHL can deny membership to any person who:
   - Violates or has violated any provision of the SHL Certificate.
   - Misrepresents and/or fails to disclose a material fact which would affect coverage under this Plan.
   - Fails to follow SHL rules.
   - Fails to make a premium payment.

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

1.5 Effective Date of Coverage

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

When a person applies to become an Insured on or before the date he is eligible, coverage starts as shown in the GEA signed by Group.

1. If a person applies to be an Insured within thirty-one (31) days of the date he is first eligible to apply, coverage starts on the first day of the calendar month following the month when the Enrollment Form is received by SHL.

2. Subscriber's newborn natural child is covered for the first thirty-one (31) days from birth. Coverage continues after thirty-one (31) days only if the Subscriber enrolls the child as a Dependent and pays the premium within sixty (60) days of the date of birth.

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

   Coverage continues after the applicable thirty-one (31) day period only if the Subscriber enrolls the child as a Dependent and pays any premium within sixty (60) days following the placement of the child in the Subscriber's home. In the event adoption proceedings are terminated, coverage of a child Placed for Adoption ends on the date the adoption proceedings are terminated.

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

5. For a Special Enrollee, the Effective Date of Coverage is on the first day of the calendar month after an Enrollment Form is received, unless otherwise specified in the GEA.

6. When a person applies to become an Insured during the Open Enrollment Period, coverage starts on the first day of the calendar month following the Open Enrollment Period.

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

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

2.1 Termination by SHL

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

- Failure to maintain eligibility requirements as set forth in Section 1.
- On the first day of the month that a contribution was due and not received by SHL.
- With thirty (30) days written notice, if the Insured allows his or any other Insured's SHL ID Card to be used by any other person, or uses another person's SHL ID Card. The Insured will be liable to SHL for all costs incurred as a result of the misuse of the SHL ID Card.
- If the Insured performs an act or practice that constitutes fraud, or makes any intentional misrepresentation of material fact, as prohibited by the terms of coverage, SHL has the right to rescind coverage and declare coverage under the Plan null and void as 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. An Insured has the right to appeal any such rescission.
- In the case of a Small Group Insured, when information provided to SHL by a Small Group Insured in his Enrollment 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.
- Subject to Section 3., Continuation of Coverage, on the last day of the calendar month (or sooner, if provided in the GEA) when an Insured no longer meets the requirements of Section 1.; this paragraph also applies to Dependents who become ineligible as Insureds for any reason including the death of the Subscriber.
- On the date the GEA terminates for any reason, including but not limited to:
  1. Nonpayment of premiums.
  2. Failure to meet minimum enrollment requirements.
  3. SHL amends this Certificate and the Group does not accept the amendment.

2.2 Termination by the Subscriber

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

2.3 Reinstatement

Any Certificate which has been terminated in any manner may be reinstated by SHL at its sole discretion.

2.4 Retroactive Termination

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

2.5 Effect of Termination

No benefits will be paid under this Plan by SHL for services provided after termination of an Insured's coverage under this Plan. You will be responsible for payment of medical services and supplies incurred after the Effective Date of the termination of this Plan and/or the GEA.

SECTION 3. Continuation of Coverage

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

3.1 COBRA

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

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

a) A Subscriber and any enrolled Dependent who would lose coverage under this Plan because of: 1) a reduction in the Subscriber's regularly scheduled work hours, or 2) because of termination of the Subscriber's employment with the Group for any reason, other than gross misconduct, has the right to elect COBRA continuation coverage. Such coverage may continue for up to eighteen (18) months.

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

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

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

1. The Subscriber's death.

2. The Subscriber's divorce or legal separation.

3. The Subscriber becomes entitled to Medicare benefits under Part A, Part B, or both.

4. A Dependent no longer qualifies as a Dependent child as provided in Section 1. of this Certificate.

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

c) **Election of COBRA Continuation Coverage**. A Subscriber or Dependent identified in 3.1(a) or (b) above must elect to continue coverage within sixty (60) days of the election notice which qualifies him to continue coverage under this Plan.

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

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

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

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

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

SHL assumes no further obligation to provide COBRA continuation coverage if:

- The Plan Administrator does not notify the Insured within forty-four (44) days of the qualifying event; or
- The Insured does not make a timely election; or
- The Plan Administrator fails to notify SHL of the election within thirty (30) days of the election; or

- Timely premium payments are not made as described in 3.1(f).

