

SIERRA HEALTH AND LIFE INSURANCE
COMPANY, INC.

**BENEFIT
ADMINISTRATOR'S
GUIDE**

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

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Information in this document is presented in summary form for convenience purposes only. When determining cost, access or eligibility of benefits, consult the relevant Evidence of Coverage and all other applicable endorsements, riders and attachments, if any, to determine the governing contractual provisions.

Welcome

Dear Employer:

We are honored that you have chosen our health plan and extend a sincere thank you for the trust you have placed in us. Sierra Health and Life Insurance Company is a health and life insurance company that provides group insurance products to our customers in 41 states and Washington, D.C.

Through our parent company, Sierra Health Services, we have provided employer groups with quality healthcare benefits for more than a decade. We integrate efficiency, flexibility, affordability and quality in all of our health insurance products, making us a good choice for your comprehensive healthcare needs.

This Benefit Administrator's Guide has been designed to facilitate your understanding of Sierra Health and Life's managed health care plan. Please refer to the Table of Contents to locate specific topics. If you need additional assistance, please contact your Sales Representative or the Member Services Department, Monday - Friday, 8:00 a.m. - 5:00 p.m., at (702) 242-7700 or (800) 888-2264.

Thank you for selecting us as your healthcare partner.

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathon W. Bunker". The signature is stylized with a large, circular initial "J" and a long, horizontal flourish extending to the right.

Jonathon W. Bunker, President
Sierra Health and Life Insurance Company, Inc.

Telephone Reference

If you have any questions....

<i>If you have questions regarding...</i>	<i>Contact this department</i>	<i>Telephone Number</i>
Your bill	Group Services	(702) 242-7575 M-F, 8:00 a.m. - 5:00 p.m.
New enrollments, terminations, enrollment changes and documentation requests, HIPAA and COBRA	Group Services	(702) 242-7575 M-F, 8:00 a.m. - 5:00 p.m.
Prior Authorization <ul style="list-style-type: none"> • Medical Services 	Member Services	(702) 242-7700 (800) 888-2264
Prior Authorization <ul style="list-style-type: none"> • Mental Health and Substance Abuse Services 	Behavioral Healthcare Options	(702) 364-1484 (800) 873-2246 24 hours, 7 days a week
Medical Services	Southwest Medical Associates Scheduling	(702) 877-5199
	24-hour Telephone Advice Nurse	(702) 242-7330 (800) 288-2264
Health Education & Wellness Programs	Health Education & Wellness	(702) 877-5356 M – F 8:00 a.m. – 5:00 p.m.
Member Questions	Member Services	(702) 242-7700 (800) 888-2264 M-F, 8:00 a.m. - 5:00 p.m.

Please mail ***Membership Change Forms, Enrollment Applications*** to:

Sierra Health and Life
ATTN: Group Services
P.O. Box 18407
Las Vegas, Nevada 89114-8407

Please mail ***Billing Statements and Premium Payments*** to:

Sierra Health and Life
ATTN: Group Services
P.O. Box 98563
Las Vegas, Nevada 89193-9633

Enrollment

A. Eligibility

Who is eligible?

For purposes of this document, insureds refers to employees and their eligible dependents enrolling in the plan.

Employees - To be eligible to enroll must:

- Meet the guidelines established in the Group Enrollment agreement; and
- Complete and submit to Sierra Health and Life such applications, forms or medical statements that Sierra Health and Life may reasonably request

Family Members - Eligible dependents of your employees

To be eligible to enroll as an eligible dependent, a person must be listed on an Enrollment Application completed by the insured. Eligible dependents include:

- Subscriber's lawful spouse;
- Any never-married children, adopted children, stepchildren or a minor for whom a court has appointed legal guardianship. A child placed with the employee for adoption as certified by the public of private agency making the placement. A child for whom a court has appointed the employee or the employee's spouse the legal guardian.

The child must be under the limiting age of 19 years and, except in the case of a child for whom a court has ordered coverage, the child must qualify as a dependent of the subscriber under the Internal Revenue Code Regulations.

- Any unmarried child, under the age of 23 (or age 24, if your employer is considered to be a "small" employer, 2-50 employees, as defined by Nevada law), who is a full-time student in an accredited educational institution which is eligible for payment of benefits

under the Veterans Administration Program, and who is financially dependent on the employee. Proof of full-time student status must be given to Sierra Health and Life each semester.

- Any unmarried child, under the age of 24, who is on a religious mission and who is financially dependent on the employee. The religious organization must give Sierra Health and Life a letter which states the dependent is on a religious mission. Proof of the religious mission status must be given to Sierra Health and Life at the time of mission.
- Any unmarried child who is incapable of self-sustaining employment due to mental or physical handicap, chiefly dependent upon the employee for economic support and maintenance, and who has satisfied all of the requirements below:
 - a) The child must be a dependent enrolled under the Sierra Health and Life Certificate of Coverage before reaching the limiting age, and proof of incapacity and dependency must be given to Sierra Health and Life by the employee within 31 days of the child reaching the limiting age; or
 - b) The handicap started before the child reached the limiting age, but the group was enrolled with another health insurance carrier that covered the child as a handicapped dependent prior to the group enrolling with Sierra Health and Life.

Sierra Health and Life may require proof of continuing incapacity and dependency, but not more often than once a year after the first two years beyond the date when the child reaches the limiting age. Sierra Health and Life's determination of age is final. Evidence of any court order needed to prove eligibility must be given to Sierra Health and Life.

B. Changes in Eligibility Status

It is the insured's responsibility to notify Sierra Health and Life of any changes which will affect their eligibility, or that of their dependents, for benefits under the Sierra Health and Life Membership Change Form. Changes include.

- Reaching the limiting age
- Death
- Divorce
- Marriage
- Employment/actively-at-work status

Special Documentation

Special documentation (i.e., birth certificates, marriage certificate) may be required in certain situations. All special documentation should be submitted to Sierra Health and Life

with the required Enrollment Application or Membership Change Form. Sierra Health and Life's special documentation guidelines are outlined below.

Birth Certificate

Sierra Health and Life may request a certified copy of a birth certificate or other appropriate information if:

- The newborn's mother is not a Sierra Health and Life insured;
- There is no proof of marriage between the insured and the newborn's mother;
- The newborn has a different last name than that of the insured; or
- Other instances that Sierra Health and Life may contend are reasonable to require proof of eligibility.

Legal Guardianship, Adoption, Placement for Adoption

In all instances, Sierra Health and Life will request a copy of court appointee legal guardianship papers, adoption papers, or legal certification of placement for adoption by a public or private agency making the placement. Due to the potential for change, Sierra Health and Life may require documentation every 60 days for court appointed legal guardianship and children placed for adoption.

New Spouse

In order to add a new spouse, an insured must provide Sierra Health and Life with a completed Membership Change Form and a copy of his/her certified marriage certificate.

Full-Time Student

Once a dependent reaches the applicable limiting age, proof of full-time student status is required to maintain coverage. Sierra Health and Life will only accept verification from the Office of the Registrar at the dependent's school (proof will be required at the beginning of each semester).

