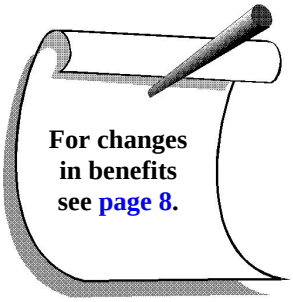
Health Plan of Nevada

http://www.sierrahealth.com

2002

A Health Maintenance Organization with a point of service product

Serving: Las Vegas and Reno metropolitan areas



Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

This Plan has "Accredited" status from the National Committee for Quality Assurance (NCQA) for Commercial and Medicare Products.

Enrollment codes for this Plan:

NM1 Self Only
NM2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-129

Table of Contents

Introduction

Health Plan of Nevada
P.O. Box 15645
Las Vegas, NV 89114-5645

This brochure describes the benefits of Health Plan of Nevada under our contract (CS 1942) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means Health Plan of Nevada.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (702) 242-7300 or (800) 777-1840 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We also have Point-of-Service (POS) benefits:

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

When we contract with a doctor or medical group to provide health care services, the contract specifies the amount the doctor or medical group will be paid for providing services—either on a fixed monthly basis or as a payment per service provided. In some cases, we and the doctor or group agree upon financial goals based in part on the expected use of special services by patients of the doctor who belongs to our plan. These special services may include referrals to specialists, lab tests, and hospital admissions. These types of arrangements are known as incentive plans. In most incentive plans, the health plan retains a portion of this money. At the end of the year, if the doctor or medical group meets the budgeted goals, the health plan may give part or all of the withheld money to the doctor or medical group.

We have several types of payment arrangements with our doctors:

Arrangement A: Your doctor may be part of a contracted medical group and may receive a salary. Some medical groups may pay their doctors a bonus.

Arrangement B: Your doctor may receive a fixed amount of money each month, called a "capitation" to provide services to all Health Plan patients they see. Capitation may be considered to be an incentive plan.

Arrangement C: Your doctor may be paid a pre-determined amount for each service he/she provides. The plan may designate a separate amount of money to pay for special services (as described above). At the end of the year, that money may be paid to the doctor or medical group, depending upon the management and use of special services.

Your Rights

OPM requires that all FEHB Plans to provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Health Plan of Nevada, Inc. has operated as a mixed model HMO in Nevada for 19 years. Health Plan of Nevada, Inc., has been awarded "Accredited" status by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization

dedicated to measuring the quality of America's healthcare. Accreditation is for the Commercial HMO, Commercial POS and Medicare HMO product lines in Nevada effective August 2000.

- We understand the importance of getting your questions answered. Whether you need an answer to a benefit question or have a concern about a claim, or need help in selecting a provider, we are available Monday through Friday, 8am to 5pm at (702) 242-7300 or (800) 777-1840.
- At times, services requested on your behalf by your provider may not be approved by Health Plan of Nevada, Inc. The decision to deny coverage for services requested, courses of treatment or inpatient care is made by a physician. These denials are based upon medical necessity, benefit coverage and your individual needs. Written notification of the denial will be sent to you, your primary care physician and the provider who requested the service. You have the right to appeal these decisions.

If you want more information about us, call (702) 242-7300 or (800) 777-1840, or write to Health Plan of Nevada, P.O. Box 15645, Las Vegas, NV 89114-5645. You may also contact us by fax at (702) 242-9350 or visit our website at www.sierrahealth.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

The Nevada counties of Clark, Nye, Mineral and Lyon. Portions of Washoe County in Nevada are also within the service area, as indicated by the zip codes: 89431, 89432, 89433, 89434, 89435, 89436, 89442, 89501, 89502, 89503, 89504, 89505, 89506, 89507, 89509, 89510, 89511, 89512, 89513, 89515, 89520, 89523, 89533, 89570.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

- Your share of the non-Postal premium will increase by 7.9% for Self Only or 8.0% for Self and Family.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover routine screening for chlamydial infection. (Section 5(a))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We require a 50% coinsurance for Vision care (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (702) 242-7300 or (800) 877-1840.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

· **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

· **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. This plan has a provider directory, which we urge you to review before choosing your primary care physician.