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

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

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

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

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

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

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

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

     The Insured who seeks the disability extension must notify the Plan Administrator and SHL of the Social Security Administration disability determination no later than sixty (60) days after the latest of:
     1) The date of Social Security Administration determination;
     2) The date on which the qualifying event occurs;
     3) The date on which the Subscriber or Dependent loses coverage under the Plan as a result of a qualifying event;

4) The date on which the Subscriber or Dependent is informed through the Plan's Certificate or the general COBRA notice of their obligation to provide notice.

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

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

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

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

- The GEA is terminated in its entirety.

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

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

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

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

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

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

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

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

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

h) **Plan Contact Information**. For additional information about the Plan or your rights under COBRA continuation coverage, contact SHL's Member Services Department by calling (702) 242-7700 or 1-800-888-2264.

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

For purposes of an FMLA leave, the Subscriber and Dependents will be eligible for COBRA continuation coverage only if:
- The Subscriber and Dependents are covered by the Group Health Benefit Plan on the day before the leave begins (or become covered during the FMLA leave);

- The Subscriber does not return to employment at the end of the FMLA leave; and
- The Subscriber or Dependents lose coverage under SHL's Group Health Benefit Plan before the end of what would be the maximum COBRA continuation coverage period.

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

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

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

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

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

2. the day after the date on which the Subscriber fails to apply for or return to work with the Group as follows:

   a. If the Subscriber served in the uniformed services and is absent from work for less than thirty-one (31) days;

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

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

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

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

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

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

3.3 Total Disability of Subscriber

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

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

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

3.4 Non-Election

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

3.5 State Law

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

SECTION 4. Managed Care Program

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

4.1 Managed Care Program

SHL's Managed Care Program, using the services of professional medical peer review committees, utilization review committees, and/or the Medical Director, determines whether services and supplies are Medically Necessary. SHL's Managed Care Program helps direct care to the most appropriate setting to provide healthcare in a cost-effective manner.

4.2 Managed Care Program Requirements

SHL's Managed Care Program requires the Insured, Plan Providers and SHL to work together.

All Plan Providers have agreed to participate in SHL's Managed Care Program. Plan Providers have agreed to accept SHL's Reimbursement Schedule amount as payment in full for Covered Services, less the Insured's payment of any applicable 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 that the Provider selected is a Plan Provider before receiving any non-Emergency Services and to comply with all other rules of SHL's Managed Care Program.

Benefits payable for expenses incurred in connection with Covered Services which are not 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 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. The Prior Authorization form will specify approved Covered Services and supplies. **Prior Authorization is not a guarantee of payment for Covered Services**.

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

4.4 Services Requiring Prior Authorization

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

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

4.5 Emergency Admission Notification

The Insured must report all emergency admissions to the Member Services Department within 24 hours of admission or as soon as reasonably possible to authorize continued care at (702) 242-7300 or 1-800-777-1840.

All emergency admissions are reviewed Retrospectively to determine if the treatment received was Medically Necessary and appropriate and was for Emergency Services as defined in this Certificate.

4.6 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.

The Independent Medical Review will include a physical exam of the Insured 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) business days after the review.

If the Insured disagrees with the findings of the review, he must 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 Certificate for more information.

4.7 Appeals Rights

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

SECTION 5. Obtaining Covered Services

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

5.1 Availability of Covered Services

Insureds are entitled to receive the Covered Services set forth in Section 6 herein and the Attachment A Benefit Schedule subject to all terms and conditions of this Certificate, and payment of required premium. These Covered Services are available only if and to the extent that they are:
(a) Prescribed by a duly licensed Provider; and;
(b) Medically Necessary as defined in this Certificate.

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

5.2 Provider Selection

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

5.3 Continuity of Care from Plan Providers

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

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

- The 120th day following the date the contract was terminated between the Provider and SHL; or
- If the medical condition is pregnancy, the 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.

Address:

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

Phone:

(702) 242-7700
1-800-888-2264

SECTION 6. Covered Services

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

6.1 Healthcare Facility Services

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

Accommodations:

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

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

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

6.2 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;
- examination of some aspect of the patient by means of pathology laboratory or electronic monitoring procedure which is a generally recognized and accepted procedure for diagnostic or therapeutic purposes in the treatment of an Illness or Injury;
- procedures for prescribing or administering medical treatment;
- Manual Manipulation (except for reductions of fractures or dislocations);

- treatment of the temporomandibular joint including Medically Necessary dental procedures, such as dental splints, subject to the maximum benefit limitation;
- anesthesia services;
- 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.

6.3 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 the Medical Director for further evaluation of an Illness or Injury on an Inpatient or outpatient basis.