C. Enrollment Period

Eligible employees and eligible family members must enroll during the initial enrollment period or within 31 days of first becoming eligible in order to have coverage under the Certificate of Coverage.

Initial Enrollment Period - An initial enrollment period is the period of time during which an eligible individual may enroll under the Certificate of Coverage, as shown in the Group Enrollment Agreement.

Group Open Enrollment Period - An open enrollment period of at least 31 days may be held at least once a year allowing eligible employees and eligible family members to enroll under the Certificate of Coverage without giving evidence of good health.

Special Enrollment Event - A special enrollment event allows a qualified late enrollee to enroll for coverage under the Certificate of Coverage. Special enrollment events include:

- A change in marital status
- An addition of a newborn or adopted child
- Loss of eligibility with other group health care coverage

Enrollment must take place within 31 days of the special enrollment event.

D. Enrollment Application Process

Sierra Health and Life requires each insured to complete and submit an Enrollment Application at the time of initial enrollment, including COBRA or State Continuation enrollment. The Enrollment Application is forwarded to our Group Services Department.

NOTE: It is very important for the insured to correctly complete every section of the Enrollment Application and sign where indicated. For all newly eligible insureds, an Enrollment Application must be signed and, if applicable, returned to the employer along with special documentation (see Eligibility Guidelines). The insured must submit the Enrollment Application and appropriate documentation to Sierra Health and Life within 31 days of the qualifying event.

E. Plan Benefit Information and Membership Card

Each employee and their dependent(s) enrolling in Sierra Health and Life will be issued a **Plan Benefit Information** packet which includes a membership card. It is essential that insured and their dependents present the Membership Card at the time services are rendered.

The yellow copy of the Enrollment Application should be used until the permanent membership card is received. Within 31 days of receipt of enrollment application, the permanent card will be sent to the insured's home address along with the Plan Benefit Information packet, unless the broker has already delivered them.

NOTE: Providers are not required to accept temporary membership cards. Therefore, it may be necessary for them to verify eligibility prior to rendering services. If an insured does not receive a permanent membership card within 31 days of receipt of enrollment application, our Member Services Department should be notified. If a membership card is lost or stolen, please contact our Member Services Department at (702) 242-7700.

F. Membership Change Form

A Sierra Health and Life Membership Change Form is used to inform us of changes to an existing insured's file. An insured is required to complete, including signature and date, a Membership Change Form and supply proof of change under the following circumstances:

- Name Change
- Change of Address
- Change of Telephone Number
- Status Change (e.g. Marriage/Divorce)
- Addition of Dependent(s)
- Removal of Dependent(s)
- Termination of Coverage (Employee and Dependents)
- Change of Life Beneficiary

NOTE: For all new dependents, a Membership Change Form must be signed by the insured and returned along with all required documentation to the employer or Sierra Health and Life. The Membership Change Form and required documentation must be submitted to Sierra Health and Life within 31 days of the qualifying event.

G. COBRA

COBRA is a federal law requiring employers with 20 or more employees to continue to offer group coverage for terminated employees, widows, divorced spouses, dependent children and spouses of Medicare eligible employees whose coverage would otherwise terminate. COBRA is an abbreviation for Consolidated Omnibus Reconciliation Act of 1985 (COBRA).

NOTE: For all new insureds and their dependents, an Enrollment Application or Membership Change Form must be signed by the subscriber and returned along with special documentation, if applicable, to the employer. The Enrollment Application or Membership Change Form and all applicable documentation must be submitted to Sierra Health and Life.

Insured's Right To Continue Coverage

Employees and dependents must be given the right to continue their group health care coverage for up to 18 months for any of the following qualifying events:

- A termination of employment (for reasons other than gross misconduct)
- A layoff
- A reduction of work hours

Criteria for Continuation of Coverage

Continuation of coverage must be made available to qualified dependents for 36 months if their coverage terminated for any of the following qualifying events.

- Divorce or legal separation
- Death of the employee
- Dependent ceases to be a “covered dependent” under the terms of your group health plan
- Employee actually applies for and receives Medicare coverage
- Employee becomes entitled to Medicare benefits, regardless of whether such entitlement is a qualifying event
- Retired employee’s employer files Chapter 11 (Bankruptcy)*

*Retirees and widows/widowers of retirees (who died before the employer filed Chapter 11) are eligible for lifetime coverage.

Employer’s Right *Not* To Continue Coverage

The employer is *not* required, however, to provide continuation of coverage and may terminate existing continuation of coverage in the event of any of the following occurrences.

- The GEA is terminated in its entirety.
- The employer no longer provides group health coverage to any of its employees.
- The premium for the continuation of coverage is *not* paid.
- The qualified beneficiary obtains coverage under another group health plan (which does *not* have any pre-existing condition limitations that apply to the beneficiary) or Medicare.

COBRA makes it increasingly important for employers to keep abreast of enrollment status changes, termination, etc., within their group.

NOTE: The law states that it is your responsibility as an employer to provide written notification to employees and dependents affected by this law. Once a qualifying event occurs, such as those stated above, the employer has 14 days to notify the employee and/or dependents of their continuation rights. Once the notification has been given, the affected beneficiary has 60 days from the date of postmark of employer’s written notification to elect to continue coverage.

The health coverage provided under COBRA must be the same as the coverage provided under the group health plan to similarly situated employees or family members. In

addition, the premium for such coverage cannot exceed 102 percent (except for disabled individuals during months 19-29, premium cannot exceed 150 percent) of the applicable group premium. If the employer bills for the continuation of coverage, the employer retains two percent of the premium for administrative costs. For disabled individuals, the additional forty-eight percent is remitted to the insurance company to offset medical expenses.

Instructions for Submitting COBRA Documentation

- Submit a completed Membership Change Form to Sierra Health and Life's Group Services terminating the employee or dependent from regular group coverage;
- Ensure that the employee or dependent is eligible for COBRA coverage;
- Submit a completed Election of Continuation Form to Group Services (if adding a new dependent, a new enrollment application needs to be submitted). This is an important document. It informs Sierra Health and Life of the reason for termination and qualifying event for COBRA, and the length of continuation. More importantly, this form verifies that you (the employer) informed your employee of his/her COBRA rights and that you (the employer) complied with the federal law.

NOTE: Failure of the employer or the employee to provide Sierra Health and Life with the necessary documentation within the time frame identified in the COBRA regulations will result in no coverage under Sierra Health and Life.

H. State Continuation

If a Nevada employer employing less than 20 employees maintains a policy of group health insurance for the benefit of his/her employees, the policy must permit an employee to elect continuation of group health insurance coverage under certain circumstances.

The premium for the continuation of coverage under this law is 125% of the applicable group premium.

Insured's Right to Continue Coverage

Employees and their dependents must be given the right to continue their medical care coverage for up to 18 months for any of the following qualifying events:

- Applicant must have had prior health coverage for 12 consecutive months prior to the date coverage is terminated.
- A non-voluntary termination of employment (for reasons other than gross misconduct);
- A non-voluntary reduction of work hours.