· **Primary care**

Your primary care physician can be a family practitioner, pediatrician, Obstetrician/Gynecologist or internist. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

· **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, women may see their Obstetrician/Gynecologist without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with the plan and your specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our

criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

· **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (702) 242-7300 or (800) 777-1840. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior authorization. Your physician must obtain prior authorization for the following services:

- All non-emergency hospital admissions
- Admissions to skilled nursing facilities and inpatient hospice facilities
- All non-emergency inpatient and outpatient surgeries
- Many diagnostic services
- Physical, occupational and speech therapy
- Inpatient and outpatient mental health and substance abuse services
- Home health services
- Prosthetic devices and durable medical equipment

It is best to contact your plan physician before you seek any services. Failure to follow the requirements of the referral process will result in higher out of pocket costs to you.

- In order for certain services to be covered under your Point of Service benefit, you must also get prior authorization from the plan. Failure to comply with the prior authorization requirements may result in a reduction of benefits. Refer to Section 5(i) for additional details on coverage under the Point of Service benefit.

Contact our customer service department at (702) 242-7300 or (800) 777-1840 for additional details.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

· **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $100 per day, not to exceed $200 per admission.

· **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. We do not have a deductible for HMO coverage, but your point of service benefit does include a deductible.

- The calendar year deductible is $250 per person for Point of Service benefits. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $750.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

· **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 50% of our allowance for infertility services and durable medical equipment. You also pay 20% of our allowance for most services obtained under the point of service benefit.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

After your copayments total $3,320 per person or $7,804 per family enrollment in any calendar year, you do not have to pay any more for covered services.

After you have met the calendar year deductible for point of service benefits, if your coinsurance payments total $1,500 per person or $4,500 per family enrollment in any calendar year, you do not have to pay any more for covered services.

Be sure to keep accurate records of your copayments and coinsurance payments since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 59 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at (702) 242-7300 OR (800) 777-1840 or at our website at www.sierrahealth.com.

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar deductible for HMO benefits.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	$10 per office visit
At home	$20 per visit

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms	Nothing if you receive these services during your office visit.
• Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG • Nuclear scans	$5 per diagnostic service
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 • Screening for chlamydial infection	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	$10 per office visit

Preventive Care - Adult -- continued on next page

Preventive care, adult *(continued)*	**You pay**
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit No charge at immunization clinics.
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit No charge at immunization clinics.
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction. - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 per office visit
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit. See section 5(f). NOTE: Other co-pays may apply for surgical services. See section 5(b).	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)*	$10 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete GIFT and zygote ZIFT* - *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Injectible and oral fertility drugs*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 28. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We will only cover GHT when we prior authorize the treatment. Call (702) 242-7300 or (800) 777-1840 for prior authorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per office visit
Not covered: Sports medicine treatment plan intended to primarily improve athletic ability.	*All charges.*

Physical and occupational therapies	You pay
• 2 consecutive months per condition for the services of each of the following: - qualified physical therapists and - occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • Cardiac rehabilitation is provided for up to 30 days following a heart transplant, bypass surgery or a myocardial infarction. Cardiac rehabilitation is not covered unless provided in a physician-monitored program.	$10 per office visit Nothing per visit during covered inpatient admission
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *Milieu therapy, behavior modification, sensitivity training, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolfing, residential treatment, vocational rehabilitation or wilderness programs*	*All charges.*
Speech therapy	
• 2 consecutive months per condition for the services of a speech therapist	$10 per office visit

Hearing services (testing, treatment, and supplies)	You pay
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit and 50% of costs associated with vision supplies.
• Annual eye refractions Note: See Preventive care, children for eye exams for children	$10 per office visit
Not covered: • *Eyeglasses, frames or contact lenses, including fitting of lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.	Nothing
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	50% of our plan allowance.
Note: Coverage of services and devices for treatment of TMJ is limited to $2,500 per member per year with a lifetime maximum of $4,000 per member. Note: orthopedic and prosthetic devices are limited to a combined HMO/POS lifetime maximum of $10,000 including repairs, except externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy.	

