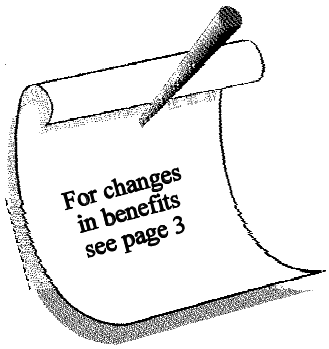
Health Plan of Nevada, Inc. 2000

A Health Maintenance Organization



Serving: Clark, Nye, Mineral and Lyon Counties and parts of Washoe County in Nevada and Mohave County, Arizona.

Enrollment in this Plan is limited; see page 4 for requirements.

Enrollment code:

NM1 Self Only
NM2 Self and Family

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.sierrahealth.com

Authorized for distribution by the:

United States Office of
Personnel Management
Retirement and Insurance Service

Federal Employees
Health Benefits Program

Table of Contents

Introduction

Health Plan of Nevada
P.O. Box 15645
Las Vegas, NV 89119-5645

This brochure describes the benefits you can receive from Health Plan of Nevada under its contract (CS 1942)with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 3. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Health Plan of Nevada as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not rewritten the Benefits section of this brochure. You will find new benefits language next year.

How To Use This Brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.

4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay co-payments and coinsurance listed in this brochure. When you receive emergency services or point-of-service benefits (POS) 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program (See Section 3, How to get benefits, for more information).

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, relevant, or complete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of the non-postal premium will increase by 0.9% for Self Only or 12.3% for Self and Family.

Co-payments for prescriptions have changed for this plan. Members will now pay a $6 co-payment for generic drugs, a $12 co-payment for brand name formulary drugs and a $25 co-payment for non-formulary drugs. See page 14.

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, you must live 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 and the Arizona county of Mohave. 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 or point-of-service benefits. We will not pay for any other health care services.

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.

How much do I pay for services?

You must share the cost of some services. This is called either a co-payment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services. There are no co-payments or coinsurance for the following services, when provided under the HMO benefit provisions: laboratory tests; x-rays; home visits by nurses and health aids; short term rehabilitation therapy; inpatient sessions, entereal formulas and special food products, outpatient hospice services; and the first 30 days of inpatient mental health and/or substance abuse care. .

After **you pay** $3,320 in co-payments or coinsurance for one family member, or $7,084 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, co-payments or coinsurance for your prescription drugs, dental services and services provided under your Point of Service (POS) benefit do not count toward these limits and you must continue to make these payments. If you decide to use your POS benefits, your maximum benefit is $1,500 per member and $4,500 per family each year.

Be sure to keep accurate records of your co-payments and coinsurance, since you are responsible for informing us when you reach the limits.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us, or you use point-of-service benefits. If you file a claim, please send us all of the documents for your claim 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.

Who provides my health care?

This plan has been approved as a mixed model prepayment plan. This means that doctors who practice in medical centers (groups) or in individual offices provide your care. You must choose a primary care doctor when you choose this plan. This plan has a provider directory which lists primary care doctors with their locations, and phone numbers. Primary care doctors generally include family practitioners, pediatricians, OB-GYN's and internists.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

Section 3. How to get benefits *continued*

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care. All hospitalizations which are planned, or are not emergency admissions require prior authorization from the plan. If you need to be admitted to the hospital because of an emergency, prior authorization may not be required. Please refer to page 12 for more information on benefits for emergency situations.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at (702) 242-7300 or toll free, (800) 777-1840. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist. The plan requires that the referral be made to the specialists listed in the plan's directory. A woman may see her Plan Obstetrician/Gynecologist directly, with no need to be referred by her Primary Care Doctor. Referrals to specialty providers not listed in the plan's directory must be arranged by your PCP and will only be allowed if services are not available through plan providers. You must also seek the plan's 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 (refer to page 9 for additional information)
- Physical, occupational and speech therapy.
- Inpatient and outpatient mental health and substance abuse services
- Home health care 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.

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will 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 plan has dedicated clinical staff to work with you and your provider to provide an assessment of your medical needs and assist you with planning your care. Please contact your plan physician or member services at (702) 242-7300 or toll free, (800) 777-1840 if you have any questions.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide 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.

What do I do if my 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.

Section 3. How to get benefits *continued*

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice. Our decisions are based only on reviews of appropriateness of the requested care and/or service. The plan uses nationally accepted guidelines which are reviewed on an annual basis and take into consideration the individual circumstances and needs of each case. The plan does not pay clinical staff conducting reviews based upon the outcome of the review.