Continuation of coverage must be made available to qualified dependents for 36 months if their coverage is terminated for any of the following qualifying events.

- Divorce or legal separation
- Death of the employee
- The dependent ceases to be a “covered dependent” under the terms of the group medical plan
- The employee becomes enrolled with Medicare

Insurer’s Right to Discontinue Coverage

The insurer is *not* required to provide continuation of coverage in the event of any of the following occurrences:

- The employer no longer provides group medical coverage to any of its employees;
- The premium for the continuation of coverage is not paid within 30 days after the due date;
- The qualified beneficiary obtains coverage under another group medical plan;
- The qualified beneficiary is entitled to Medicare benefits;
- The spouse remarries and becomes eligible for coverage under the new spouse’s policy of group medical insurance;
- The employee voluntarily leaves his/her employment (in this case neither the employee, spouse or dependent child of that employee is eligible to continue coverage); or
- The employee, spouse or dependent child has not been covered under any group policy of the employer for at least 12 consecutive months before the termination of his/her coverage.

Other Provisions

- The coverage provided under State Continuation *must be identical* to the coverage provided under the group medical plan to similarly situated employees or family members, excluding coverage for vision or dental care;

NOTE: In the case of a qualifying event, the employer is responsible for providing an employee or eligible dependent with notification of the right to elect continuation of coverage. The eligible employee or dependent has 60 days from the postmarked date of written notification from employer to notify the employer of his/her decision to continue coverage and pay the first quarterly premium.

- The premium cannot exceed 125% of the applicable group premium;

- If there is a change in the employer's rates of those individual's that have elected continuation of coverage, it will be 125% of the new rate. Such individuals will also receive the new medical benefits, since the continuation of coverage is required to be identical to the coverage provided under the group plan; or
- An employee or qualified dependent may not choose the continuation of coverage if he/she has opted out of the medical plan prior to a qualifying event.

Instructions for Enrolling an Employee in State Continuation

- Submit a completed Membership Change Form to Sierra Health and Life Group Services terminating the employee or dependent from regular group coverage.
- Submit a new, completed Sierra Health and Life Enrollment Application to Group Services. Please mark "State Continuation" in red ink at the top of the application.
- Submit a completed NRS 689B.245 Election of Continuation of Coverage Form to Group Services.
- Submit the first monthly premium payment to Sierra Health and Life.

I. HIPAA (Health Insurance Portability & Accountability Act, 1996)

Federal and state governments have each passed legislation affecting health care coverage. These laws, including the Health Insurance Portability & Accountability Act of 1996 (HIPAA), were passed to provide more access to health care coverage with minimal interruption.

Pre-Existing Condition

A "pre-existing condition" is any condition, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received during the six months preceding the date the employee becomes covered under SHL. No benefits will be payable for any pre-existing condition during the first twelve months of coverage (including any waiting period the employer may have set). A pre-existing limitation will not be applied to any pregnancy.

Credit for Prior Coverage

Credit for periods of coverage under certain types of previous health care plans will be applied toward the twelve-month period in which coverage for pre-existing conditions is not available. Only certain kinds of coverage called "creditable coverage" will be applied toward the twelve-month period. "Creditable coverage" includes coverage by a group health plan or other health benefit plan, Medicaid, Medicare, Indian Health Plan, Federal Employees Health Benefit Plan, Public Services Act Plan, or Peace Corp. In order to have creditable coverage, this prior coverage must have been continuous with a break in coverage no more than 63 days, excluding any time in an employer waiting period.

Certificates of Creditable Coverage **(“Certificates of Group Health Plan Coverage”)**

If an employee had prior health care coverage after 7/1/96, the previous employer or insurance carrier can send SHL a certificate proving coverage. If the employee does not have a copy of the certificate, he or she should contact the previous employer or insurance carrier and request one. SHL must receive a Certificate of Creditable Coverage from the previous plan or other proof of prior coverage in order to apply the prior coverage credit.

Special Enrollment Events

If an employee does not enroll when first eligible for coverage under the health plan, he/she will have a special 30 day period to enroll if any of the following events happen:

- The employee or his/her dependents previously declined coverage due to coverage election elsewhere and that coverage terminated through no action by the employee;
- The employee has changed marital status; or
- The employee has added a dependent because of birth, adoption or placement for adoption.

Late Enrollment

In the absence of one of these Special Enrollment Events, the employee cannot apply for coverage as a Late Enrollee. The employee can enroll in the future if he/she qualifies for coverage due to a Special Enrollment Event or during the plan’s open enrollment period.

Maternity Length of Stay

The plan cannot limit the hospital stay for normal deliveries to less than 48 hours or, for cesarean section deliveries, to less than 96 hours. The insured may choose to discharge from the hospital earlier based on consultation with the physician.

Privacy Notification

The notice describes the privacy practices of Sierra Health and Life Insurance Company, Inc. and any third parties that assist us in the performance of our duties involving the use of insured's Protected Health Information (PHI).

Our Pledge Regarding your Protected Health Information

When we say "Protected Health Information" or "PHI" we mean: information created or received by a health care provider, health plan, or employer that relates to the insured's past, present, or future physical or mental health or condition; the provision of health care to the insured; or the past, present, or future payment for the insured's health care. The information must also identify the insured or be the type that could reasonably be used to identify the insured.

We understand that the insured's PHI is personal. We are committed to protecting that information. The privacy notice applies to all of the PHI we maintain. The insured's personal doctor or health care provider may have different policies or notices regarding his or her use and disclosure of the insured's PHI created in his or her office or clinic.

The privacy notice tells the insured about the ways we may use and disclose their PHI. It also describes our obligations and the insured's rights regarding use and disclosure of their PHI.

We are required by law to:

- make sure that the insured's PHI is kept private;
- give the insured notice of our legal duties and privacy practices with respect to the insured's PHI; and
- follow the terms of the privacy notice for as long as it remains in effect.

Right to a Paper Copy of the Privacy Notice

The insured has the right to a paper copy of the privacy notice. A paper copy is provided to subscribers with their enrollment materials. The insured may ask us to give them a copy of the notice at any time. Even if they have agreed to receive the privacy notice electronically (via e-mail), they are still entitled to a paper copy of the privacy notice.

The insured may obtain a copy of the privacy notice at our **website, www.sierrahealth.com**.

To obtain a paper copy of the privacy notice, please contact Member Services at **(702) 242-7700 or 1-800-888-2264**, Monday through Friday, 8 a.m. to 5 p.m.

Insured Authorization Form

Uses and disclosures of PHI not covered by the Privacy Notice or allowed by the laws that apply to us will be made only with the insured's written authorization.

You may obtain a copy of the insured authorization form at our website www.sierrahealthandlife.com or please contact Member Services at **(702) 242-7700** or **1-800-888-2264**, Monday through Friday, 8 a.m. to 5 p.m.

