YOU GOT THIS!

Discover how you and your employees can get the most out of your group health plan in this easy-to-use administrator’s guide.
TOGETHER, **WE ARE ONE.**

We’ve been in the health care industry for a long time. It’s our purpose - and our passion. And the best part, we’re local.

Our approach is simple. We help you navigate your group health plan so you can keep your team – and your business – healthy.

Everything you need to get started is right here at your fingertips.
INSIDE THIS GUIDE

Define health care industry terms. Understand the complex world of health care in a way that makes sense to you. Want to know more? See the Health Care Simplified section on page 4.

Find out who's eligible for coverage under your group health plan. Learn more about the enrollment process, COBRA and HIPAA. Want to know more? See the Group Enrollment Process section on page 4.

Pay your premium. Submit your premium payment by mail, e-invoice, online or wire transfer. Want to know more? See the Monthly Billing section on page 7.

Understand how a Preferred Provider Organization (PPO) plan works. A PPO plan gives members the choice of two benefit levels. Want to know more? See the PPO Explained section on page 8.

Get convenient and accessible health care. Health plan members can choose from a large network of doctors, specialists and facilities. Want to know more? See the Strong Provider Network section on page 8.

Access health information on the go. Employers and health plan members can view payment information and health plan documents in one place. Want to know more? See the Online Member Center section on page 9.

Find out where to go for care. When an emergency strikes, health plan members need care fast. But what if it's not an emergency? Want to know more? See the Getting Care section on page 9.

Prepare for a hospital stay. Planning for a lengthy stay (and return home) can lead to better care and faster recovery. Want to know more? See the Hospital Stay section on page 11.

Get help reaching health goals in person or online. Watch more than 15 webisodes or sign up for health education classes. Want to know more? See the Health and Wellness section on page 11.

Review our Preferred Drug List. Find out if a prescription drug is covered under your group health plan. Want to know more? See the Pharmacy Benefits section page 12.

Determine if a procedure, service or medication is covered. Learn about prior authorization and how to request it. Want to know more? See the Prior Authorization section on page 13.

Privacy is important to us. We take measures to protect our health plan members’ personal information. Want to know more? See the Privacy Rights section on page 13.

Know who to call when you have a question. If you can’t find the answer to your question in this guide, call us. Want to know more? See the Contact Us section on page 14.
HEALTH CARE SIMPLIFIED

Before we get started, here are some key words to help you better understand your group health plan:

- **Preferred Provider Organization (PPO)** is a managed care plan which gives members access to more health care providers and services.
- **In-network** refers to a group of doctors, specialists, urgent cares and hospitals we’ve partnered with to help health plan members save money.
- **Out-of-network** allows for greater choice of doctors, but comes with higher out-of-pocket cost.
- **Primary care provider (PCP)** is the doctor a health plan member sees for common health concerns and continuing care. Although not required with a PPO plan, we recommend your employees choose a PCP for their continuing care.
- **Specialist** is a provider or doctor who has advanced education and clinical training in a specific area of medicine. PPO members can access a specialist without a referral.
- **Copay** is the fixed amount a health plan member pays when he/she receives health care services.
- **Coinsurance** is a health plan member’s share of the costs of a covered health care service.
- **Deductible** is the amount a health plan member owes for health care services before his/her health insurance kicks in.
- **Out-of-pocket maximum** is the most a member will pay for covered benefits in any one year.
- **Claim** is a request for payment a health plan member or his/her doctor sends to Health Plan of Nevada.

GROUP ENROLLMENT PROCESS

Your employees count on workplace benefits. Your business does too. By investing in health insurance for your employees now, you can reap the rewards in the long run. Let’s get started.

Who’s eligible to enroll under your group plan?

An eligible employee meets the guidelines established in the Certificate of Coverage (COC) and Group Enrollment Agreement (GEA).

An eligible dependent meets the following requirements:
- An employee’s lawful spouse unless legally separated.
- An employee’s child or the child of the employee’s lawful spouse under age 26.
- A child who is dependent upon an employee as his/her legal guardian.
- An employee’s registered domestic partner.

When can an eligible employee and eligible dependent enroll?

- **Initial Enrollment**: The timeframe eligible employees and eligible dependents may enroll in your group health plan.
- **Group Open Enrollment**: A period of at least 31 days may be held at least once a year allowing eligible employees and eligible dependents to enroll.
• **Late Enrollment:** In the absence of a special enrollment period, an employee cannot apply for coverage as a late enrollee. An eligible employee or any eligible dependents can enroll in the future if he/she experiences a qualifying life event or during the plan’s open enrollment period.

