

SIERRA HEALTH AND LIFE INSURANCE COMPANY (SHL)

# An Administrator's Guide to SHL Benefits



SIERRA HEALTH AND LIFE  
A UnitedHealthcare Company

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

# Table of Contents

Introduction	3
Chapter 1 Telephone Reference	4-5
Chapter 2 Enrollment	6-14
Chapter 3 Claims	15-17
Chapter 4 Billing	18-19
Chapter 5 Medical Services	20-27
Chapter 6 Behavioral Healthcare Options	28-31
Chapter 7 Health Education and Wellness	32-37
Chapter 8 Retiree Coverage	38-39
Chapter 9 Individual Conversion	40-41
Chapter 10 Appeals Procedures	42-44

Information in this document is presented in summary form for convenience purposes only. When determining cost, access or eligibility of benefits, consult the relevant Certificate 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, Inc. (SHL) is a health and life insurance company that provides group insurance products to our customers in 43 states and Washington, D.C.

We have provided employer groups with quality health care benefits for more than 20 years. We integrate efficiency, flexibility, affordability and quality in all of our health insurance products, making us a good choice for your comprehensive health care 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 health care partner.

Sincerely,



Don Giancursio  
President  
Sierra Health and Life

# Chapter 1

## Telephone Reference

If you have questions regarding...	Contact this department	Telephone Number
Your bill	Group Services	(702) 242-7575 (800) 274-1573 Monday - Friday 8:00 a.m. - 5:00 p.m.
New enrollments, terminations, enrollment changes, documentation requests, HIPAA and COBRA	Group Services	(702) 242-7575 (800) 274-1573 Monday - Friday 8:00 a.m. - 5:00 p.m.
Prior authorization for medical services	Member Services	(702) 242-7700 (800) 888-2264
Prior authorization for 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  24-hour Telephone Advice Nurse Service	(702) 877-5199  (702) 242-7330 (800) 288-2264
Health education and wellness programs	Health Education and Wellness	(702) 877-5356 Monday - Friday 8:00 a.m. - 5:00 p.m.
Member questions	Member Services	(702) 242-7700 (800) 888-2264 Monday - Friday 8:00 a.m. - 5:00 p.m.

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

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

Please mail *Billing Statements and Premium Payments* to:

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

# Chapter 2

## Enrollment

### A. Eligibility

#### Who is eligible?

For purposes of this document, insured refers to employees, subscribers and their enrolled dependents.

#### Employees - To be eligible to enroll you must:

- Meet the guidelines established in the Certificate of Coverage (CoC) and Group Enrollment Agreement (GEA); and
- Complete and submit to Sierra Health and Life (SHL) such applications, forms or medical statements that SHL 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 subscriber and meet the guidelines established in the CoC and GEA.

### B. Changes in Eligibility Status

It is the subscriber's responsibility to give SHL written notice within 31 days of any changes which will affect their eligibility, or that of their dependents, on a SHL Membership Change Form. Changes include:

- Reaching the limiting age
- Ceasing to be a full-time student
- Ceasing to satisfy the handicap requirements
- Death
- Divorce
- Marriage
- Transfer of residence or work outside the Service Area
- Or any other event which affects a Dependent's eligibility

If subscriber fails to give notice, which would have resulted in termination of coverage, SHL shall have the right to terminate coverage retroactively and refund any corresponding premium.

### **Special Documentation**

Special documentation (i.e., birth certificates, marriage certificate) may be required in certain situations. All special documentation should be submitted to SHL with the required Enrollment Application or Membership Change Form. SHL special documentation guidelines are outlined below.

### **Birth Certificate**

SHL may request a certified copy of a birth certificate or other appropriate information if:

- The newborn's mother is not a SHL 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 SHL may contend are reasonable to require proof of eligibility.

### **Legal Guardianship, Adoption, Placement for Adoption**

In all instances, SHL will request a copy of court appointed 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, SHL 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 SHL with a completed Membership Change Form and a copy of his/her certified marriage certificate within 31 days of the marriage.