Orthopedic and prosthetic devices -- continued on next page

Orthopedic and prosthetic devices *(Continued)*	**You pay**
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, and prior authorized by the Plan such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs - limited to coverage of single standard manual wheelchairs as deemed medically necessary and appropriate; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. Note: Combined HMO/POS maximum benefit of $4,000 per member per calendar year. Note: Call us at (702) 242-7300 or (800) 777-1840 as soon as your Plan physician prescribes this equipment. All DME must be medically necessary and prior authorized by the Plan to be covered.	50% of our plan allowance.
Not covered: • *Motorized wheelchairs* • *Custom wheelchairs* • *More than one piece of equipment serving essentially the same function except for replacements as authorized by the health plan. Coverage for alternate or spare equipment is not provided.* • *Outpatient oxygen and its administration unless prior authorized*	*All charges.*

Home health services	You pay
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;.* • *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*
Chiropractic	
Chiropractic services for manual manipulation of the spine (except for reductions of fractures or dislocations)	$10 per office visit
Alternative treatments	
No Benefit	*All charges.*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	$10 per office visit
• Diabetes self-management – includes coverage for medication, equipment, supplies and appliances for treatment of diabetes. Diabetes includes type I, type II and gestational diabetes. Covered services include training and education for: - The care and management of diabetes after an initial diagnosis, including counseling in nutrition and the proper use of equipment and supplies; - Necessary because of a significant change in your symptoms or condition which requires a modification of self management program; - Necessary because of the development of new techniques or equipment for the treatment of diabetes.	$10 per office visit $5 per educational site visit

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for HMO benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- YOU MUST GET PRIOR AUTHORIZATION OF SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. Surgical treatment of morbid obesity is covered only when authorized and only as a treatment of last resort. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information.	$10 per office visit, plus $5 per procedure $50 per outpatient facility visit, plus $50 per procedure $100 per inpatient visit, plus $100 per procedure

Surgical procedures -- continued on next page.

Surgical procedures *(continued)*	**You pay**
• Voluntary sterilization • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit, plus $50 per procedure $50 per outpatient facility visit, plus $50 per procedure $100 per inpatient visit, plus $100 per procedure
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$10 per office visit, plus $5 per procedure $50 per outpatient facility visit, plus $50 per procedure $100 per inpatient visit, plus $100 per procedure

Reconstructive surgery -- continued on next page

Reconstructive surgery *(continued)*	**You pay**
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges.*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit, plus $5 per procedure $50 per outpatient facility visit, plus $50 per procedure $100 per inpatient visit, plus $100 per procedure
• Temporomandibular (TMJ) joint pain dysfunction Note: Coverage for treatment of TMJ is limited to $2,500 per member per year with a lifetime maximum of $4,000 per member.	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Surgical procedures that are dental in nature* • *Shortening of the mandible or maxillae for cosmetic purposes*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Kidney • Liver • Allogenetic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	$10 per office visit, plus $5 per procedure $50 per outpatient facility visit, plus $50 per procedure $100 per inpatient visit, plus $100 per procedure
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges.*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Physician Office	Nothing

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible for HMO benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF ELECTIVE HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room or special duty nursing when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per day, to a maximum of $200 per admission

Inpatient hospital -- continued on next page.