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

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

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

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

6.4 Preventive Healthcare Services

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

If your employer believes that it is a Grandfathered Health Plan, as defined under the Patient Protection and Affordable Care Act (PPACA), it may continue to maintain the applicable Copayment, and/or Calendar Year Deductible and Coinsurance amounts for covered Preventive Healthcare Services. Please check with your employer to determine whether this benefit is included in your Plan.

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.sierrahealthandlife.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.

6.5 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.

6.6 Oral Physician Surgical Services

Although dental services are not Covered Services, except as otherwise provided in the Attachment A Benefit Schedule, the following Oral Surgical Services are Covered Services:

- For Insureds up to age 19, services include the Medically Necessary treatment of:
  - Oral cancer;
  - Dental Fractures; and
  - Dental Biopsies
- 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:
  - Root canal therapy, post and build up.
  - Temporary crowns.
  - Temporary partial bridges.
  - Temporary and permanent fillings.
  - Pulpotomy.
  - Extraction's of broken teeth.
  - Incision and drainage.
  - Tooth stabilization through splinting.

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

6.7 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.

6.8 Assistant Surgical Services

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

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

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

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

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

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.

6.10 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.

6.11 Home Healthcare Services

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

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

6.12 Short-Term Rehabilitation Services – Inpatient and Outpatient

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.

6.13 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.

6.14 Routine Radiological and Non-Radiological Diagnostic Imaging Services

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

6.15 Other Diagnostic and Therapeutic Services

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

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

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

6.16 Prosthetic and Orthotic Devices

Covered Services include the following devices when received in connection with an Illness or Injury occurring after Insured's Effective Date under this Plan and authorized by SHL's Managed Care Program:

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

6.17 Corrective Appliances

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

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

Corrective Appliances do not include:

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

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

6.18 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.

6.19 Mental Health Services and Severe Mental Illness Services

All benefits for Mental Health and Severe Mental Illness Services are subject to SHL's Managed Care Program through Behavioral Healthcare Options and shown in the Attachment A Benefit Schedule.

Mental Health Services. When authorized by Behavioral Healthcare Options, Covered Services include evaluation, crisis intervention or psychotherapy only.

- Inpatient: Covered Services for the diagnosis and treatment of a Mental Illness.
- Outpatient: Outpatient evaluation and treatment of Mental Illness including individual and group psychotherapy sessions.

Severe Mental Illness Services. When authorized by SHL, Covered Services include Inpatient and outpatient treatment for Severe Mental Illness as defined in this Certificate. Benefits for the treatment of Severe Mental Illness are subject to the benefit levels shown in the Attachment A Benefit Schedule.

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

6.20 Substance Abuse Services

All benefits for Inpatient Substance Abuse Services are subject to SHL's Managed Care Program through Behavioral Healthcare Options and listed in the Attachment A Benefit Schedule.

- **Inpatient**: when there has been a history of multiple outpatient treatment failures or when outpatient treatment is not feasible, services for diagnosis and medical treatment for alcoholism and abuse of drugs.
- **Outpatient:** services for the diagnosis, medical treatment and rehabilitation, including individual, group, and family counseling, and outpatient detoxification services for recovery from the effects of alcoholism and abuse of drugs.
- **Detoxification**: treatment for withdrawal from the physiological effects of alcohol and drug abuse. Inpatient detoxification is considered appropriate treatment only for life-threatening withdrawal syndromes associated with drug and alcohol dependence.

All admissions for Emergency Services are reviewed Retrospectively to determine if the treatment received was Medically Necessary and appropriate. If the Insured is admitted to a Mental Health or Substance Abuse facility for non-emergency treatment without Prior Authorization, Insured will be responsible for the cost of services received.

6.21 Mastectomy Reconstructive Surgical Services

Benefits are available for Subscribers and their enrolled Dependents for Mastectomy Reconstructive Surgery. Mastectomy Reconstructive Surgery is the surgical procedure performed following a mastectomy on one or both breasts to re-established symmetry between the two breasts. Such surgery includes, but is not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy.

The following services received in connection with Mastectomy Reconstructive Surgical Services are Covered Services subject to the terms and conditions of this Certificate:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending Physician and the patient.

The first three (3) years after mastectomy:

Benefits for reconstructive surgery, including complications relating to the reconstructive surgery, performed while the patient is covered under this Plan, and within the three (3) years immediately following a mastectomy that was covered under this Plan, will be paid at the same level as would have been provided at the time of the mastectomy.

Benefits for reconstructive surgery performed within three (3) years following a mastectomy that was covered under this Plan, while the patient is no longer covered by SHL under this Plan, will be paid at the same level as would have been provided at the time of the mastectomy except that no coverage will be provided for any complications relating to the reconstructive surgery.