If the insured provides us with written authorization to use or disclose their PHI, they may revoke that authorization, in writing, at any time. If they revoke their authorization, we will no longer use or disclose their PHI for the reason covered by their written authorization.

The insured understands that we are unable to take back any disclosures we have already made with their authorization and that we are required to keep certain records in our files even if they leave our health plan.

Claims

A. Claims Processing Procedures

Employees choosing coverage through Sierra Health and Life will be required to submit claim forms in certain instances.

In-Plan Provider Claims Submission

When the insured has met their Sierra Health and Life plan calendar year deductible (if applicable), he/she must present an Explanation of Benefits (EOB), which he/she receives from Sierra Health and Life, to the plan provider. The plan provider will then collect only the insured's portion of the copayment or co-insurance (if applicable). If the insured has not met his/her Sierra Health and Life Plan calendar year deductible, the plan provider will collect all charges for the covered services received. In this instance, the insured may need to complete and submit a claim form to Sierra Health and Life of the charges for covered services so that Sierra Health and Life can apply the appropriate charges against the insured's deductible.

Non-Plan Provider Claims Submission

When using non-plan providers, all Sierra Health and Life benefit plans require that a claim form for covered services be completed and submitted to Sierra Health and Life, along with the originals of all bill(s) and/or receipt(s). When using non-plan providers and Sierra Health and Life as the secondary carrier, the same information is required as well as a copy of the primary carrier's Explanation of Benefits. The insured's co-insurance amount will be based on Sierra Health and Life's Eligible Medical Expenses (EME). (Please refer to the Certificate of Coverage.) Additionally, the insured will be responsible for 100% of the charges for covered services exceeding Sierra Health and Life's EME.

Claims Processing

All claims are assigned a number by the system when they are scanned into our imaging system. The claim number identifies the date the claim form was received and is used to retrieve claim information from the claims processing and imaging systems.

All claims are reviewed for the insured's name, identification number, group number and effective date of coverage.

NOTE: All information on the claim form must be completed. This information is necessary for prompt claims processing. If any information is missing, the bill(s)/claim form(s) may be returned to the insured/dependent or to the provider with a request to furnish the required information.

Claim forms should also contain a correct CPT service code, ICD9 Diagnosis codes and complete Provider name and TIN.

Several common situations that may delay the processing of a claim are outlined below:

- Complex/comprehensive surgeries or procedures require a copy of the operative report and/or medical records for proper adjudication.
- If the insured is a new hire or has had less than 12 months of coverage with the employer's prior group carrier and Sierra Health and Life, medical records may be requested from the provider(s) to review for possible pre-existing condition(s).
- If the patient is a dependent of the insured and/or the treatment rendered appears to be accident-related, the claim(s) will be reviewed for possible coordination of benefits with another insurance carrier.
- If services requiring prior authorization by the plan are performed and prior authorization was not obtained, medical records will be required to determine medical necessity of treatment rendered. If the treatment is determined to be medically necessary, benefits will be paid at 50% of what the insured would have received had prior authorization been obtained.
- Incomplete or illegible submission of information

LIFE AND AD&D CLAIMS PROCESS

The employer, broker or beneficiary should notify the Claims Investigation & Recovery (CIR) department within ten (10) days of the date of death of an insured member. Upon notification, the CIR department will forward a letter and/or a claim form to the beneficiary. CIR will need the following information within thirty (30) days of the date the beneficiary received the letter and/or claim form to process the death claim.

- Claim form (completed by employer and beneficiary)
- Certified copy of the death certificate
- Police report (if applicable)
- Accident report (if applicable)
- Attending physician's report (if applicable)
- Other requested forms or information depending on case

The above items will be obtained by the CIR department and are not the responsibility of the broker/agent. Please mail the completed claim form to:

Sierra Health & Life Insurance Company, Inc.
CIR Department
PO Box 15645
Las Vegas, NV 89114-5645

OTHER INFORMATION

Claims are discussed with the beneficiary and/or their guardian only. The beneficiary will be confirmed by a copy of the most recent enrollment card. If a beneficiary has not been designated, an "Affidavit of Preference of Beneficiary" form will be sent to the claimant. If the beneficiary is a minor, proof of parent or guardianship will be required. A birth certificate may also be required. The check will be made payable to the adult guardian.

AD&D CLAIMS

Accidental deaths may require a police report, medical records and/or coroner's report. Benefits for Accidental Death & Dismemberment may require additional processing time. If so, the beneficiary will be notified by letter.

Upon the completion of the claims process, CIR will mail the check to the beneficiary. If you have any questions, please contact the CIR Department at 242-7433.

Billing

A. Monthly Billing

Each month you will receive a premium billing statement from Sierra Health and Life. Forward a copy of the statement and your premium payment to Sierra Health and Life by the due date reflected on your billing statement.

SHL strongly encourages you to pay the billed amount. However, if you choose to adjust your billing payment, please include documentation of your adjustments with your payment.

The monthly statement is separated into six sections:

Section 1. Account Summary

This section identifies invoice #, premium due date, Group Services Contact name and telephone number, the balance forward from prior month, date, check number, amount of payments received, amount of premium due for the current month, amount due for retroactive adjustments, administration fees, and the total amount due.

Section 2. Account Detail

This shows the current and retro charges by category and coverage types (i.e. medical, dental, vision, life, etc.).

Section 3. Subscriber Details

This section contains specific information about each enrolled employee such as: name, subscriber id number, coverage type (single, family, etc.) and amount of premium due for each type of category (i.e. medical, dental, vision, life, etc.).

NOTE: If any member listed in this section has terminated employment, you may have their coverage terminated by listing their last date of employment in the “Term Date” column. Notification of termination must be received within 31 days of the termination date. However, this is the only change SHL will make from the billing. All other changes require the appropriate forms.

Section 4. COBRA Subscriber Detail

This section contains specific information about each enrolled Cobra participant such as: name, subscriber id number, coverage type (single, family, etc.) and amount of premium due for each type of category (i.e. medical, dental, vision, life, etc.).

NOTE: If any member listed in this section has terminated Cobra participation, you may list the termination date of the COBRA in the “Term Date” column. Notification must be received within 31 days of the effective date. However, this is the only change SHL will make from the billing.

Section 5. Retro Adjustment Details

This section identifies changes to a subscriber’s coverage that have been processed since the last statement such as: termination of subscriber, changes in subscriber’s dependent status, and any new subscribers. Each adjustment is identified by subscriber’s name and subscriber id number. The detail includes the effective date of the adjustment and the amount of premium adjustment listed by category.

Section 6. Discretionary Items – Manual billing adjustments which were not reflected within the retroactive adjustment detail

Payment

Each group should remit, on behalf of each subscriber and their dependents, the amounts specified in the subscriber detail section of the monthly bill. Also, any administration fees, retro adjustments and discretionary billing items.

NOTE: Premiums are due on or before the 1st day of coverage, i.e. premium for the coverage month of September are due September 1st. If payment is not received by the end of your contracted grace period, you will be subject to termination of coverage. Only subscribers for whom premiums are received are entitled to receive coverage for covered services.