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	$100 per surgical procedure to a maximum of $200 per admission
Not covered: • *Custodial care* • *Non-covered facilities* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$50 per visit
Not covered: blood and blood derivatives not replaced by the member	*All charges.*

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): • Bed. board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided by the skilled nursing facility when prescribed by a plan doctor	$100 per day, up to a maximum of $200 per admission
Not covered: custodial care	*All charges.*
Hospice care	
Supportive and palliative care for terminally ill members is covered in the home or in a hospice facility. Covered services include:	$100 per day, up to a maximum of $200 per admission.
• Inpatient and outpatient care and counseling	$20 per visit
• Outpatient bereavement counseling for each family member upon the death of a terminally ill member up to a maximum of 5 group therapy visits or $500 in benefits per calendar year, whichever is less.	Nothing
• Outpatient Respite care for family members of a terminally ill member, up to a maximum benefit of $1,000 per calendar year.	$10 per visit
• Inpatient Respite care for a terminally ill member, up to a maximum benefit of $1,500 per calendar year.	$100 per day, up to a maximum of $200 per admission
Not covered: Independent nursing, homemaker services	*All charges.*
Ambulance	
• Local professional ambulance service when medically appropriate and ordered or authorized by a plan physician	$25 per trip

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible for HMO benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care physician. In extreme emergencies, if you are unable to contact your physician, contact your local emergency system (e.g. 911) or go to the nearest hospital emergency room. Be sure to tell the emergency personnel that you are a plan member so they can notify the plan. You or a family member must notify the Plan within 48 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan receives timely notification.

You may also receive care at the Plan's 24 hour Urgent Care Center at 888 South Rancho Drive, Las Vegas, NV. Benefits are available from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers, except as covered by your Point of Service benefit.

We pay reasonable and customary charges for emergency services to the extent the services would have been covered if received from plan providers.

Emergencies outside our service area: You are covered for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be provided in a Plan hospital, you will be transferred when medically appropriate with any charges covered in full.

To be covered by this plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers except as covered by your Point of Service benefit.

We pay reasonable and customary charges for emergency services to the extent the services would have been covered if received from Plan providers.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per office visit $15 per visit $25 per visit
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per office visit $15 per visit $25 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	$25 per trip
Not covered: air ambulance unless medically appropriate	*All charges.*

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible for HMO benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit

Mental health and substance abuse benefits -- continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
• Diagnostic tests	$10 per visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$100 per day to a maximum of $200 per admission
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

Contacting Behavioral Healthcare Options (BHO) to make arrangements to authorize medically necessary care. BHO may be contacted at (800) 873-2246. You may obtain more information on BHO by visiting their website at www.sierrahealth.com

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible for HMO benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription.** Except for emergencies or services obtained from a non-plan provider accessed under the point of service benefit, a plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for certain maintenance medications. Medications available through mail order are limited to those determined by the Plan to be maintenance medications. The list of maintenance medications is maintained by the Plan at its sole discretion.
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan provider. Our Formulary is a list of FDA approved Generic and Brand Name medications developed and maintained by the Plan. The Formulary is reviewed by physicians and pharmacists on a regular basis and may change throughout the year at the Plan's sole discretion. Patient needs, scientific data, drug effectiveness, availability of drug alternatives currently on the Formulary, and cost are considerations in selecting medications for inclusion on the Formulary. Inclusion of drugs on the Formulary does not guarantee that your provider will prescribe that medication.
- **These are the dispensing limitations.** A dispensing limitation is the quantity of a medication for which benefits are available for a single applicable co-payment, or in the case of maintenance drugs, two co-payments. The dispensing limitation may be 1) a predetermined period of time established by the Plan; or 2) a period of time that a specific medication is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition. Dispensing limitations may be less than but shall not exceed a 30-day supply for drugs obtained at a Plan pharmacy. Maintenance drugs dispensing limitations may be for up to a 90-day supply provided the medication is on the Plan maintenance drug list. Prescriptions that exceed the dispensing limitations established by the Plan will not be covered.