### **Full-Time Student**

Once a dependent reaches the applicable limiting age, proof of full-time student status is required to maintain coverage. SHL will accept verification from the Office of the Registrar at the dependent's school. (Proof will be a one time request.)

### 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 CoC except that an additional 10 days is provided for the enrollment of newly born children.

**Initial Enrollment Period** - An initial enrollment period is the period of time during which an eligible individual may enroll under the CoC, 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 CoC without giving evidence of good health.

**Special Enrollment Event** - A special enrollment event allows a special enrollee to enroll for coverage under the CoC. Special enrollment events include but are not limited to:

- 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. Please refer to the CoC for a complete list of special enrollment events.

### D. Enrollment Application Process

SHL 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 insured, 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 SHL within 31 days of the qualifying event.

## E. Plan Benefit Information and Membership Card

Each employee and their dependent(s) enrolling in SHL 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 employee 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 (800) 888-2264.

## F. Membership Change Form

A SHL 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)

NOTE: For all new dependents, a Membership Change Form must be signed by the subscriber and returned along with all required documentation to the employer or SHL. The Membership Change Form and required documentation must be submitted to SHL 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). Please refer to the CoC for additional information on COBRA administration.

NOTE: For all new subscribers 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 SHL.

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

NOTE: It is your responsibility as the employer to provide written notification to employees and dependents affected by this law. Once a qualifying COBRA event occurs, an employer has 14 days to notify the insured of their continuation rights. Once the notification has been given, the insured has 60 days from the date of postmark of employer's written notification to elect to continue coverage.

### Instructions for Submitting COBRA Documentation

- Submit a completed Membership Change Form to SHL'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 SHL 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 SHL with the necessary documentation within the time frame identified in the COBRA regulations will result in no coverage under SHL.

Please refer to the CoC for additional information on State Continuation of 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 subscriber has 60 days from the qualifying date to elect State Continuation coverage. All premiums must be paid up to date at the time of election of State Continuation coverage.

### Instructions for Enrolling an Employee in State Continuation

- Submit a completed Membership Change Form to SHL Group Services terminating the employee or dependent from regular group coverage.
- Submit a new, completed SHL Enrollment Application to Group Services. Please mark "State Continuation" in red ink at the top of the application.
- Submit the monthly premium payment to SHL.

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

Federal and state governments have 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: 1.) the date the employee becomes covered under SHL, or 2.) the first day of the waiting period. 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 condition limitation will not be applied to any pregnancy, complications of pregnancy, newborns or newly adopted children.

### **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. For a complete list of the types of coverage considered to be “creditable coverage” please refer to CoC.

### **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 31 day period to enroll upon the occurrence of a Special Enrollment Event as defined in the CoC.

### **Late Enrollment**

In the absence of a Special Enrollment Event, the employee cannot apply for coverage as a Late Enrollee. The employee or any eligible dependents 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.

### **Privacy Notification**

This notice describes the privacy practices of SHL 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.sierrahealthandlife.com](http://www.sierrahealthandlife.com).

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

## **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](http://www.sierrahealthandlife.com) or please contact Member Services at (800) 888-2264, Monday through Friday, 8 a.m. to 5 p.m. PST.

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.

# Chapter 3

## Claims

### A. Claims Processing Procedures

Employees choosing coverage through SHL will be required to submit claim forms in certain instances.

#### **In-Plan Provider Claims Submission**

When the insured has met their SHL plan calendar year deductible (if applicable), he/she must present an Explanation of Benefits (EOB), which he/she receives from SHL, to the plan provider. The plan provider will then collect only the insured's portion of the copayment or coinsurance (if applicable). If the insured has not met his/her SHL 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 SHL of the charges for covered services so that SHL can apply the appropriate charges against the insured's deductible.