How do you decide if a service is experimental or investigational?

The plan regularly evaluates for possible coverage new medical technologies and new application of existing technologies (including medical procedures, drugs and devices). The evaluation includes a review of information on the proposed service from appropriate government regulatory bodies as well as published scientific evidence.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

Section 4. What to do if we deny your claim or request for service *continued*

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at (702)242-7300 or (800)777-1840 and we will expedite your review

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Section 4. What to do if we deny your claim or request for service *continued*

Where should I mail my disputed claim to OPM?

Send your request for request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division 3, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. BENEFITS

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services provided by Plan doctors and other Plan providers. This includes all necessary office visits, where **you pay** a $10 office visit co-payment, but no additional co-payment for laboratory tests and X-rays. Within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; **you pay** a $20 co-payment for a doctor's house call, nothing for home visits by nurses and health aides.

Co-payments for surgery are shown under the section labeled limited benefits.

The following services are included and are subject to the office visit co-payment unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through age 49, one mammogram every one or two years; for women age 50 through age 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Fecal occult blood test for members age 40 and over. Sigmoidoscopy screening every 5 years starting at age 50.
- Routine immunizations and boosters.
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, kidney and liver transplants; allogeneic (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. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Prosthetic devices, such as artificial limbs, breast prosthesis and surgical bras, as well as their replacement. Lenses following cataract removal (initial device covered only).
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need

Section 5. BENEFITS *continued*

What is covered *continued*

- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.
- Chiropractic services
- Blood and blood derivatives

Limited benefits

Surgical procedures are subject to a $50 per outpatient procedure copayment for all procedures, except those performed in the doctor's office which alone are subject to a $5 copayment per procedure in addition to the office visit copayment: however, sterilizations performed in a doctor's office are subject to the $50 outpatient surgical procedure copayment. Surgery performed in an outpatient surgical facility is also subject to a $50 facility copayment for each visit. Inpatient surgical procedures are subject to a $100 per procedure copayment.

Oral and maxillofacial surgery is provided for nondental surgical procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes and correction of malocclusion. Dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome is covered at 50% of eligible medical expenses and limited to a $2,500 maximum per member per calendar year.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist you to achieve and maintain self-care and improved functioning in other activities of daily living. For these services, **you pay** nothing for inpatient sessions and a $10 co-payment per outpatient session.

Diagnosis and treatment of infertility is covered; **you pay** $10 per visit. The following types of artificial insemination are covered: intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay** $10 per visit; cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided at a Plan facility for up to 30 days; **you pay** $10 per visit.

Enteral formulas and special food products are covered, when prescribed by a physician and authorized by the Plan for the treatment of an inherited metabolic disease. Special food products are limited to a combined HMO/POS maximum benefit of $2,500 per member per calendar year. **You pay** nothing under the HMO benefit.

Medication, equipment, supplies and appliances used for the treatment of type I and type II diabetes and gestational diabetes are covered. Covered services include, training and education for the care and management of diabetes, after the member is initially diagnosed with diabetes. **You pay** a $5 copay per visit and per therapeutic supply and a $20 copay per unit for diabetic equipment.

Durable Medical Equipment (DME) is covered at 50% of the EME and is subject to a combined HMO/POS maximum benefit of $4,000 per member per calendar year.

Section 5. BENEFITS *continued*

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Homemaker services
- Orthopedic devices, such as braces and foot orthotics
- Long-term rehabilitative therapy
- Transplants not listed as covered

Hospital/ Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** a $100 co-payment per day not to exceed $200 for each admission; and a $100 co-payment per surgical procedure. All necessary services are covered, including:

- Semiprivate room accommodations. When a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. Such care must be recommended by a Plan doctor and approved by the Plan. **You pay** a $100 co-payment per day not to exceed $200 per admission. All necessary services are covered, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. For inpatient hospice services, **you pay** a $100 copayment per day not to exceed $200 per admission. Outpatient bereavement counseling for each family member upon the death of a terminally ill member is covered for either 5 group therapy visits or a maximum of $500 in benefits per calendar year, whichever is less. **You pay** a $20 copayment per visit. Respite care for family members of a terminally ill patient is also covered. **You pay** nothing for outpatient respite services, with a maximum benefit of $1,000 per calendar year. **You pay** $100 per day (not to exceed $200 per admission) for inpatient respite services with a maximum benefit of $1,500 per calendar year

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay** a $25 co-payment per trip. (See page 12 for Emergency Benefits)

Limited benefits

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 14 for nonmedical substance abuse benefits.