More than three (3) years after mastectomy:

Benefits for reconstructive surgery performed more than three (3) years following a mastectomy that was covered under this Plan (if the patient is still covered by SHL under this Plan) will be paid subject to all of the terms, conditions and exclusions contained in the Certificate at the time of the reconstructive surgery.

No benefits will be paid for reconstructive surgery performed, or any complications relating to the reconstructive surgery, more than three (3) years following a mastectomy that was covered under this Plan if the patient is no longer covered by SHL under this Plan.

6.22 Special Food Product / Enteral Formulas

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

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

6.23 Self-Management and Treatment of Diabetes

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

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

6.24 Dental Anesthesia Services

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

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

Coverage for dental anesthesia pursuant to this section is limited to that provided by a Plan 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.

6.25 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 three (3) 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.

6.26 Genetic Disease Testing Services

Covered Services include Prior Authorized Medically Necessary Genetic Disease Testing, when:

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

6.27 Clinical Trial or Study

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

- The clinical trial or study is conducted in the state of Nevada and the medical treatment is provided:
  1. In a Phase I, Phase II, Phase III or Phase IV clinical trial or study for the treatment of cancer or other life-threatening disease or condition;
  2. In a Phase II, Phase III or Phase IV clinical trial or study for the treatment of chronic fatigue syndrome;
  3. For cardiovascular disease (cardiac/stroke) which is not life-threatening, for which, as SHL determines, a clinical trial meets the qualifying clinical trial criteria stated below.
  4. For surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which, as SHL determines, a clinical trial meets the qualifying clinical trial criteria stated below.
  5. Other diseases or disorders which are not life-threatening 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.

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.

6.28 Medical Supplies

Medical Supplies are routine supplies that are customarily used during the course of treatment for an Illness or Injury. Medical Supplies include, but are not limited to the following:

- Catheter and catheter supplies – Foley 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, sterile solutions, ointments, sterile applicators, sterile gloves;
- Elastic stockings;
- Enemas and douches;
- IV supplies;
- Sheets and bags;
- Splints and slings;
- Surgical face masks; and
- Syringes and needles.

6.29 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.

6.30 Hearing Aids

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

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

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

6.31 Autism Spectrum Disorder

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 Certified Autism Behavior Interventionist) 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.

6.32 Pediatric Dental and Vision Services

Covered services are available to enrolled children up to age nineteen (19) when authorized by SHL's Managed Care Program. Please refer to the SHL Attachment A Benefit Schedule for a complete list of services and the associated Insured cost share.

6.33 Habilitative Services

Benefits are provided for Habilitative Services provided on an outpatient basis 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 or Investigational.

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.

SECTION 7. Exclusions

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

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

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

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

7.4 Personal comfort, hygiene or convenience items such as a hospital television, telephone, or private room when not Medically Necessary. 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. Housekeeping or meal services as part of Home Healthcare. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.

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

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

7.6 Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function. Cosmetic procedures include:

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

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

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

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

7.8 Reversal of surgically performed sterilization or subsequent resterilization.

7.9 Elective abortions.

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

7.11 Any services or supplies rendered in connection with an Insured acting as or utilizing the services of a surrogate mother.

7.12 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.

7.13 Venipuncture (drawing of blood for laboratory tests).

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

7.15 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.

7.16 Treatment of:

- Marital or family problems;
- Occupational, religious, or other social maladjustments;
- Chronic behavior disorders;
- Codependency;
- Impulse control disorders;
- Organic disorders;
- Learning disabilities or mental retardation or any Severe Mental Illness as defined in the Certificate and otherwise covered under the Severe Mental Illness Covered Services section.

For purposes of this Exclusion,

- "chronic" means any condition existing for more than six (6) months.
- Counseling and other forms of cognitive and behavioral therapy is excluded in connection with the treatment of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD). This section is not meant to exclude an evaluation for a diagnosis of ADD or ADHD, or to exclude any corresponding outpatient prescription drugs (if otherwise available under the outpatient Prescription Drug Benefit Rider if applicable to your Plan) when prescribed by a treating Plan Provider, nor is this meant to exclude an evaluation for the diagnosis of any other co-morbid issues.

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

7.18 Except as otherwise provided in the SHL Attachment A Benefit Schedule, vision exams to determine refractive errors of vision and eyeglasses or contact lenses other than as specifically covered in this Certificate. Coverage is provided for vision exams only when required to diagnose an Illness or Injury.