#### **Non-Plan Provider Claims Submission**

When using non-plan providers, all SHL benefit plans require that a claim form for covered services be completed and submitted to SHL, along with the originals of all bill(s) and/or receipt(s). When using non-plan providers and SHL is the secondary carrier, the same information is required as well as a copy of the primary carrier's Explanation of Benefits. The insured's coinsurance amount will be based on SHL'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 SHL'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 SHL, medical records may be requested from the provider(s) to review for possible pre-existing condition(s).
- If the patient is the insured's dependent 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 obtained without the required prior authorization, then 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 Accidental Death and Dismemberment (AD&D) Claims Process**

The employer, broker or beneficiary should notify the Claims Investigation & Recovery (CIR) department within 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 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 and Life Insurance Company, Inc.  
Attn: 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 Member Services Department at (702) 242-7700.

# Chapter 4

## Billing

### A. Monthly Billing

Each month you will receive a premium billing statement from SHL. Forward a copy of the statement and your premium payment to SHL 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 1<sup>st</sup> day of coverage, i.e. premiums for the coverage month of September are due September 1<sup>st</sup>. 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.

# Chapter 5

## Medical Services

### A. Member Services

The Member Services Department has a staff of representatives who can assist you with questions about your health plan benefits and with the following:

- Eligibility
- Copayment amounts
- ID card questions or requests
- Check status of a claim
- Prior authorization status
- Verification of prescription drug coverage
- Find out how much has been paid toward your calendar-year deductible

The Member Services Department can be reached at (800) 888-2264 or (702) 242-7700, Monday - Friday, 8:00 am - 5:00 pm PST.

These services are also available through our website 24 hours a day, 7 days a week at [www.sierrahealthandlife.com](http://www.sierrahealthandlife.com) by clicking on "Current Customers" or "Employers" and entering SHL@YourService, our online member center.

### B. Providers

This section provides important information about SHL'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

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

Insureds and their dependents may choose a provider from a current SHL 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.

Changes can occur to the SHL provider list to accommodate additions, registrations, address changes or other changes in practice arrangements which are beyond SHL'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**

SHL 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 throughout the Las Vegas Valley, or 2) a SHL "network" plan provider who practices in a private office. The SHL provider list provides names, addresses and telephone numbers of all contracted plan providers. SHL insureds and their dependents that do not wish to use plan providers may seek services from certain other licensed health care providers.

When elective 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 SHL Managed Care Services Department.

### **Making Appointments with Plan Physicians**

To schedule an appointment with a Southwest Medical Associates' provider, call the scheduling line at (702) 877-5199. Appointments with other providers, whether plan providers or non-contracted providers (non-plan providers), should be made directly with the provider'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 may be charged for the missed appointment.

### **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 provider. The provider may arrange to see the insured immediately, provide medical information on the phone, or schedule an appointment.

### **Extended Hours**

Many of the SHL's plan providers have extended hours for the convenience of SHL's insureds. Southwest Medical Associates has five urgent care locations for the treatment of urgent conditions. Evening and weekend appointments at certain Southwest Medical Associates offices may be arranged by calling the scheduling line at (702) 877-5199.

### **C. Specialty Care Referrals and Managed Care Services**

Plan specialists (i.e., physicians who practice cardiology, neurology, surgery, etc.) can be found on the SHL provider list. SHL 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 SHL.

NOTE: If the physician wants to order tests, perform a procedure or start a course of therapy which exceeds \$200, prior authorization is required. The insured should contact the SHL Member Services Department at (702) 242-7700 to check on the status of a prior authorization.

### **Prior Authorization**

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

- All mental health and substance abuse visits.
- More than six physical therapy visits for insureds with "Sierra Select" series coverage.
- More than two 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.

#### D. Managed Care Services Department (PPO)

One of the ways SHL 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 two 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 provider. SHL is only making a determination as to whether or not the procedure is a covered benefit and will be paid by SHL. 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.