Section 5. BENEFITS *continued*

What is not covered

- Personal comfort items, such as telephone and television
- Dental hospitalization
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

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 the Plan may determine are medical emergencies what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room 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 has been timely notified.

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 you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

You may also receive care at the Plan's 24-hr Urgent Care Center at 888 South Rancho Drive, Las Vegas, NV. Benefits are available for care 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 under POS benefits.

Plan pays...

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

You pay...

$25 per hospital emergency room visit (waived if admitted as an inpatient) or $15 per urgent care center visit for emergency services that are covered benefits of this Plan. $25 per ambulance trip, co-payments as shown on page 10 for outpatient/inpatient surgical procedures and outpatient surgical facility visits and inpatient admissions, $25 per non-Plan doctor's office visit (except $15 per urgent care center), and all charges for services which are not a covered benefit of this Plan.

Emergencies outside the service area

Benefits are available 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 better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance 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 under POS benefits.

Section 5. BENEFITS *continued*

Plan pays...

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay...

$25 per hospital emergency room visit (waived if admitted as an inpatient) or $15 per urgent care center visit for emergency services that are covered benefits of this Plan. $25 per ambulance trip, co-payments as shown on page 10 for outpatient/inpatient surgical procedures and outpatient surgical facility visits and inpatients admissions, $25 per non-Plan doctor's office visit (except $15 per urgent care center), all charges for services which are not a covered benefit of this Plan.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered

- Elective care or nonemergency care, except as covered under POS benefits.
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area, except as covered under POS benefits.
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area, except as covered under POS benefits.

Filing claims for non-plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on a HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 6.

Mental Conditions/ Substance Abuse Benefits

Mental conditions

For services, you must contact Behavioral Healthcare Options, Inc. at 800/873-2246, prior to services being rendered.

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year. For these services, **you pay** a $20 co-payment per visit for each covered visit; **you pay** $10 co-payment per group therapy visit. **You pay** for all charges for visits after you have reached the benefit limit.

Inpatient care

You pay nothing for the first 30 days of hospitalization each calendar year. **You pay** for all charges thereafter.

Section 5. BENEFITS *continued*

What is not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance Abuse

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, (including alcoholism and drug addiction), the same as for any other illness or condition. Services for diagnosis and rehabilitative treatment are covered under the mental conditions benefits as shown above and in addition, to the extent shown below.

What is covered

Outpatient care

Treatment for individual, group and family counseling is covered to a maximum of $2,500 per calendar year. **You pay** a $20 co-payment per visit for individual counseling and $10 per group therapy visit.

Inpatient care

Treatment is covered up to a maximum of $9,000 per calendar year and **you pay** nothing.

What is not covered

- Treatment that is not authorized by the Plan.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. **You pay** a $6 copay per prescription unit or refill for generic drugs. **You pay** a $12 copay per prescription unit or refill for name brand drugs. If a name brand is chosen but is not required/specified by your doctor, **you pay** a $12 copay and the difference in cost between the name brand and the generic drug. If a name brand is required/specified by your doctor, **you pay** a $12 copay. **You pay** a $25 copay per prescription unit or refill for non-formulary drugs.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. A formulary is a list of drugs covered by the Plan and this list is updated on a regular basis. The Plan's formulary is determined by reviewing pertinent medical literature, provider feedback, and changes or improvements in medical technology. A copy of this Plan's current drug formulary is available by contacting the Plan.

Mail Order Pharmacy Option

A mail order program is available for up to a 90-day supply of covered maintenance medications for the treatment of long-term conditions such as, diabetes, arthritis, heart disease and high blood pressure if authorized by a Plan provider. **You pay** two prescription co-payments for up to a 90-day supply.

Section 5. BENEFITS *continued*

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Insulin, with a co-payment charge applied to each whole vial up to 40 ml
- Diabetic supplies, including insulin syringes, needles, blood glucose measuring strips, and urine checking reagents
- Nitroglycerin, phenobarbital or Thyroid U.S.P. When prescribed in quantities of 100, a single co-payment charge will apply.
- Vitamins which require a prescription
- Disposable needles and syringes needed to inject covered prescribed medication
- Contraceptive devices, injectable, implantable and oral contraceptive drugs which require a prescription; contraceptive diaphragms
- Smoking cessation drugs and medication, including nicotine patches.
- Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under the requirements of Medical and Surgical Benefits.

Limited Benefits

- Sexual dysfunction drugs have dispensing limitations. Contact the Plan for details.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Injectable and oral prescription drugs to treat infertility

Other Benefits

Dental Care Accidental Injury Benefit

What is covered

Restorative services and supplies necessary to promptly repair (but not replace) sound, natural teeth. The need for these services must directly result from an accidental injury. **You pay** $25 per emergency room visit and $5 per doctor's office visit. The outpatient/inpatient surgery/admissions co-payments noted on pages 10 and 11 also apply.