Medical Services

A. Providers

This section provides important information about Sierra Health and Life's provider network and managed care requirements. If you or your employees have questions regarding this information, please call the Member Services Department.

Selecting a Provider

Sierra Health and Life's plans provide insureds and their dependents with the option of choosing to receive their medical care from either a Sierra Health and Life plan provider or from any licensed health care professional.

Insureds and their dependents may choose a provider from a current Sierra Health and Life provider list. Although they are not required to see the same provider each time they seek care, we encourage each insured to establish a relationship with a specific provider who will become acquainted with his/her medical history and needs.

As you can appreciate, changes occur to the Sierra Health and Life provider list because of additions, registrations, address changes or other changes in practice arrangements which are beyond Sierra Health and Life's control.

NOTE: The insured and/or their dependents are required to confirm the provider's "plan provider" status prior to receiving services. This confirmation can be completed (1) at the time the appointment is made, and (2) at the time services are rendered.

Provider Locations

Sierra Health and Life insureds and their dependents using plan providers have the option of choosing to receive their care from either: (1) a provider who practices at one of the Southwest Medical Associates' offices located in Las Vegas, Green Valley, North Las Vegas or Boulder City, or (2) a Sierra Health and Life "network" plan provider who practices in a private office. The Sierra Health and Life provider list provides names,

addresses and telephone numbers of all contracted plan providers. Sierra Health and Life insureds and their dependents that do not wish to use plan providers may seek services from certain other licensed health care providers.

When hospital care is necessary, the insured and their dependents should ask their physician to make the arrangements at a participating hospital and to contact the Sierra Health and Life Managed Care Services Department.

Making Appointments with Plan Physicians

To schedule an appointment with a Southwest Medical Associates' physician, call the Scheduling line at 877-5199. Appointments with other physicians, whether plan physicians or non-contracted physicians (non-plan physicians), should be made directly with the physician's office.

Keeping appointments is one way to save time. If an insured or their dependents must cancel an appointment, they should call to cancel the appointment as far in advance as possible, but at least 24 hours before the scheduled appointment. If they do not cancel the appointment, they have prevented another patient from seeing the provider.

Same Day Appointments

If an insured or their dependents have a sudden illness, pain, severe coughing, numbness, or other injury or illness requiring attention, they should call their physician. The physician may arrange to see the insured immediately, provide medical information on the phone, or schedule an appointment.

Extended Hours

Many of the Sierra Health and Life's plan physicians have extended hours for the convenience of Sierra Health and Life insureds. Southwest Medical Associates has three Urgent Care offices for the treatment of minor emergencies or acute illnesses. In the event of a non-life-threatening emergency, the insured should call the Urgent Care office for medical instructions for receiving care. Evening and weekend appointments at certain Southwest Medical Associates offices may be arranged by calling the Scheduling line at 877-5199.

B. Specialty Care Referrals and Managed Care Services

Plan specialists (i.e., physicians who practice cardiology, neurology, surgery, etc.) can be found on the Sierra Health and Life provider list. Sierra Health and Life insureds are not required to obtain a referral for office visit consultations with specialist physicians, whether or not the physician or provider is contracted with Sierra Health and Life.

NOTE: If the physician wants to order tests, perform a procedure or start a course of therapy which exceeds \$200, prior authorization is required. Employees should contact the Sierra Health and Life Prior Authorization Department at (702) 242-7345.

Prior Authorization

It is important for insureds to obtain prior authorization for any services other than simple primary care or specialist physician office visits. Services requiring prior authorizations include but are not limited to, the following.

- All mental health and substance abuse visits.
- More than six (6) physical therapy visits for insureds with “Sierra Select” series coverage.
- More than two (2) visits for all outpatient courses of treatment (excluding mental health and substance abuse treatments) for insureds with “Sierra 2000” coverage.

Additional covered services that require prior authorization through the managed care program include, but are not limited to, the following.

- Inpatient admissions - extensions of stay beyond the original certified length of stay
- Outpatient surgery
- Outpatient tests costing more than \$200 (i.e., angiogram, psychological testing, treadmill stress test)
- Outpatient courses of treatment (i.e., allergy testing/treatment, physiotherapy, manual manipulation, radiation therapy and mental health/substance abuse treatment)

NOTE: It is the insured’s responsibility to obtain prior authorization for services. For a more detailed explanation, please refer to Section V, Managed Care Program, of the Certificate of Coverage.

C. Managed Care Services Department (PPO)

One of the ways Sierra Health and Life keeps its commitment to providing quality medical care is through the Managed Care Services Department which coordinates the prior authorization process.

The prior authorization process for approval or denial generally takes 2 business days after receipt of clinical information (obtained by telephone) or receipt of medical records. All emergencies are retrospectively reviewed.

Once the determination is made, the insured is notified as soon as possible by letter (usually within five to seven working days of the prior authorization request date). The letter will include the name of the requested procedure(s) and/or tests and the status of the request

(approved or denied). All denials will contain an explanation of the reason services were denied.

NOTE: The ultimate decision as to whether any care should be received is made between the insured and the physician. Sierra Health and Life is only making a determination as to whether or not the procedure is a covered benefit and will be paid by Sierra Health and Life. The prior authorized treatment must begin within 30 days from the date of the prior authorization approval notice.

All denials may be appealed by the insured through the **Grievance Procedure** discussed in Chapter 11 or, if time is of the essence, directly to the **Medical Affairs Department**.

All questions regarding the prior authorization process for **medical services** should be referred to the Member Services Department.

All questions regarding the prior authorization process for **mental health and substance abuse** services should be referred to Behavioral Healthcare Options.

D. Prescription Drug Coverage

If your benefit package includes coverage for prescription drugs, here are some of the most important things you should know:

- Sierra Health and Life (SHL) uses a Preferred Drug List (PDL) (also known as a Drug Formulary) as a tool to guide providers to prescribe clinically sound and cost-effective drugs. The PDL was established to give our members access to the prescription drugs they need at a reasonable cost.
- The Preferred Drug List is a list of FDA approved generic and brand name medications recommended for use by SHL. The PDL is developed and maintained by the SHL Pharmacy and Therapeutics (P&T) Committee comprised of actively practicing primary care and specialty providers, pharmacists, and other healthcare professionals. Patient needs, scientific data, drug effectiveness, availability of drug alternatives currently on the PDL and cost are all considerations in selecting “preferred” medications. Due to the number of drugs on the market and the continuous introduction of new drugs the PDL is a dynamic and routinely updated document screened regularly to help ensure that it remains a clinically sound tool for our providers.
- Prescription medications included on the SHL PDL are available to members for the applicable preferred generic or preferred brand-name copayment. In addition, covered drugs not listed on our PDL may be available to our members for a higher, non-preferred copayment as identified in the member’s Prescription Drug Benefit Rider or Summary of Benefits.
- Prescriptions must be filled at plan pharmacies.
- SHL offers a mail-order pharmacy program. Prescriptions for preferred maintenance medications may be filled for up to a 90-day supply through the mail-order pharmacy. Maintenance medications are drugs prescribed for certain long-term or life-threatening conditions such as arthritis, high blood pressure, heart conditions and diabetes. Members should refer to their specific plan information for copayments and program details.