• **Special Enrollment:** An eligible employee can change or enroll in your group plan if he/she has experienced a life event — like getting married, having a baby, losing other coverage, or moving — this qualifies him/her for a special enrollment period.
  - He/she must submit proof, such as a birth certificate, court appointee legal guardianship papers, adoption papers or marriage license to Health Plan of Nevada within 31 days of experiencing his/her qualifying life event.

### How do eligible employees and eligible dependents enroll?

Each eligible employee, interested in receiving health coverage under your group plan, must complete an enrollment form during one of the enrollment periods or within 31 days of becoming eligible. To enroll as an eligible dependent, he/she must be listed on the employee’s enrollment form.

It’s very important for each employee to fill out the enrollment application correctly. Failure to complete every section and/or sign may delay the implementation process. Once an application(s) is complete, please give it to your Group Services representative.

### What if an employee’s or a dependent’s eligibility status changes?

If one of your employees experiences a qualifying life event or change in employment status, which affects his/her eligibility or his/her dependent’s eligibility to receive health benefits under your group plan, it’s your responsibility to provide written notice within 31 days of the event or change. Simply complete a membership change form, enrollment form or approved electronic method and send it to your Group Services representative.

#### Common life/family events may include but are not limited to:

- Marriage or commencement of domestic partnership
- Divorce, legal separation or termination of domestic partnership
- Addition of a child via birth or adoption
- Death of the health plan member or his/her dependent(s)
- Change of home address outside the plan’s service area

#### Common employment status changes may include but are not limited to:

- Employee becomes newly eligible to receive coverage
- Employee becomes ineligible to receive coverage or loses employment
- Spouse/domestic partner obtains health benefits in another group health plan
- Spouse/domestic partner loses employment or coverage in another group health plan

*If proper notice is not provided, which would have resulted in termination of coverage, Health Plan of Nevada shall have the right to terminate coverage.*
When will new members receive their health plan ID card?

Each member should receive a health plan ID card in the mail within 10 business days. If a member doesn’t receive his/her health plan ID card within 31 days of submitting an enrollment application, or if it’s lost or stolen, contact Member Services at 1-800-888-2264.

What do I need to know about COBRA?

The following rules apply only to groups with 20 or more employees on 50 percent of the workdays in the previous calendar year. Note: This information is only intended to be a brief overview. Federal laws and regulations regarding COBRA are publicly available online at dol.gov.

Who is eligible to receive COBRA?

A subscriber (employee) and any enrolled dependent have the right to elect up to 18 months of COBRA continuation coverage if they lose coverage under your group health plan due to:

- A reduction in hours
- Termination of the subscriber’s employment for any reason other than gross misconduct

A dependent has the right to elect up to 36 months of COBRA continuation coverage if he/she loses coverage under your group health plan due to:

- The subscriber’s death
- The subscriber’s divorce or legal separation
- The subscriber becomes entitled to Medicare benefits under Part A, Part B or both
- The dependent no longer qualifies as a dependent child

How do eligible participants enroll in COBRA?

1. The COBRA administrator must notify Sierra Health and Life of a qualifying event within 30 days.
2. Eligible participants (subscribers and dependents) must be sent an election notice no later than 14 days after Sierra Health and Life receives notice that a qualifying event has occurred.
3. The plan offered to eligible participants must be the same plan offered to other participants in similar situations. The same applies for State Continuation with the exception of vision and dental care.
4. Eligible participants must elect to continue coverage within 60 days of the election notice via a membership change form or enrollment form. Submit the form to your Group Services representative and be sure to include the reason for termination and what qualifies the participant to receive COBRA. If the election is not made within 60 days, the participant is not eligible to continue coverage under this plan.
5. Initial premiums are due within 45 days after the participant elect’s continuation coverage. Subsequent premiums are due on the first day of the month during which coverage is extended.
Sierra Health and Life assumes no responsibility for the COBRA administrator’s failure to provide notifications to eligible participants. In addition, Sierra Health and Life assumes no obligation to provide COBRA continuation coverage if:
- The COBRA administrator does not notify eligible participants within 44 days of the qualifying event
- The eligible participants do not make a timely election
- The COBRA administrator fails to notify Sierra Health and Life of the election within 30 days of the election
- Timely premium payments are not made

What’s HIPAA?