  A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

  You can save money by using generic drugs. However, you and your physician have the option to request a name-brand if a generic option is available. Using the most cost-effective medication saves money.

- **When you have to file a claim.** You normally won't have to submit claims to us. If you do need to file a claim, please send us all of the documents for your claim (including itemized billings) as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time. Send completed claims to Health Plan of Nevada Attn: Claims Department, P.O. Box 15645, Las Vegas, NV 89114-5645.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin (whole vials up to 40 ml) • Diabetic supplies, including insulin syringes, needles, blood glucose measuring strips, and urine checking reagents • Nitroglycerine, phenobarbital or Thyroid U.S.P. when prescribed in quantities of 100, a single co-payment will apply • Vitamins which require a prescription • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction. Sexual dysfunction drugs have specific dispensing limitations and require prior authorization by the Plan. Contact the Plan for details. • Contraceptive drugs and devices • Smoking cessation drugs and medication, including nicotine patches • Growth hormone	$5 per generic prescription $20 per brand name prescription $35 for non-formulary drugs You pay two applicable co-payments for medications obtained through our mail order program Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

Covered medications and supplies -- continued on next page

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription medicines* • *Anorexic agents* • *Injectible and oral drugs to treat infertility* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	*All charges.*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call (800) 622-6252 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	We have a TTY/TDD number for use by hearing impaired members. The TTY/TDD number is (702) 242-9214 or (800) 349-3538.
Preventive Health/ Disease Management	• Health Plan of Nevada offers numerous preventive health management programs to assist members with early detecting and prevention of serious illnesses. These programs promote services such as childhood immunizations, breast and cervical cancer screenings, or prenatal care. • HPN also offers disease management programs to assist members with chronic conditions such as pediatric asthma, diabetes, and congestive heart failure. These are comprehensive programs that usually include patient education classes, specialty clinics, or case management monitoring.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We do not have a calendar year deductible for HMO benefits.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$25 per emergency room visit $10 per office visit

Dental benefits

We have no other dental benefits.

Section 5 (i). Point of service benefits

Point of Service (POS) Benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

- Physician services including primary care and specialist office visits
- Care and consultations received while inpatient
- Preventive healthcare (well child care, routine physical exams and pap smear, routine diagnosis) subject to a maximum benefit of $100 per member per calendar year
- Manual manipulation performed by a chiropractor, D.O. or physical therapist, subject to a maximum benefit of $500 per member per calendar year and a $5,000 maximum lifetime benefit per member
- Inpatient hospital services
- Outpatient hospital and ambulatory surgical facility services
- Skilled nursing facility services subject to a maximum benefit of 12 days per calendar year
- Surgical assistant services
- Anesthesia services
- Ambulance services (non-emergent)
- Laboratory services
- Routine outpatient radiological and non-radiological diagnostic imaging services
- Diagnostic and therapeutic services including chemotherapy, dialysis, therapeutic radiology, allergy testing and serum injection, otologic evaluations, complex diagnostic imaging, vascular diagnostic and therapeutic services, pulmonary diagnostic services, neurological or psychiatric testing
- Home health services, subject to a maximum of the lesser of 30 visits or $5,000 per calendar year
- Prescription drugs (prescription drug fee)
- Durable medical equipment, covered at 50% of plan allowance and a combined HMO/POS maximum benefit of $4,000 per member per calendar year
- Enteral and special food products, subject to a combined HMO/POS maximum coverage limit of $2,500 per member per calendar year
- Self management and treatment of diabetes
- Short term inpatient and outpatient rehabilitation services subject to a combined HMO/POS maximum coverage limit of two months per condition
- Prosthetic and orthotic devices, including repairs, subject to a combined HMO/POS maximum coverage limit of $10,000 per calendar year
- Mental health and substance abuse services

Precertification

In order for services to be covered under your Point of Service benefit, you must get prior authorization from the plan. Failure to comply with the prior authorization requirements may result in a reduction of benefits. If you obtain services without prior authorization from the plan, payment will be reduced to 50% of plan allowance, up to a maximum penalty of $500.