## E. Prescription Drug Coverage

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

- 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 insureds access to the prescription drugs they need at a reasonable cost.
- The PDL 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 health care 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 insureds for the applicable preferred generic or preferred brand name copayment. In addition, covered drugs not listed on our PDL may be available to our insureds for a higher, non-preferred copayment as identified in the insured’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. Insureds 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 insured 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 insured 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 PDL

### Limitations

- Certain dispensing or therapeutic limitations may apply (i.e. quantity limitations, number of fill limitations).
- Certain covered drugs may require prior authorization from SHL
- 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 SHL Group Certificate of Coverage for additional information regarding prescription drug coverage and exclusions.

### F. Emergency Procedures

Emergency Services means covered services provided for a true emergency medical condition when the sudden onset of symptoms is severe enough that a person could reasonably expect serious danger to his/her health.

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 SHL 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

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 go to the nearest hospital emergency room *immediately* or dial 911.
- Identify himself/herself to the emergency facility as a SHL insured.
- Notify his/her regular provider or have the emergency room call him/her as soon as possible.

### Emergencies that are NOT Life Threatening

Notify his/her regular provider as soon as possible. The insured should then go to a SHL contracted urgent care facility for treatment. No appointment is necessary.

There are several conveniently located urgent care facilities in the SHL 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

## Chapter 6

### Behavioral Healthcare Options (BHO)

Behavioral Healthcare Options, Inc., (BHO) is a specialized behavioral health care company which focuses on the promotion, delivery and coordination of mental health, chemical dependency and employee assistance programs. BHO is structured to provide its health plan members with appropriate access for all behavioral health needs. BHO's goal is to provide quality and clinically effective treatment in the most appropriate clinical setting.

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, such as BHO's. These programs are designed to be proactive in managing appropriate utilization and to work towards effective results and quality outcomes in achieving patient well being. BHO has made a commitment to provide specialized attention to this growing need for behavioral health programs by offering mental health, chemical dependency and employee assistance program benefits as a component of its managed care program.

BHO enhances SHL's benefit package by providing specialized attention to mental health and chemical dependency issues, not only at home, but at the job site. BHO is available 24 hours a day, 7 days a week.

BHO has the largest, most comprehensive behavioral health care network in Nevada and has affiliate providers throughout the U.S. Our provider network is staffed by licensed, trained professionals including psychiatrists, psychologists, social workers and masters prepared therapists, 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 BHO professional is to return the patient to normal functioning as quickly as possible in the most effective and clinically appropriate manner.

## **Employee Assistance Programs**

You may choose to purchase an Employee Assistance Program (EAP) for your employees at any time. An EAP program is a short term assessment, referral and brief 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 provided appropriate assistance to deal with personal problems, their home life improves, work improves and everyone benefits. An EAP program provides problem identification and solution focused 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 EAP is available to all employees, as well as immediate family members. Family members are included because their problems often affect the health and well-being 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

In addition, BHO's EAP program affords access to BHO's interactive website where employees and family members may log on to access resources that are tailored to specific life needs. The website provides clients with the right tools to help them through some of life's toughest challenges.

Employees and family members can access the user-friendly website through BHO's portal or via direct link from the employer group website. The content

includes articles, self-help questionnaires, interactive tools and additional resources in several key contact areas. All of the 2,000+ behavioral health articles are reviewed by Harvard physicians; there are 450+ financial articles, including 150 interactive tools. Legal information is provided by Nolo, offering self-help information to clients for everyday legal matters for over 30 years. Finally, there are over 300 articles regarding worksite issues (including such topics as effective communication with employees/supervisors, listening skills and communication styles). Whether employees and their families are interested in managing their time more wisely, getting help with a legal issue, or learning new stress management skills, BHO's website has the information they need.