- Most of our prescription drug plans include a mandatory generic requirement, therefore, if a brand-name drug is dispensed when a generic equivalent is available, the member is required to pay the difference between the cost of the generic and brand-name drug in addition to the preferred generic (Tier I) copayment.

Coverage Limitations

Covered prescription medications shall be dispensed to the member in **generic** form if:

- the generic has been approved by the Food and Drug Administration (FDA)
- the particular generic substitute has been manufactured by an FDA approved manufacturer
- the generic equivalent has been shown through bio-equivalent studies to be equivalent to the brand name product in terms of bio-availability and therapeutic effectiveness
- the approved generic medication is included in the **preferred drug list**

Limitations

- Certain dispensing or therapeutic limitations may apply (i.e. quantity limitations, number of fill limitations).
- Certain covered drugs may require prior authorization from Sierra Health and Life
- A pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

NOTE: Please refer to the Prescription Drug Rider in the Sierra Health and Life Group Evidence of Coverage for additional information regarding prescription drug coverage and exclusions.

E. Emergency Procedures

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/her health; jeopardy to the health of an unborn child, impairment of bodily function or dysfunction of any bodily organ or part.

Benefits incurred in connection with Emergency Services are subject to any limit shown in the Benefit Schedule. If Emergency Services are required during an emergency as defined within the Sierra Health and Life Certificate of Coverage, all covered services which are medically necessary and appropriate will be paid for within the limit, if any, established in Attachment A Benefit Schedule.

Emergency rooms are best used for treating medical conditions such as:

- Serious burns
- Major trauma
- Poisoning
- Serious breathing difficulties
- Heavy bleeding
- Severe chest pain
- Sudden paralysis
- Loss of consciousness

A **mental health emergency** is defined as: “A situation in which a person with a mental disorder displays behavior that represents a clear and present danger to self or danger to others.”

A **substance abuse emergency** is defined as “A situation in which an intoxicated person with a substance abuse disorder displays behavior that represents a clear and present danger to self or danger to others.”

In an emergency, all covered services that are medically necessary and appropriate will be paid (at the Eligible Medical Expense) for or provided directly within the limit, if any, established in the Attachment A Benefit Schedule.

NOTE: Refer to the Certificate of Coverage for more detailed information regarding emergency services, mental health emergencies and substance abuse emergencies.

Life Threatening Emergencies

- When immediate attention is needed to save an insured’s life, the insured should to go the nearest hospital emergency room *immediately* or dial 911.
- Identify himself/herself to the emergency facility as a Sierra Health and Life insured.
- Notify his/her regular physician or have the emergency room call him/her as soon as possible.

Emergencies that are NOT Life Threatening

Notify his/her regular physician as soon as possible. The insured should then go to a Sierra Health and Life contracted Urgent Care Facility for treatment. No appointment is necessary.

There are several conveniently located urgent care facilities in the Sierra Health and Life network. Please refer to your provider directory for the exact locations. Employees should consider visiting an urgent care facility for medical conditions such as:

- Ear infections, colds and other respiratory problems
- Sprains and strains
- Abdominal pain, vomiting and diarrhea
- Most cuts
- Most burns
- Most fractures
- Back pain
- On-the-job injuries and illnesses

Behavioral Healthcare Options, Inc.

Behavioral Healthcare Options, Inc., (BHO) is a specialized behavioral health care company which focuses on the promotion, easy access, delivery and coordination of mental health and chemical dependency care. BHO is a subsidiary of Sierra Health Services, (SHS). Sierra developed BHO to provide its health plan members with immediate access for behavioral health needs. BHO goal is to provide quality and clinically effective treatment for mental health and chemical dependency needs.

The rising prevalence of alcohol, drug abuse, adult, adolescent and child emotional problems, and other mental health difficulties, has led to the development of managed behavioral health programs. These programs are designed to be proactive in managing appropriate utilization and to work towards effective results in achieving patient well being. Sierra Health & Life has made a commitment to provide specialized attention to this growing need for dedicated behavioral health programs by offering mental health and chemical dependency benefits as a component of its managed care program.

BHO enhances Sierra Health & Life's benefit package by providing specialized attention to mental health and chemical dependency problems. BHO is available 24 hours a day, 365 days a year to help its members *Meet life's challenges when you need us!*

Behavioral Healthcare Options is staffed by trained professionals, including medical doctors who specialize in psychiatry, psychologists, social workers, allied behavioral health and addictions specialists. All of our staff members are committed to the highest quality patient care, collegial relationships with our providers and evidence based outcomes. Staff members work closely with patients to help ensure proper treatment while minimizing disruption in the patient's normal routine, including work and leisure activities. The goal of each Behavioral Healthcare Options professional is to return the patient to normal functioning as quickly as possible in the most effective and clinically appropriate manner.

Employee Assistance Program

You may choose to purchase an Employee Assistance Program, (EAP) for your employees at any time. An EAP program is a short term counseling service designed to help employees and their families work through personal problems. The program encourages early use - when members first notice a problem and their own efforts to resolve it have not been satisfactory. When members are helped with a personal problem, their home life improves, work improves and everyone benefits. An EAP program provides mental health and chemical dependency related services as well as assessment and referral to other community based programs and services including; financial, legal, elder and child care resources.

Who is eligible?

The Employee Assistance Program (EAP) is available to all employees, as well as immediate family members. Family members are included because their problems often affect the health and wellbeing of the employee.

What does the EAP do?

The EAP helps find solutions to personal problems. **Available 24-hours a day, 7-days a week** - EAP has the resources to deal with a variety of problems, including:

- Emotional/Personal Conflicts
- Grief and Loss
- Anxiety/Depression
- Financial Problems
- Legal Problems
- Questions About Alcohol/Drug Use
- Marital Conflicts
- Parenting
- Family Blending
- Gambling Problems
- Work Performance Issues
- Managing Stress and Change

THE LIFE CONNECTION PROGRAM (TLC)

"THE LIFE CONNECTION (TLC) PROGRAM" integrates four components: a comprehensive EAP, written information and resource modules, telephonic access to professional advisors and a training and wellness component.

The Life Connection (TLC) integrates services that far exceed those offered by a standard EAP. Based upon years of experience with clients and families, BHO provides one of the industry's most comprehensive approaches to enable employees and their household members to deal with the conflicting demands and questions they face without missing valuable time from work.

TLC is comprised of four components, which include:

EAP COMPONENT:

Eligible employees and their household members can access free face-to-face visits with an EAP counselor by calling the local or toll free telephone numbers listed on their wallet card (provided upon enrollment in the program). Counseling sessions are provided at convenient times and locations, and crisis services are available 24 hours a day, 7 days a week. Information shared with the EAP counselor is confidential and is only released upon the written request of the employee.