Services that require prior authorization under the Point of Service benefit include:

- All elective inpatient admissions and extensions of stay beyond the original certified length of stay to a hospital or skilled nursing facility;
- All outpatient surgery provided in any setting if the charges exceed $200;
- All outpatient tests, including technical and professional services if the charges exceed $200; and
- All outpatient courses of treatment including, but not limited to: allergy testing/treatment; angioplasty; chemotherapy; dialysis; manual manipulation; radiation therapy; and rehabilitation therapy.

Deductible

Your calendar year deductible for point of service coverage is $250 per member and $750 per family.

Coinsurance

After the deductible is met, you pay 20% of the plan's allowance, except for coverage of durable medical equipment, which is covered at 50% of the plan's medical expenses. You will be responsible for your coinsurance plus charges in excess of the Plan's allowance for all services obtained under the point of service benefit. The Plan's allowance is established with reference to:

- The amount most consistently paid to the provider; or
- The amount paid to other providers of similar qualifications; or
- The relative value or worth of allowances for similar services comparable in severity and nature with reference to other industry and governmental sources

Your coinsurance maximum is limited to $1,500 of the Plan's allowance per member per calendar year or $4,500 per family per calendar year.

Maximum benefit

The point of service benefit is limited to a maximum Plan payment of $2,000,000 per member per lifetime

Hospital/extended care

For authorized care obtained from a non-participating hospital, you pay 20% of the plan's allowance. Care accessed from participating hospitals using the POS benefit and non-Plan doctors will be paid under the terms of this POS benefit. The hospital charge, sometimes called facility charge, does not cover any charges for doctors' services.

Emergency benefits

Emergency care is always covered under the HMO benefit.

What is not covered

- Hospice care
- Temporomandibular Joint Dysfunction treatment
- Sterilization
- Organ or tissue transplants
- Care or treatment of an illness or injury cause by or arising out of riots, wary, insurrection, rebellion, armed invasion or aggression
- Any services for which a claim is not received by the Plan within 12 months after the date services are provided

How to obtain benefits

Contact the Plan if you want to access services under your POS benefits. For services which may need prior authorization, be prepared to supply the provider name and telephone number, the service requested, the service date and your member number. Member Services will assist you in submission of your prior authorization request. If you need to submit a claim, follow the instructions for submission of a claim outlines on page 46 of this brochure.

Section 5 (j). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Health Plan of Nevada is pleased to offer a Supplemental Dental program to FEHBP members with dentists who have agreed to participate in our dental program and provide dental care services to members. You may obtain information regarding this program by contacting us, or by obtaining an enrollment packet during open season. Procedures not listed on the benefit schedule are not covered. You are required to re-enroll into the supplemental dental plan every year during the open enrollment period. Please refer to the supplemental dental information provided by the plan for further information on this program, including premiums, what is covered under the supplemental program and limitations and exclusions.

If you are enrolled in this Plan through FEHBP, have Medicare Part A coverage and have purchased Part B coverage, you may also enroll in the Health Plan of Nevada Senior Dimensions program. The Senior Dimensions plan provides all Medicare covered Part A and Part B benefits, as well as some benefits not covered by Medicare. It is an arrangement between Medicare and this Plan in which Medicare pays a specific amount to this plan for each Medicare beneficiary who enrolls in the Plan.

Like your FEHBP enrollment in this Plan, you are required to obtain your services from this Plan's doctors and providers, except for emergencies and out-of-area urgent care. The rules regarding enrollment and disenrollment are fully explained in the Plan's Evidence of Coverage. For a copy of these rules and or more information, please contact Member Services at (702) 242-7300 or (800) 777-1840.