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

MONTHLY BILLING

Each month you’ll receive a premium billing statement. Your billing statement reflects the following information:
- A summary of the monthly premium billing
- A detailed listing of premium billed by employee
- Retroactivity identifying changes to a subscriber’s coverage that has been processed after the last billing cycle

To request an e-invoice, please contact your Group Services representative.

How to pay your premium

Premiums are due on or before the first day of the calendar month. We encourage you to pay the billed amount. If you choose to adjust your premium payment, please contact your Group Services representative.

Group Services offers several ways to pay your monthly statement:
- Mail a check with a copy of the monthly statement to:
  Sierra Health and Life, P.O. Box 749546, Los Angeles, CA 90074-9546
- Pay your premium online through the online employer center (@YourService)
- Submit a wire transfer*
- Submit an ACH transfer*

*To submit a payment via wire or ACH transfer, please contact your Group Services representative.

If you have any questions about your billing statement, call 1-800-274-1573.
PREFERRED PROVIDER ORGANIZATION (PPO) EXPLAINED

Enjoy the freedom and flexibility of a PPO plan. Your group health plan covers nearly all of your enrolled employees’ medical expenses as long as they stay within our preferred network of doctors, urgent cares and hospitals. Treatment outside of our network is covered but only at a higher rate.

The greatest advantages of the PPO plan are:
• Larger network of providers and specialists
• Lower out-of-pocket costs for in-network health care services
• Allows health plan members to see a specialist without a referral

Save money on out-of-pocket medical expenses

Your group health plan also covers preventive care screenings at no cost when health plan members see a network provider; even if they have not met their deductible. During the visit, the doctor will review their health history and may recommend preventive screenings, depending on age and risk factors.

STRONG PROVIDER NETWORK

The relationship your employees have with their doctor is important to us. That’s why we offer a large network of health care providers.

Members in Southern Nevada also have access to Southwest Medical Associates, one of Nevada’s largest multi-specialty medical groups. Throughout the Las Vegas Valley and Pahrump, Southwest Medical has:
• 330 providers
• 22 care centers
• 7 on-site laboratories
• 6 urgent cares
• 4 convenient cares
• An outpatient surgery center

In addition, members can take advantage of Southwest Medical’s Urgent Care Home Waiting Room, express check-in and SMA app.

Members can visit smalv.com to find the nearest Southwest Medical location. If they need help scheduling an appointment with a Southwest Medical provider, they can call 702-877-5199.

See a doctor online, anytime. With NowClinic® online services, health plan members can connect with a provider via computer, smartphone or tablet. To get started, they can enroll at NowClinic.com or download the app from the App Store℠ or Google Play™. For more information about NowClinic, advance to the Getting Care section on page 9.

For a complete list of network providers, members can visit mySHLonline.com.
ONLINE MEMBER CENTER

Our online member center brings health information together in one place. With a separate interface for you (employers) and your employees (health plan members), our online center provides secure, 24/7 access to important tools and information.

Employers can take advantage of this convenient service to:
- View eligibility and medical/pharmacy copays
- View plan documents
- View membership roster
- View invoices and pay premiums
- Maintain eligibility online (add, change, term) for employees

Members can visit the online member center to:
- View their plan documents
- Change their address
- Request a replacement health plan ID card
- View or print a temporary health plan ID card
- Verify their coverage for pharmacy, dental or vision services
- Check their copayment amounts for medical services
- Review the status of a claim
- Find out who is on record as their primary care provider
- Check the status of a prior authorization request
- Find out how much has been applied toward their deductible, if applicable
- Watch more than 15 health education webisodes
- Take a health risk assessment (HRA)
- Download and print a member guide

Visit mySHLonline.com and sign in to the online member center. First time users will need to create an account.

GETTING CARE

Educate your employees on where to go for care. Choosing wisely may save them both time and money. Before they go to urgent care or the emergency room, they can:

Use the HPN/SHL Symptom Checker to guide them on what type of care, if any, they may need. They may also find symptom relief for minor illnesses and injuries. They can simply visit mySHLonline.com or download the free HPN/SHL Symptom Checker app from the App Store℠ or Google Play™ (available in English and Spanish).