INFORMATION AND RESOURCE MODULES COMPONENT:

BHO has developed written materials in a variety of life areas, based upon years of experience with our EAP clients and their family members' needs. The materials are grouped into six life areas, or "modules," and there are many topics within each module. Each topic contains general information and practical advice on the subject as well as a resource section which provides national "800" numbers, printed materials (low/no cost brochures, pamphlets and books), local resources and web sites for further information. The information is mailed to the member and, with prior permission, a follow up call is made within ten days to see if additional information or other services are needed.

TELEPHONIC CONSULTATION COMPONENT:

Employees and their household members may request telephonic access to professionals in the following areas:

Legal Consultation:

Licensed/certified attorneys are available to answer legal questions, or you may be referred to carefully screened local attorneys.

Financial Consultation:

Financial advisors are available for assistance in areas such as personal financial planning, debt counseling, investments or tax consultation.

Elder Care:

Professionals will assist with referrals to licensed elder care facilities or various types of in-home or agency care for aging family members.

Child Care:

Professionals will assist with referrals to licensed childcare facilities.

TRAINING AND WELLNESS COMPONENT:

BHO's integrated approach to employers includes employee orientations (on-site and via videotape), supervisory training and "Lunch 'n Learn" workshops on more than 40 wellness topics. TLC also provides newsletter articles, flyers and paycheck stuffers to promote program visibility throughout the year.

To arrange for a private and confidential appointment employees should call, **call (702) 364-1484 or 1-800-873-2246**. Their call will be returned as soon as possible. After hours calls are monitored by an answering service. In a crisis situation, professional therapists are available on a 24-hour basis by calling the same telephone number.

Our website address is www.behavioralhealthcareoptions.com. Please take a moment to look at the full compliment of services and quality driven care that BHO provides. Members can learn about their Sierra Health & Life mental health and chemical dependency benefits, EAP/TLC programs and how to access services from the privacy and convenience of their choosing.

Health Education and Wellness

Chapter

7

Good health is an ongoing process that begins with prevention. At the Health Education & Wellness Division, we offer a variety of programs that focus on preventive health care, as well as improving the quality of life for those diagnosed with health problems like diabetes, asthma or high blood pressure. The programs are offered through the Health Education & Wellness Center at diverse locations and times. Programs are also delivered to your employees at your place of work. Combined expertise of the Health Education & Wellness staff include certified health educators, registered dietitians, certified diabetes educator, Bachelor's, Master's and Ph.D. degrees. All are committed to providing your employees with the skills they need for lifelong wellness. Classes and one-on-one consultations are available. Please call the Health Education & Wellness Division at (702) 877-5356 for additional information. Programs and services are available on the following health topics:

Arthritis

Within Your Grasp

Asthma – Adult & Childhood

Blueprint for Breathing

One Small Breath at a Time

Back Care

Back to Back

Carpal Tunnel Syndrome

Wrist Watch

Cholesterol Reduction

Take It To Heart

Chronic Obstructive Pulmonary Disease

Your Second Wind

Congestive Heart Failure

The Heart of the Matter

Diabetes

The Balancing Act

Advanced Diabetes

A Refresher

Hypertension

Lowering Blood Pressure

Nutrition & Fitness

Fit for Life

Pregnancy

Healthy Expectations

Stop Smoking

The Puff Stops Here

Stress Management

Tension Tamers

Weight Management -

Adults & Children/Young Adults

Lean on Me

Camp LEAN

Women's Issues (Age 50+)

Staying Strong

NOTE: Each of our wellness programs will charge a nominal materials fee which will cover the cost of the course curriculum and information distributed at the class.

Statistics

- Course curricula and workbooks are written and developed in-house and reviewed annually.
- There is an average of 1,000 to 1,100 patient contacts per month.
- There is an average of 800-1,000 provider referrals a month (not including targeted member interventions).

Special Services

All health education programs and special services are available to employer and community groups at our education center or at the work site. For more information on these services, please call 877-5356.

- **Lunch and Learn Workshops** offer a brief and often fun look at the most popular prevention and disease management topics. Workshops can be held at our education center or on-site for employer and community groups. The Health Education & Wellness Division also provides **Train the Trainer Courses** for employers who have an on-site staff person available to facilitate programs.
- **Needs Assessments/Consulting Services** are available from the Health Education & Wellness staff for employer groups seeking to implement health promotion/wellness activities at their worksite. Programs can be customized to meet the overall objectives of employers. Outcome measurements will be developed for program planning, implementation and evaluation.

NOTE: For Northern Nevada members, onsite employer based programs are available on a fee for service basis. Fees charged to employer groups are at a per participation or flat fee rate. Clinic or community based programs are not available in the Northern Nevada.

5 Las Vegas Locations

Health Education & Wellness – Main Campus
900 South Rancho Drive, First Floor
Las Vegas, NV 89106
(702) 877-5356
*Full-time Health Educator

South Eastern Clinic
4475 South Eastern Avenue
Las Vegas, NV 89119
*Full-time Health Educator

Nellis Clinic
650 North Nellis Boulevard
Las Vegas, NV 89110
*Part-time Health Educator

North Tenaya Clinic
2704 North Tenaya Way
Las Vegas, NV 89128
*Full-time Health Educator

Green Valley Clinic
2651 North Green Valley Parkway
Henderson, NV 89014
*Part-time Health Educator

Retiree Coverage

Health Plan of Nevada offers a group retiree program for Medicare-eligible retirees over the age of 65. The program is called *Senior Dimensions' Retiree Choice or Retiree Choice Plus*. Senior Dimensions is Health Plan of Nevada's Medicare "Risk-Contract" plan.

Health Plan of Nevada was granted this contract by the federal government because it satisfied strict federal requirements regarding its financial stability, provider relationships and health care delivery systems. Under this contract, the government pays Health Plan of Nevada a fixed monthly amount for each Medicare member enrolled in the program. Senior Dimensions' members enjoy comprehensive medical benefits with minimal out-of-pocket expense. There are no claim forms and members agree to receive all medical care (except emergency care worldwide or urgently needed care while temporarily away from the service area) through Health Plan of Nevada's network of providers.

Employer Qualifications

The group Senior Dimensions program is available to employers with 20 or more employees.

Dependent Coverage

Benefits for non-Medicare eligible dependents of retired employees enrolled in Senior Dimensions will be provided by the employer. The retired employee's Medicare-eligible dependents will receive benefits through Senior Dimensions *Retiree Choice or Retiree Choice Plus*.

Renewing Coverage

Due to Medicare regulations, Senior Dimensions *Retiree Choice or Retiree Choice Plus* benefits and premiums will change each January 1st.

Monthly Billing

The Group Services Department will provide a monthly premium bill for Senior Dimensions participants. This is a two-part form. The original (Part 1) of the bill is for your records. The second part of the bill (including any corrections) and your premium payment must be remitted by the first of the month. The Senior Dimensions *Retiree Choice* and *Retiree Choice Plus* bill contain three sections and are identical to the Health Plan of Nevada premium bill, except for the termination process.