### **The Life Connection (TLC) Program**

The Life Connection (TLC) Program integrates four components: a comprehensive EAP, 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 have 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/Website Component**

Employees and their families can access legal, financial, self-help and behavioral health information via our interactive website, which can be made available through BHO's portal, [www.bhoptions.com](http://www.bhoptions.com) or via your Intranet site.

## 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 child care 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 (702) 364-1484 or (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.bhoptions.com](http://www.bhoptions.com). Please take a moment to look at the full range of services and quality driven care that BHO provides. Additionally, BHO can provide temporary access to all interactive components of our website upon request. Members can learn about their SHL mental health and chemical dependency benefits, EAP/TLC programs, and how to access services from BHO.

We look forward to serving you.

# Chapter 7

## Health Education and Wellness (HEW)

Our Health Education and Wellness (HEW) Division offers 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 HEW at the Southwest Medical Associates (SMA) clinics at diverse locations and times and can also be delivered to your employees at your place of work. Combined expertise of the HEW staff includes certified health education specialists, registered dietitians, certified diabetes educator, Bachelor's and Master's 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 HEW Division at (702) 877-5356 for additional information. Programs and services are available on the following health topics:

### **Asthma**

- Toddler/Caregiver - ages 1-4
- Child/Caregiver - ages 5-15
- Adult - ages 18 and up

### **Chronic Obstructive Pulmonary Disease (COPD)**

### **Diabetes**

- Insulin Startup/Management
- Meter Training
- New Onset

### **Heart Failure**

### **Heart Health**

- (Cholesterol, Blood Pressure, Triglycerides)

### **Lifestyle Management**

### **Medical Nutrition**

- Hypoglycemia
- Renal Diet
- Specific Issues (as directed by provider)

### **Nutrition and Fitness**

### **Pregnancy**

### **Preventive Healthcare**

### **Senior Health**

### **Tobacco Cessation Program\***

### **Weight Management**

- Bariatric
- Adult - ages 18 and up

### **Healthy Nutrition**

- Toddler Nutrition - ages 2-6
- Child - ages 7-13
- Teen - ages 14-17

### **Women's Health**

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

**Las Vegas Locations**

*To schedule an appointment, please call (702) 877-5356.*

Rancho/Charleston Clinic 2300 W. Charleston Blvd Las Vegas, NV 89106	North Tenaya Clinic 2704 North Tenaya Way Las Vegas, NV 89128	West Flamingo Clinic 6330 West Flamingo Road Las Vegas, NV 89103
South Eastern Clinic 4475 South Eastern Ave Las Vegas, NV 89119	Centennial Hills Clinic 7061 Grand Montecito Pkwy Las Vegas, NV 89149	
Nellis Clinic 650 North Nellis Boulevard Las Vegas, NV 89110	Siena Heights Clinic 2845 Siena Heights Henderson, NV 89052	

**New Offerings from HEW**

**Online Learning**

Online learning is a computer-based, step-by-step program to help manage your health concerns.

The *Online Learning Modules* include the following topics:

- Living with diabetes
- Keeping your heart healthy
- Great expectations - pregnancy and beyond
- Taking care of yourself - preventive healthcare
- Kick the habit - stop smoking
- Meeting your weight loss goals.

There is also a personal Health Risk Assessment (HRA) available online. The HRA can be your first step on the road to better health. It is designed to help you identify and prioritize your health and wellness goals. After completing the HRA, a profile will be generated automatically for you to print. The profile provides the following information:

- Your personal health risk factors
- Health and screening recommendations
- Programs and services that meet your needs.

## Spanish Language Classes

Spanish language classes are available for diabetes, heart health, weight management and pregnancy. Spanish language consultations are available for all topics.

## Scheduling Information

HEW 877-5356

## Worksite Wellness Program

Below are components/options for a Managed Health & Wellness Program. This is a brief explanation of each component; however, more detail and pricing for each component can be given upon further interest in our program.