Get health care advice 24 hours a day. Our Telephone Advice Nurse is available to answer questions, provide self-care advice and help a health plan member decide whether to seek urgent care, emergency care or schedule an appointment with his/her provider. Just call 1-800-288-2264.
See a doctor anytime, anywhere. NowClinic lets them connect with a provider via computer, smartphone or tablet. Appointments aren’t necessary, and they can connect whenever it’s convenient for them. Just as with an in-person office visit, they’ll receive a diagnosis and individualized care plan. Prescriptions, if needed, can be sent to their chosen pharmacy.

Health plan members can use NowClinic for common illnesses,* such as:

- Allergies
- Bladder infection/UTI
- Bronchitis
- Eye infections/Pink eye
- Sinus infections
- Viral illness
- And more

For children under 18 years old, a parent member can sign into his/her NowClinic account and select his/her child’s record. The parent must also be present during the visit. Children 18 years or older will need to create their own NowClinic account.

To enroll, health plan members can visit NowClinic.com or download the NowClinic mobile app.

*The conditions treated are subject to NowClinic provider discretion and may require a visual interaction such as a webcam. Video may also be required for prescribing.

NowClinic is not intended to address emergency or life-threatening medical conditions. Please call 911 or go to the emergency room under those circumstances.

NowClinic providers do not replace your primary care physician. The services are not covered by Medicare and may not be covered by your private health plan or Medicaid, so check with them prior to using the services. If covered, copays and deductibles may apply. NowClinic providers do not prescribe controlled substances and reserve the right to refuse to prescribe other drugs that are restricted by state law or may be harmful or non-therapeutic. Providers may also decline an individual as a patient if the medical problem presented is not appropriate for NowClinic care or for misuse of services.

When health plan members need care quickly, and their doctor’s office is closed, they should consider urgent care. Offering evening, weekend and holiday hours, there’s likely a contracted urgent care close by.

Members may use urgent care for non-life threatening injuries or illnesses, such as:

- Ear infections
- Colds and other respiratory problems
- Sprains and strains
- Most abdominal pain
- Vomiting and diarrhea
- Most cuts
- Most burns
- Most fractures
- Most back pain
In an emergency, health plan members should call 911 or go to the nearest hospital emergency room. A true medical emergency is when symptoms are severe enough they could reasonably expect serious danger to their health.

A health plan member should seek emergency care if he/she experiences a life-threatening condition, such as:

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

If he/she goes to the ER and it’s not a true emergency, he/she may be responsible for the entire cost of the visit.

**HOSPITAL STAY**

A health plan member’s doctor is his/her partner in health. The doctor will help coordinate care if he/she should ever need to be admitted to a hospital on a non-emergency basis.

Sierra Health and Life will stay involved in the member’s care. Our team will help monitor the care by performing initial and ongoing reviews. This is to make sure the health care services received are appropriate, provided in the right setting, and medically necessary. If he/she is admitted to a hospital outside of our service area, we may review the medical records to evaluate the appropriateness of the medical care, services, treatments and procedures he/she received.

Returning home after a long hospital stay also requires a plan. Depending on the situation, we'll arrange for any ongoing medically necessary care, services, and equipment health plan members need after leaving the hospital. This may include in-home care or transferring to another facility.

**HEALTH EDUCATION AND WELLNESS**

Whether your employees want to eat right, exercise more, stop smoking, or just relax, they have a variety of resources at their fingertips. As health plan members, they have access to health education classes, webisodes, and reading materials. Spanish language materials are available for all topics. To get started, they can call **1-800-720-7253** or sign in to the online member center at [mySHLonline.com](http://mySHLonline.com).

*Coaching is available to provide support but doesn’t replace treatment plans put into place by a doctor. A member should always talk to his/her doctor about any important health issues.*
When your employees learn how to make good decisions for their health, everyone wins. They may stay healthier. You, as their employer, may see that healthier employees can work better and miss work less often. There’s a lot you can do to help your employees stay healthy, such as:

• **Encourage and reward.** SimplyEngaged® for Small Business is a personal health and wellness program which offers members rewards for completing health and wellness actions, including:
  - Participate in a biometric health screening
  - Complete an online health survey
  - Visit a participating fitness center at least 12 times per month
  - Complete a telephone-based health coaching program
  - Complete at least three missions through the Rally℠ experience

To learn more about SimplyEngaged, call **1-855-215-0230**.

• **Better health starts online.** Rally℠, an interactive digital health experience, provides members with the support and tools they need to move more, eat better, feel better and take care of themselves. And the best part, members earn rewards for their tracked success!