Eligibility

In order to be eligible for Senior Dimensions *Retiree Choice* or *Retiree Choice Plus*, the applicant.

- must be retired and non-working
- must reside inside the Health Plan of Nevada service area
- must have Medicare Parts A and B
- must *not* have had a kidney transplant within the last 36 months
- cannot be outside the service area for more than 90 consecutive days

Enrollment Guidelines

The enrollment process for Senior Dimensions *Retiree Choice* or *Retiree Choice Plus* takes approximately 45 to 60 days due to coordination with the Federal Medicare Program. Applicants should continue any current medical coverage until notified of their approval for group retiree coverage.

Enrollment procedures for Senior Dimensions *Retiree Choice* or *Retiree Choice Plus* are as follows:

1. The employer is required to submit a completed Senior Dimensions application and a copy of their Medicare card to Health Plan of Nevada's Senior Dimensions sales office for each eligible retired employee enrolling in the program and any applicable dependents who are Medicare-eligible.
2. Upon receipt of the application, Health Plan of Nevada will verify that the retired employee is eligible.
3. Once eligibility is verified, Health Plan of Nevada will notify the beneficiary and employer that Health Plan of Nevada has accepted the application. Health Plan of Nevada then forwards the information to the Federal Medicare program.
4. Health Plan of Nevada will notify the applicant of acceptance, in writing, including the Medicare approved effective date.

Individual Conversion

Eligibility

Subject to the additional eligibility requirements below, only certain insureds that have been enrolled under the Certificate of Coverage will have the right to convert to the applicable non-group health care program available at the time of application without having to furnish Evidence of Insurability as follows:

Those Eligible

- Employees and their covered family members leaving a group
- Employees who would otherwise cease to be eligible for Sierra Health and Life group membership due to ineligibility

NOTE: The benefits provided by conversion will not be as comprehensive as the benefits offered by the group health plan.

Those Not Eligible

- Employees whose Group Enrollment Agreement is discontinued in its entirety or with respect to an insured class (except for groups terminated for non-payment of premium)
- Employees whose group replaced the Certificate of Coverage with another insured or self-insured health care program within 31 days after termination of the Group Enrollment Agreement

NOTE: An employee must apply for conversion and pay any applicable premiums within 31 days of the date of ineligibility for the group plan.

Election

If a terminated insured wishes to elect Individual Conversion, please have the member contact our Individual Conversion department by calling (702) 562-8022.

Sierra Health and Life will send them an informational letter on our Individual Conversion plans with the monthly premium amount for each plan option.

Requirements

When insureds elect Individual Conversion, they are required to:

- Complete and submit an enrollment application, plus two months of premium, to Sierra Health and Life within 31 days of their group coverage termination
- Have had continuous coverage with Sierra Health and Life under a group plan

NOTE: In order to terminate an insured from Sierra Health and Life group coverage, a Membership Change Form must be completed and submitted to Sierra Health and Life within 31 days of the date of termination. Sierra Health and Life does not consider eliminating the insured from your bill without appropriate notice of termination. A membership change form must be submitted.

Grievance Procedures

To receive the full benefits of Sierra Health and Life, we suggest each of your employees know their rights and try to meet their responsibilities as active participants in the grievance process.

Insured's Rights

- To be treated with respect and dignity and every effort will be made to protect their privacy.
- To select a physician from Sierra Health and Life provider list.
- To be provided the opportunity to voice complaints or appeals about the plan and/or the care provided.
- To receive information about the plan, its services, its providers and insureds' rights and responsibilities.
- To participate with their physician in the decision making process regarding their health care.
- To receive quality health care.
- To have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of the cost or benefit coverage.

Insured's Responsibilities

- To provide, to the extent possible, information that Sierra Health and Life and its providers need in order to provide the best care possible.
- To follow the health care plan that they, their physician and Sierra Health and Life have agreed upon.
- To consult their physician and Sierra Health and Life before seeking non-emergency care in the service area. We urge insureds to consult their physicians and Sierra Health and Life when receiving urgently needed care while temporarily outside the service area.
- To obtain prior authorization from Sierra Health and Life and their physician for any routine or elective surgery, hospitalization or diagnostic procedures.
- To be on time for appointments and call, when possible, 24 hours in advance to cancel any appointments they cannot keep.

- To pay all applicable copayments at the time of service.
- To know how Sierra Health and Life Managed Care Program operates.

Sierra Health and Life encourages insureds to communicate any problems and concerns they may have about the plan and/or the delivery of health care by plan providers. Insureds can express their concern through a telephone call, written complaint, or walk-in visit to Member Services. If dissatisfied with the solution or answer received, he/she should then forward a formal complaint, in writing, for review. If the insured is still dissatisfied, the Grievance Committee will review the complaint.

Appeals Process

This section tells you what your employees should do when they have a complaint that they believe has not been resolved.

Verbal or Written Complaint

Every insured has the right to file a verbal or written complaint. Complaints should be filed within 60 days from the date the insured is notified of a denial of benefits or the date of the event giving rise to the complaint. Upon receipt of the written complaint, Sierra Health and Life immediately makes an administrative investigation of the insured's complaint and attempts to resolve the complaint informally through the reconsideration process. All complaints by insureds concerning adequacy or competency of a physician's services are referred to the Medical Director for quality assurance review.

Grievance Committee

If the complaint is not resolved through the reconsideration process to the satisfaction of the insured, then the insured may submit the complaint to Sierra Health and Life's Grievance Committee. The Grievance Committee will schedule a hearing on the complaint at one of the regularly scheduled Grievance Committee meetings. At the close of the hearing, the Grievance Committee will make findings and issue a written decision within 10 working days.

Board of Directors Hearing

If the insured does not accept the written decision of the Grievance Committee, they may submit a request to the Sierra Health and Life Board of Directors for a hearing. The insured's written request must be received by Sierra Health and Life within ten days of the insured's receipt of the Grievance Committee's written decision. The Board of Directors will review the documented history of the complaint and make its decision based on the file submitted. The Board of Directors may request the insured to attend the hearing in order to obtain additional information. The Board of Directors will respond to the insured within 10 working days of the meeting.

Arbitration

In the event the insured is dissatisfied with the findings and rulings of the Sierra Health and Life Board of Directors, or if Sierra Health and Life is dissatisfied with the decision of the Grievance Committee, either the insured or Sierra Health and Life has the right to have the dispute submitted to binding arbitration before an arbitrator under the commercial arbitration rules then in effect, adopted and applied by the American Arbitration Association. The arbitrator shall be selected by mutual agreement of Sierra Health and Life and the insured. The cost and expense of arbitration will be paid by the party initiating the demand for arbitration. The decision of the arbitrator will be binding upon the insured and Sierra Health and Life and the arbitrator's ruling will be enforceable pursuant to state law.

Complaint Procedure Limitation

Insured's will be bound by the complaint procedure outlined in Section XV of the Certificate of Coverage prior to instituting any claim in any court.

We hope this information has been helpful and answers any questions you may have. Please contact your Sales Representatives at 821-2200 if you have other questions.