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

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

7.20 Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.

- Bone anchored hearing aids are excluded except when either of the following applies:
  - for Insured's with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
  - for Insured's with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Also excluded is more than one bone anchored hearing aid per Insured who meets the above coverage criteria during the entire period of time the Insured is enrolled under the Plan, as well as repairs and/or replacements for a bone anchored hearing aid

for Insured's who meet the above coverage criteria, other than for malfunctions.

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

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

7.23 Acupuncture or Hypnosis.

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

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

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

7.27 Outpatient Prescription Drugs, nutritional supplements, vitamins, herbal medicines, appetite suppressants, Specialty drugs, and other over-the-counter drugs, except as specifically covered in the outpatient Prescription Drug Benefit Rider, if applicable to your Plan. This includes drugs and supplies for a patient's use after discharge from a Hospital. Drugs and medicines approved by the FDA for experimental or investigational use or any drug that has been approved by the FDA for less than six (6) months unless Prior Authorized by SHL.

7.28 Care for conditions that federal, state or local law requires to be treated in a public facility.

7.29 Any equipment or supplies that condition the air. Arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace. Heating pads, hot water bottles, wigs and their care and other primarily nonmedical equipment.

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

7.31 Special formulas, food supplements other than as specifically covered in this Certificate or special diets on an outpatient basis.

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

7.33 Milieu therapy, biofeedback, behavior modification, sensitivity training, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolffing, residential treatment, vocational rehabilitation and wilderness programs.

7.34 Experimental or investigational treatment or devices as determined by SHL.

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

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

7.37 Any services given by a Provider to himself or to members of his family.

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

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

7.40 Telemetry readings, EKG interpretations when billed separately from the EKG procedure. Arterial blood gas interpretations when billed separately from the procedure.

7.41 Services of more than one (1) assistant surgeon at one (1) operative session, unless approved in advance by SHL or its Medical Director. Service of an assistant surgeon when the Hospital provides or makes

available qualified staff personnel (including Physicians in training status) as surgical assistants. Services of an assistant surgeon provided solely to meet a Hospital's institutional requirements when the complexity of the surgery does not warrant an assistant surgeon.

7.42 Autologous blood donations.

7.43 Healthcare services or supplies required as a result of an attempt to commit, or committing a felony by the Insured.

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

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

7.45 Charges for services by a vision Plan Provider to his or her Dependents.

7.46 Visual therapy.

7.47 Replacement of lost or stolen eyewear.

7.48 Two pairs of eyeglasses in lieu of bifocals.

7.49 Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.

7.50 Any services and supplies not provided for in the Certificate of Coverage, not Medically Necessary as defined by the Certificate of Coverage or not required in accordance with the accepted standards of dental practice of the community, including:

- Services provided by non-participating dentists.
- 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 (3^{rd}) molar teeth.
- Routine extraction of loose deciduous teeth.
- Telephone consultations.

SECTION 8. Limitations

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

8.1 Calendar Year and Lifetime Maximum Benefit Limitations

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

8.2 Emergency Services

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

SECTION 9. Coordination of Benefits (COB)

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

9.1 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.

9.2 Benefits Subject to COB

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

9.3 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 Group 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 trusteed 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.

   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.

9.4 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.

9.5 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.

9.6 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.

9.7 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.

9.8 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.

9.9 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 group insurance companies or service plans.
(c) Any other organizations.

9.10 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 10. Subrogation

If an Insured's Illness or Injury is caused by a third party, and the Insured has the right to recover damages from that third party, SHL will provide or make payment for Covered Services related to such Illness or Injury. Acceptance of such Covered Services or payment shall constitute consent to the provisions of this section.

10.1 Insured Reimbursement Obligation

If an Insured receives payment for medical services and supplies from a third party through a suit or settlement, the Insured will be obligated to reimburse SHL for the actual cost incurred by SHL for benefits provided under this Plan for such services and supplies, but no more than the amount the Insured recovers.

10.2 SHL's Right of Recovery

SHL shall place a lien on all funds recovered by the Insured up to the actual cost incurred by SHL for the services and supplies provided to the Insured. SHL may give notice of that lien to any party who may have contributed to the loss.

SHL has the right to be subrogated to the Insured's rights to the extent of the benefits payable for Covered Services received under this Plan. This includes SHL's right to bring suit against a third party in the Insured's name.

10.3 Insured Cooperation

The Insured must take such action, furnish such information and assistance, and execute such instruments as SHL may require to facilitate enforcement of its rights under this provision. The Insured shall take no action prejudicing the rights and interests of SHL under this provision.