### Option 1: Needs Assessments

Employee needs assessments and/or interest surveys are an important part of any health and wellness program. Our HEW team will provide these assessments and surveys. Needs Assessments can be developed to target medical costs, disease management areas, employee health interests, etc. Please note that an initial needs assessment is crucial for a HEW Program in order to benchmark outcome measures and to drive utilization.

### Option 2: Health Education Programs

Following is a list of Disease Management and Health Promotion Programs that can be delivered on-site to your employees in both a classroom setting or in one-on-one consultations.

- Arthritis
- Asthma (Toddler, Child, Adult)
- Back Care
- Carpal Tunnel Syndrome
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Fitness
- Heart Failure
- Heart Health
- Hypertension
- Lifestyle Management
- Nutrition & Fitness
- Pregnancy
- Preventive Healthcare
- Smoking Cessation
- Stress Management
- Weight Management Adults (ages 18+)
- Healthy Nutrition for Teens, Child, and Toddler
- Women's Health

NOTE: Programs can be customized to meet the overall objectives of your employees.

### **Option 3: Full time health educator(s) on site**

Our health education team is comprised of Certified Health Education Specialists, Registered Dietitians, and Certified Diabetes Educators who are dedicated to teaching the skills needed for lifelong health by focusing on both preventive care and the management of existing health concerns. The Health Educators hold Bachelor's and Master's level degrees. In addition, HEW is supervised by a Medical Director-Educator who is board certified in Preventive Medicine, Pediatrics, holds a Master's Degree in Public Health and more than 25 years of university teaching. Currently we employ health educators who work onsite in our Southwest Medical Associates clinics. They interact daily with our providers and our members. We would propose this same concept for a Health Educator to be housed onsite at your organization. Our management team would recruit, train and manage this Health Education professional, either on a full or part-time basis.

### **Option 4: Reporting System**

Depending on what options are chosen, HEW will provide reporting to Employer Group Management. Due to confidentiality issues, any outcome data from 1:1 and group sessions would be reported in aggregate.

- A computer database system to support data tracking and health profiles would be utilized.

### **Option 5: Health Educator**

A Health Educator will be assigned to your health program. This educator will be responsible for tracking and managing the employees' health education needs. This will be for any onsite education, promotions as well as e-mail communication for people in targeted programs (i.e., diabetes, cholesterol, smoking, weight loss, etc.). Educator can conduct monthly lunch-and-learn programs and desired health education programs onsite if requested, as well as develop monthly health articles for employee newsletters. This person would work out of our Corporate office on a full or part-time basis.

### **Option 6: Customized "Care Plans"**

Customized "Care Plans" can be developed for employees that are determined "high risk" from risk factor analysis on the initial needs assessment.

### **Option 7: Health Communication Options**

Communication methods such as newsletters or newsletter articles, paycheck stuffers, etc. can be implemented as a good source of information and for directing attention to specific health and wellness issues and driving utilization to health education and wellness services.

### **Option 8: Monthly Special Events**

Monthly special health and wellness events open to employees and their families, i.e., matching the National Health Observances Calendar.

### **Option 9: Safety Information**

Safety seminars/workshops could be held to address high claims issues, i.e., Back Safety, Carpal Tunnel Prevention, Stress Management, etc. (Prevention of Injuries/Claims not "After the Fact" and could also be made mandatory).

### **Option 10: Health Incentive Programs**

Quality Health Incentive Programs will be offered to employees with education materials, prizes, etc., based on selected health themes (i.e., March Madness Nutrition, Health for the Holidays, etc.)

### **Option 11: Rewards for Healthy Lifestyles**

A reward system would be offered that is either cash based, paid days off work, gifts/prizes, etc. if the employee meets the criteria. The following areas are ideas for evaluation based on status and improvements and assigned point values:

- Exercise
- Wear seatbelts
- Get annual physical
- Get health screenings
- Get immunizations
- Cholesterol within normal limits
- Take healthy pregnancy classes and make all prenatal visits
- Participate in Health Promotion and Disease Management programs
- Less than 2 sick days per year
- Blood pressure within normal limits
- Don't smoke

**NOTE:** A completed Health Risk Assessment is the first step for this program.

The employee is given a report card, and at the end of the year, if the employee meets the reward point criteria, they are awarded.