What is not covered

- Other dental services not shown as covered.

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye exams (which include the written lens prescriptions for eyeglasses) may be obtained from Plan providers. **You pay** a $10 copayment.

What is not covered

- Eye exercises
- Eyeglasses, frames, contact lenses, including the fitting of the lenses

Section 5. BENEFITS *continued*

Point of Service (POS)Benefits

Facts about Health Plan of Nevada's Point of Service Benefits

At your option, you may choose to obtain services from non-Plan doctors and hospitals, except for the benefits listed below under the heading "What is not covered". You may still be eligible for coverage under the conditions of this POS benefit. Some services must be received from or arranged by Plan doctors and cannot be obtained under the POS benefit. When you obtain non-emergency care and from a non-Plan doctor or without a referral from a Plan doctor, your coverage under this POS benefit is subject to the deductible, coinsurance and maximum benefit stated below.

Your calendar year deductible is $250 per member and $750 per family. After the deductible is met, **you pay** 20% of the plan's Eligible Medical Expenses for all covered POS services except Durable Medical Equipment (DME). DME is covered at 50% of EME. After satisfying the calendar year deductible, your coinsurance maximum is limited to $1,500 of EME per member per calendar year or $4,500 per family in any calendar year.

What is covered after satisfying your deductible:

- Physician Services (Non-specialist Office visit, Inpatient visit, Specialist visit):
- Preventive Healthcare (well child care, routine physical exams and pap smear, routine diagnostic) subject to a maximum benefit of $100 per calendar year.
- Manual Manipulation (Chiropractor, D.O., Physical Therapist) subject to a maximum benefit of $500 per calendar year and $5,000 maximum lifetime benefit.
- Physician Consultations (Non-specialist Office Visit, Specialist Office Visit)
- Inpatient Hospital Services
- Outpatient Hospital and Ambulatory Surgical Facility Services
- Skilled Nursing Services subject to a maximum benefit of 12 days per calendar year.
- Inpatient and Outpatient Physician Services
- Inpatient and Outpatient Oral Surgical Physician Services
- Surgical Assistant Services
- Anesthesia Services
- Ambulance Services (non-emergent)
- Laboratory Services
- Routine Radiological and Non-radiological Diagnostic Imaging Services – Outpatient
- Other 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 Care Services with a maximum benefit of 30 visits or $5,000 per calendar year, whichever is less.
- Prescription Drugs (prescription drug fee)
- Durable Medical Equipment is covered at 50% of the EME and subject to a combined HMO/POS maximum benefit of $4,000 per member per calendar year.
- Enteral Formulas and special food products, special food products are subject to a combined HMO/POS maximum benefit 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 calendar year maximum of two months per condition.
- Prosthetic and Orthotic Devices subject to a combined HMO/POS maximum benefit of $10,000 (including repairs).
- Mental Health and Substance Abuse Services.

Section 5. BENEFITS *continued*

What is not covered

Examples Include:

- Hospice Care Services**
- Temporomandibular Joint dysfunction Treatment**
- Sterilization**
- Organ or Tissue Transplants**
- Care or treatment of an Illness or Injury caused by or arising out of riots, war, insurrection, rebellion, armed invasion or aggression.
- No payment shall be made on any claim which is not received within 12 months after the date Covered Services are provided.

** Covered under the in-plan benefit

Prior-Authorization

In order for certain services to be covered, prior authorization must be obtained from the plan. Failure to comply with the prior authorization requirements may result in a reduction of benefits. Benefits payable for services which are not authorized as will be reduced to 50%, up to a maximum penalty $500 of coverage you would have received if the services had been properly authorized.

Benefits which require Prior-Authorization under the Point of Service benefits 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;
- All outpatient courses of treatment, including, but not limited to: allergy testing/treatment; angioplasty; chemotherapy; dialysis; manual manipulation, radiation therapy; rehabilitation therapy (physical, occupational, speech).

Eligible Medical Expenses (EME)

Means the maximum allowable amount the Plan will pay for a particular service as determined in accordance with the Plan Reimbursement Schedule.

Plan Reimbursement Schedule

Means the level of payment for EME as defined by the Plan with reference to:

- the amount most consistently paid to the Provider; or
- the amount paid to other Providers of similar qualifications; or
- is relative to the value or worth of other allowances for similar services comparable in severity and nature as determined by the Plan with reference to other industry and governmental sources.