Any Insured who fails to cooperate in SHL's administration of this section shall be responsible for the actual cost of the services rendered in connection with the Illness or Injury caused by a third party.

SECTION 11. Premium Payments and Rate Changes

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

11.1 Premium Payments

The first day of any calendar month is the Premium Due Date. On or before the Premium Due Date, the Group or its designated agent shall remit to SHL on behalf of each Subscriber and his/her Dependents the amount specified in the GEA.

11.2 Failure to Make Payments

Only eligible Insureds for whom the applicable Premium Payment is actually received by SHL shall be entitled to benefit payments for Covered Services and then only for the period for which such premium payment is made. If any required payment on behalf of an Insured is not received by the Premium Due Date, and payment is not made within the thirty-one (31)-day grace period starting on the Premium Due Date, all rights of such Insured hereunder shall terminate as of the last date for which Premium Payments have been made. Coverage may be reinstated only by renewed application and re-enrollment in accordance with all requirements of the Certificate. SHL shall not be liable for benefit payments for Covered Services incurred by any Insured beyond the period for which the Premium Payment has been paid.

11.3 Changes in Premiums

SHL reserves the right to establish a revised schedule of premium rates after providing sixty (60) days notice to the Group as set forth in the GEA.

SECTION 12. General Provisions

12.1 Relationship of Parties

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

12.2 Entire Agreement

This Certificate, 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 Certificate.

12.3 Contestability

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

12.4 Authority to Change the Form or Content of this Plan

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

12.5 Identification Card

Cards issued by SHL to Insureds are for identification only. Possession of an SHL identification card does not give the holder any right to services or other benefits under this Plan.

To be entitled to such services or benefits, the holder of the card must in fact be an Insured and all applicable premiums must actually have been paid. Any person not entitled to receive services or other benefits will be liable for the actual cost of such services or benefits.

12.6 Notice

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

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

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

12.7 Interpretation of the Certificate

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

12.8 Modifications

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

12.9 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.

12.10 Choice of Facility of Provider

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

12.11 Overpayments

SHL has the right to correct and/or collect benefit 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.

12.12 Cost Containment Features

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

12.13 Gender References

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

12.14 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 Plan. No such action shall be brought at any time unless brought within the time limit allowed by the laws of the jurisdiction of issue. If the laws of the jurisdiction of issue do not designate the maximum length of time in which such action may be brought, no action may be brought after the expiration of three (3) years from the time proof of loss is required by the Plan.

12.15 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.

12.16 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, a written notice, signed and dated by the Insured, is required. The notice must include the full name of the Authorized Representative and must indicate specifically for which Claim for Benefits or appeal the authorization is valid. The notice should be sent to:

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

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

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

12.17 Failure to Obtain Prior Authorization

All requests for Prior Authorization must be initiated by the Insured's Physician. If a Physician or Insured fails to follow the Plan's procedures for filing a request for Prior Authorization (Pre-Service Claim), the Insured shall be notified of the failure and the proper procedures to be followed in order to obtain Prior Authorization 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.

12.18 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 the time sufficiently in advance of the reduction or termination to allow the Insured to appeal and obtain a determination before the benefit is reduced or terminated. Subject to the following paragraph, such request may be treated as a new Claim for Benefits and decided within the timeframes applicable to either a Pre-Service Claim or a Post-Service Claim, as appropriate. Provided, however, any appeal of such a determination must be made within a reasonable time and may not be afforded the full 180 day period as described in the Appeals Procedures Section herein.

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

12.19 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 Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge.

SECTION 13. Claims Provisions

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

13.1 Notice and Proof of Claim

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

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

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

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

(702) 242-7700 or
1-800-888-2264.

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

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

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

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

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

13.2 Timely Filing Requirement

All claims must be submitted to SHL within sixty (60) days from the date expenses were incurred, unless it shall be shown

not to have been reasonably possible to give notice within the time limit, and that notice was furnished as soon as was reasonably possible. If the Insured authorizes payment directly to the Provider, a check will be mailed to that Provider. A check will be mailed to the Insured directly if payment directly to the Provider is not authorized. The Insured will receive an explanation of how the payment was determined.

13.3 Late Claims Exclusion

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

13.4 Examination

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

SECTION 14. Appeals Procedures

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

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

Concerns about medical services are best handled at the medical service site level before being brought to SHL. If an Insured contacts SHL regarding an issue related to the medical service site and has not attempted to work with the site staff, the Insured may be directed to that site to try to solve the problem there, if the issue is not a Claim for Benefits.

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.