Health plan members can also take charge of their health with the support of a registered nurse. Our Disease Management Program is available to eligible members (adults and children) living with asthma and/or diabetes. Participants learn how to manage their health and track key health information. They also receive invitations to health education classes. For more information, call **1-877-692-2059**.

Mental health is as important as physical health. Behavioral Healthcare Options (BHO) provides professional counseling, telephone consultations and online resources for mental health and substance abuse issues to help members maintain a balanced and healthy life. To learn more about BHO, visit [bhoptions.com](http://bhoptions.com). To get help, members can call **1-800-873-2246**.

### PHARMACY BENEFITS

If your group health plan includes pharmacy benefits, your employees have prescription drug coverage from network pharmacies and mail order.

As health plan members, their copayment is based on levels called a prescription tier. The costs are lower on tiers 1 and 2, and higher on tier 3 or tier 4, if applicable. To find what tier a medication is on, go to [mySHLonline.com](http://mySHLonline.com).

To use our contracted mail order pharmacy to save time and money, health plan members can visit [mySHLonline.com](http://mySHLonline.com) to download an order form. They complete the order form and mail it with the prescription to the address provided. Providers should write members a prescription for a 90-day supply with refills when appropriate (not a 30-day supply with three refills). If a member needs further assistance, they can fill out Section 1 of the OptumRx fax order form. Then ask his/her provider to fill out Section 2 and fax the form for him/her.
A health plan member may be required to try step therapy. This means he/she must try certain drugs to treat his/her medical condition before we'll cover another drug for that condition. He/she may submit an exception request to waive step therapy requirements or quantity limit restrictions. The exception request form is available at mySHLonline.com. For a list of medications requiring step therapy or to download an exception request form, go to mySHLonline.com.

PRIOR AUTHORIZATION

Prior authorization is necessary to ensure benefit payment. A health plan member’s provider may prescribe a health care service, treatment, equipment, or medication which requires review and approval. This process is called prior authorization, and the goal is to ensure health plan members receive the most appropriate, medically necessary care.

All requests requiring a medical or clinical decision are reviewed by a licensed physician or under the supervision of one. Furthermore, only a physician may deny a request. To learn more, health plan members should review their plan documents.

A member or his/her provider may file an appeal if coverage is denied. To appeal a decision, he/she can call Member Services or mail a written request within 180 days from the date of the denial to: Member Services, Sierra Health and life, P.O. Box 15645, Las Vegas, NV 89114-5645

RIGHT TO PRIVACY

We're careful to protect our members’ privacy. This includes oral, written and electronic information. We only share protected health information (PHI) with individuals or entities responsible for coordinating a member’s health care or administering his/her health benefits, unless we have his/her permission. And, of course, we share PHI in accordance with state and federal law. We also require our contracted providers to take similar steps to protect members’ PHI.

We may use medical data to promote and improve the quality of care our members receive. When we conduct research and measure quality, we use summary information whenever possible, not PHI. When we use PHI, steps are taken to help protect it. We do not allow PHI to be used for research by organizations without a member’s consent.

A member has the right to access his/her medical records. He/she can contact his/her provider to request a copy. When he/she requests his/her medical records to be shared with others, he/she may be required to sign an authorization form.

We may ask a health plan member for permission to use his/her personal data for non-routine purposes. Of course, when we ask, he/she has the right to refuse. If he/she lacks the ability to authorize a release, we obtain authorization from persons recognized by state and federal laws to give such permissions.

To review our entire privacy policy, visit mySHLonline.com.
CONTACT US

We’re here for you. If you need further assistance, give us a call, Monday through Friday, 8 a.m. to 5 p.m. local time.

Group Services
If you have a question about your billing statement, new enrollments, COBRA, terminations, qualifying life events, HIPAA, Certificates of Coverage or documentation requests, call 1-800-274-1573.

Small Group Sales
If you have a question about your group contract or benefit plan selection, please contact your group sales representative.

Medicare Services
If you have a question about Medicare plans for retiree coverage, call 1-800-650-6232.

Member Services
If you have a question about prior authorization or covered benefits, call 1-800-888-2264.

Behavioral Healthcare Options
If you have a question about prior authorization for mental health, severe mental illness or substance abuse services, call 1-800-873-2246, 24 hours, seven days a week.
NowClinic®
Get care anytime. Anywhere.
Thank you for your business.

We encourage you to stay informed. Sign in to our online employer center and keep a close eye on your inbox for important news.

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Insurance coverage provided by Sierra Health and Life.