### **Option 12: Annual Health Fairs**

Coordination/consultation of annual Health Fair/Health Screening events. Costs for the Health and Wellness Center program will be determined based upon options chosen. A Per Employee Per Month rate can then be calculated. Thank you and we look forward to building a partnership with you to improve your employees' health.

# Chapter 8

## Retiree Coverage

SHL offers a group retiree program for Medicare-eligible retirees. The program is called Sierra Nevada Spectrum, a Regional PPO Retiree Plan.

SHL 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 SHL a fixed monthly amount for each Medicare member enrolled in the program. Sierra Nevada Spectrum members enjoy comprehensive medical benefits with minimal out-of-pocket expense. There are no claim forms and members may elect to receive all medical care (except emergency care worldwide or urgently needed care while temporarily away from the service area) through the SHL PPO network of providers, or non-network providers for a higher cost sharing.

### **Employer Qualifications**

The group Sierra Nevada Spectrum program is available to employers with 20 or more employees.

### **Dependent Coverage**

Benefits for non-Medicare eligible dependents of retired employees enrolled in Sierra Nevada Spectrum 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, Sierra Nevada Spectrum benefits and premiums may change each January 1st.

## Monthly Billing

The SHL Group Services Department will provide a monthly premium bill for Sierra Nevada Spectrum 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 Sierra Nevada Spectrum bill contains three sections that are identical to the Health Plan of Nevada premium bill, except for the termination process.

## Eligibility

In order to be eligible for Sierra Nevada Spectrum, the applicant:

- must be retired and non-working
- must reside inside the plan service area (state of Nevada)
- 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 Sierra Nevada Spectrum 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 Sierra Nevada Spectrum are as follows:

1. The employer is required to submit a completed Sierra Nevada Spectrum 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 that are Medicare-eligible.
2. Upon receipt of the application, SHL will verify that the retired employee is eligible.
3. Once eligibility is verified, SHL will notify the beneficiary and employer that SHL has accepted the application. SHL then forwards the information to the Federal Medicare program.

SHL will notify the applicant of acceptance, in writing, including the Medicare approved effective date.

# Chapter 9

## Individual Conversion

### Eligibility

Subject to the additional eligibility requirements below, only certain insureds that have been enrolled under the CoC 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 SHL 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 CoC 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. SHL 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 SHL within 31 days of their group coverage termination
- Have had continuous coverage with SHL under a group plan

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

# Chapter 10

## Appeals Procedures

To receive the full benefits of SHL, we suggest 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 provider from SHL 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 provider 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 SHL and its providers need in order to provide the best care possible.
- To follow the health care plan that they, their provider and SHL have agreed upon.
- To consult their provider and SHL before seeking non-emergency care in the service area. We urge insureds to consult their providers and SHL when receiving urgently needed care while temporarily outside the service area.
- To obtain prior authorization from SHL and their provider for any routine or elective surgery, hospitalization or diagnostic procedures.
- To be on time for appointments, and call 24 hours in advance, if possible, to cancel any appointments they cannot keep.
- To pay all applicable copayments at the time of service.
- To know how the SHL Managed Care Program operates.

SHL encourages the insured to communicate any problems and concerns he/she 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, SHL 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 provider'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 SHL'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 SHL Board of Directors for a hearing. The insured's written request must be received by SHL within 10 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 SHL Board of Directors, or if SHL is dissatisfied with the decision of the Grievance Committee, either the insured or SHL 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 SHL 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 SHL, and the arbitrator's ruling will be enforceable pursuant to state law.

**Complaint Procedure Limitation**

Insureds 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 Representative at 821-2200 if you have other questions.