If you choose to enroll in Senior Dimensions, you will be responsible for paying the Medicare Part B premium. You must complete an additional enrollment form in order to be enrolled in Senior Dimensions.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call (702) 242-7300 or (800) 777-1840 for information on the benefits available under the Medicare HMO.

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 11.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at (702) 242-7300 or (800) 877-1840.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer -- such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: **Health Plan of Nevada, Attn: Claims, P.O. Box 15645, Las Vegas, NV 89114-5645**

Prescription drugs

To submit claims for drugs, contact the plan at (702) 242-7300 or (800) 877-1840. We will assist you in completing a Direct Member Reimbursement Form and help you process your claim with our Pharmacy Benefits Manager.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: P.O. Box 15645, Las Vegas, NV 89114-5645; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request -- go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

The Disputed Claims process *(Continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (702) 242-7300 OR (800) 777-1840 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

· What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

· The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

(Primary payer chart begins on next page.)

The following chart illustrates whether the **Original Medicare Plan** or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)		✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Claims process when you have the Original Medicare Plan -- You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (702) 242-7300 or (800) 777-1840. You may also contact us by fax at (702) 242-9350 or visit our website at www.sierrahealth.com.

We do not waive any out-of-pocket costs when you have Medicare.

· **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do/do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

· **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care that is designed essentially to assist individuals in meeting activities of daily living. These include personal care services (help in walking and getting in or out of bed; assistance in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision over medication which can usually be self-administered) that do not require the continuing attention of trained medical or paramedical personnel.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services

This plan regularly evaluates for possible coverage new medical technologies and new applications of existing technologies. New technologies may include medical procedures, drugs and devices. The evaluation process includes a review of information on the proposed service from appropriate government regulatory bodies as well as from published scientific evidence.

Medical necessity

Medical necessity means a service is needed to improve a specific health condition or to preserve your health. Medical necessity is present when the Plan determines that the care requested is: Consistent with the diagnosis and treatment of your illness or injury; the most appropriate level of service which can be safely provided to you; and, not provided solely for your convenience or that of your provider or hospital. When applied to inpatient services, “Medically Necessary” further means that your condition requires treatment in a hospital rather than any other setting. Services and accommodations are not automatically considered to be medically necessary because a physician prescribes them.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance based upon the reasonable and customary charges as determined by the Plan. Participating plan providers accept the plan allowance as payment in full.

Us/We

Us and we refer to Health Plan of Nevada.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

· When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

· Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

· Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

· Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planing.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for the Health Plan of Nevada - 2002

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital:		
• Inpatient	$100 per day up to $200	29
• Outpatient	$50 per surgical center	30
Emergency benefits:		
• In-area	$25 per visit	33
• Out-of-area	$25 per visit	33
Mental health and substance abuse treatment	Regular cost sharing	34
Prescription drugs	$5 generic preferred $20 brand preferred $35 non-preferred	36
Dental Care	No benefit	40
Vision Care	$10 per visit for one refraction annually and 50% of costs associated with vision supplies.	21
Special features: Flexible benefits option, 24 hour nurse line, Services for deaf and hearing impaired, Preventive Health/Disease Management		39
Point of Service benefits -- Yes		41
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $3,320/Self Only or $7,804/Family enrollment per year for HMO benefits or $1,500/Self Only or $4,800/Family for POS benefits Some costs do not count toward this protection	12

2002 Rate Information for Health Plan of Nevada

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

Type of **Enrollment**	Code	***Non-Postal Premium***				***Postal Premium***	
		Biweekly		**Monthly**		**Biweekly**	
		Gov't Share	Your Share	Gov't Share	Your Share	**USPS** Share	**Your** Share
Location Information							
High Option **Self Only**	**NM1**	**$73.37**	**$24.45**	**$158.96**	**$52.98**	**$86.82**	**$11.00**
High Option Self & Family	**NM2**	**$187.85**	**$62.62**	**$404.02**	**$135.67**	**$222.29**	**$28.18**