Lifetime Maximum

These Point of Service benefits are limited to a Plan payment maximum of $2,000,000 per member, per lifetime

For additional information, write or call:
Health Plan of Nevada, Inc.
P.O. Box 15645
Las Vegas, Nevada 89114-5645
(702) 871-0999

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 or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 24

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

Section 7. Limitations – Rules that affect your benefits *continued*

Other group insurance coverage *continued*

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. 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 disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call (702) 242-7300 or (800) 777-1840 or write to Health Plan of Nevada Member Services, 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.

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Section 8. FEHB Facts *continued*

Are my medical and claims records 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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.

Section 8. FEHB FACTS *continued*

What is TCC?
continued

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- **You pay** the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

Section 8. FEHB FACTS *continued*

How can I get a Certificate of Group Health Plan 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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, POS maximum benefits, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Supplemental Dental Care Services

Health Plan of Nevada, Inc. is pleased to offer a Supplemental Dental program to FEHBP members with Dentists who have agreed under contract to participate in HPN's Dental Program and provide Dental Care Services to members. Procedures not listed are not covered. You are required to re-enroll every year into the supplemental dental plan during the open enrollment period. Please refer to the supplemental dental information for further information on this program, including premiums, what is covered under the supplemental program and limitations and exclusions.

Medicare+Choice

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 702/821-2301 or 800/650-6232 for information on the Medicare prepaid plan and the cost of that enrollment. 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 702/821-2301 or 800/650-6232 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract

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
U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Health Plan of Nevada – 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, AND SERVICES AVAILABLE AS POS BENEFITS, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

Benefits		Plan pays/provides	Page
Inpatient Care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** $100 per day, not to exceed $200 per admission; $100 per surgical procedure.	11
	Extended Care	All necessary services, no dollar or day limit. **You pay** $100 per day, not to exceed $200 per admission.	11
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing	13
	Substance Abuse	Coverage under mental conditions benefits and in addition rehabilitative care up to $9,000 per calendar year. **You pay** nothing	14
Outpatient Care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and x-rays; complete maternity care. **You pay** $10 copay per office visit; $20 per house call by a doctor; $50 per surgical procedure; $50 per outpatient surgical facility visit.	9 - 10
	Home Health Care	All necessary visits by nurses and health aids. **You pay** nothing	9
	Mental Conditions	Up to 20 visits per calendar year. **You pay** a $20 copay per visit; **you pay** $10 copay per group therapy visit	13
	Substance Abuse	Coverage under mental conditions benefits an in addition counseling up to $2,500 per calendar year. **You pay** a $20 copay per visit; **you pay** $10 per group therapy visit	14
Emergency Care		Customary and reasonable charges for services and supplies required because of a medical emergency. **You pay** a $25 copay to the hospital for each emergency room visit and any non-Plan doctor's office visit and ambulance trip, $15 per urgent care center visit, surgery/admission copayments as shown, and any charges for services that are not covered by this plan.	12 - 13
Prescription Drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $6 copay per prescription unit or refill. If a name brand is chosen but is not required/specified by your doctor, **you pay** the $12 copay and the difference in cost between the name brand and the generic. If a name brand is required/specified by your doctor, **you pay** a $12 copay. If a non-formulary drug is prescribed by a Plan doctor and obtained at a Plan pharmacy, **you pay** a $25 copay per prescription unit or refill. A Mail Order is available for up to a 90 day supply of maintenance medications. **You pay** two prescription copayments	14 - 15
Dental Care		Accidental injury benefit. **You pay** a $10 per doctor's visit and a $25 for an emergency room visit and surgery/admission copayments as shown	15
Vision Care		One refraction annually. **You pay** a $10 per visit	15
Point of Service Benefits		Services of non-Plan doctors and hospitals. Not all benefits are covered. You pay deductibles and coinsurance and a maximum benefit applies	16
Out-of-Pocket Limit		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $3,30 per Self Only or $7,804 per Self and Family enrollment per calendar year under standard HMO benefits; $1,500 per member or $4,500 per family for POS benefits; benefits will be provided at 100%. This copay maximum does not include prescription drugs	16

Notes

2000 Rate Information for Health Plan of Nevada, Inc.

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 most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	**NM1**	**$55.95**	**$18.65**	**$121.22**	**$40.41**	**$66.21**	**$8.39**	**$66.21**	**$8.39**
Self and Family	**NM2**	**$143.22**	**$47.74**	**$310.31**	**$103.44**	**$169.48**	**$21.48**	**$169.48**	**$21.48**