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

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

2nd Level Formal Appeal: If a 1st Level Formal Appeal is not resolved to the Insured's satisfaction, an Insured may then file a 2nd Level Formal Appeal. A 2nd Level Formal Appeal is submitted in writing and reviewed by the Grievance Review Committee. The 2nd Level Formal Appeal is **voluntary** for all Adverse Benefit Determinations.

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

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

14.1 Informal Review

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

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

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

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

14.2 1st Level Formal Appeal

When an Informal Review is not resolved in a manner that is satisfactory to the Insured or when the Insured chooses not to file an Informal Review and the Insured wishes to pursue the matter further, the Insured must file a 1st Level Formal Appeal. The 1st Level Formal Appeal must be submitted orally or in writing to SHL's Customer Response and Resolution Department within 180 days of an Adverse Benefit Determination. Such 180 days will run concurrently with the 180 day time period applicable to an Informal Review as set forth in Section 15.1. 1st Level Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

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

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

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

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

Sierra Health and Life Insurance Co., Inc.
Attn: Customer Response and Resolution Department
P.O. Box 15645
NV017-3020
Las Vegas, NV 89114-5645
Fax: 1-702-266-8813

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

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

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

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

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

the time the Insured is informed of the resolution of his 1st Level Formal Appeal.

14.3 Expedited Appeal

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

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

14.4 2nd Level Formal Appeal

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

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

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

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

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

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

The Grievance Review Committee shall:

- consider the 2nd Level of Appeal;
- schedule and conduct a formal presentation if applicable;

- obtain additional information from the Insured and/or staff as it deems appropriate; and
- make a decision and communicate its decision to the Insured within thirty (30) days following SHL's receipt of the request for a 2nd Level Formal Appeal.

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

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

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

14.5 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.

14.6 External Review

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

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

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

Additionally, as per applicable law and regulations, the notice will provide the Insured the information outlined in Section 14.2 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 the Insured's medical records. The entire External Review process and any associated medical records are confidential.

> Office for Consumer Health Assistance
> 555 East Washington Avenue #4800
> Las Vegas NV 89101
> (702) 486-3587
> (888) 333-1597

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.

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

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

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

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

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

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

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

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

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

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

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

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

14.7 Request for an External Review Due to Denial of Experimental or Investigational 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 or investigational, is available in limited circumstances as outlined in the following sections.

14.7.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 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.

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

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

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

The Independent Review Organization shall submit a copy of its determination, including the basis thereof, to the:

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

14.7.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 or investigational, 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, OCHA shall immediately notify SHL accordingly.

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

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

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

Representative must be submitted to SHL by the IRO within one (1) business day.

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

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

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

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

14.8 Office for Consumer Health Assistance

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

SECTION 15. Glossary

15.1 "**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 not Medically Necessary or appropriate.

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.

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

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

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

15.4 **"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.

15.5 "**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.

15.6 **"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.

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

15.8 **"Blended Lenses"** means bifocals which do not have a visible dividing line.

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

15.10 "**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.

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

15.12 **"Certified Autism Behavior Interventionist"** means a person who is certified as an Autism Behavior Interventionist by the Board of Psychological Examiners and who provides Behavior Therapy under the supervision of:
1. A licensed psychologist;
2. A Licensed Behavior Analyst; or
3. A Licensed Assistant Behavior Analyst.

15.13 "**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).

15.14 **"Coated Lenses"** means a substance which is added to a finished lens on one or both surfaces.

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

15.16 **"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.)

15.17 **"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.

15.18 "**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.

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

15.20 **"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.

15.21 "**Copayment**" or **"Cost-share"** means the amount the Insured pays when a Covered Service is received.

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

15.23 "**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.

15.24 "**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.

15.25 **"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.

15.26 **"Deductible"** means the portion of Eligible Medical Expenses 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.)

15.27 **"Dentist"** means anyone qualified and licensed to practice dentistry who has a degree of Doctor or Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.)

15.28 **"Dental Director"** means a Dentist designated by SHL to review the utilization of dental services by Insureds.

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

15.30 "**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.

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

15.32 **"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.

15.33 "**Eligible Employee**" means a natural person that:
(a). Is a bona fide employee of the Group; and
(b). Meets the following criteria:
- Is employed full-time;
- Is actively at work;
- Works at least the minimum number of hours per week indicated by the Group in the Attachment A to the GEA (typically 30 hours);
- Meets the applicable waiting period indicated by the Group in the Attachment A to the GEA;
- Enrolls during an enrollment period; and
- Works for an employer that meets the Minimum Employer Contribution Percentage for the applicable coverage as set forth in the Attachment A to the GEA.

The term includes a sole proprietor or a partner of a partnership, if the sole proprietor or partner is included as an Eligible Employee under a Health Benefit Plan of a Small Employer.

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

15.35 "**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.

15.36 **"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.

15.37 "**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.

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

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

15.40 **"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.

15.41 "**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.

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

15.43 **"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.

15.44 **"Frames"** means standard eyeglass Frames adequate to hold two lenses.

15.45 "**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.

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

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

15.48 **"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.

15.49 "**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;
- Workers' compensation insurance;
- Coverage for medical payments under a policy of automobile insurance;
- Coverage for on-site medical clinics; or
- Medicare supplemental health insurance.

15.50 "**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.

15.51 "**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.

15.52 "**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.

15.53 "**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:

- residential or nonresidential treatment facilities;
- health resorts;
- nursing homes;
- Christian Science sanataria;
- 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.

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

15.55 "**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.

15.56 **"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.

15.57 "**Initial Enrollment Period**" means the period of time during which an eligible person may enroll

under this Plan, as shown in the GEA signed by the Group.

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

15.59 "**Inpatient**" means being confined in a Hospital or Skilled Nursing Facility as a registered bed patient under a Physician's order.

15.60 "**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.

15.61 **"Lenses"** mean ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Vision Plan Provider to be fitted into frames.

15.62 **"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.

15.63 **"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.

15.64 **"Low Vision"** means a significant loss of vision but not total blindness.

15.65 "**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.

15.66 "**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.

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

15.68 "**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.**

15.69 "**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.

15.70 "**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.

15.71 "**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 Certificate 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;
- Social, occupational, or religious maladjustment;
- Behavior disorders;
- Impulse control disorders;
- Learning disabilities;
- Mental retardation;
- Chronic organic brain syndrome;
- Personality disorder; or
- Transsexualism, psychosexual identity disorder, psychosexual dysfunction of gender dysphoria.

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

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

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

15.75 **"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.

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

15.77 **"Oversize Lenses"** means larger than standard lens blank, to accommodate prescriptions.

15.78 **"Photochromic Lenses"** means lenses which change color with intensity of sunlight.

15.79 "**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.

15.80 **"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.

15.81 "**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.

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

15.83 **"Plan Dentist"** means a Dentist who has an independent contractor agreement with SHL to provide Covered Services to Insureds.

15.84 "**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.

15.85 "**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.

15.86 **"Plano Lenses"** means lenses which have no refractive power.

15.87 "**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.

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

15.89 **"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.

15.90 "**Prescription Drug**" means any required by federal law or regulation to be dispensed only by a prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.

15.91 "**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.

15.92 "**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.

15.93 "**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.

15.94 **"Professional Vision Services"** means examination, material selection, fitting of glasses, related adjustments, etc.

15.95 "**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.

15.96 **"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.

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

15.98 "**Retransplant**" means the retransplantation of a previously transplanted organ or tissue.

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

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

15.101 "**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
- Major depressive disorders
- Panic disorder

- Obsessive-compulsive disorder.

15.102 "**SHL Reimbursement Schedule**" means the schedule showing the amount SHL will pay 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.

15.103 "**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.

15.104 "**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.

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

15.106 "**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.

15.107 "**Small Group**" means an employer who employed an average of at least two (2) employees, but not more than fifty (50) employees who have a normal workweek of thirty (30) hours or more and who employs at least two (2) employees on the first day of the Plan year.

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

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

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

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

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

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

15.111 "**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.

15.112 **"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.

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

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

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

15.116 **"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.

15.117 "**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.

15.118 **"Tinted Lenses"** means lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc.).

15.119 "**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.

15.120 "**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.

15.121 "**Transplant Facility**" means a Hospital that has an independent contractor agreement or other contractual relationship with SHL to provide Covered Services related to a Covered Transplant Procedure as defined in this Certificate. Non-Plan Hospitals do not have agreements with SHL to provide such services.

15.122 "**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.

15.123 "**Urgent Care Facility**" means a facility equipped and operated mainly to give immediate treatment for an acute Illness or Injury.

15.124 "**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.

15.125 **"Vision Plan Provider**" means a Provider who has an independent contractor agreement with SHL to provide certain Covered Services to Insureds.

15.126 "**Waiting Period**" means the period of time established by the Group that must pass before coverage for an Eligible Employee or Eligible Family Member can become effective. If an Eligible Employee or Eligible Family Member enrolls as a Special Enrollee, any period before such Special Enrollment is not a Waiting Period.