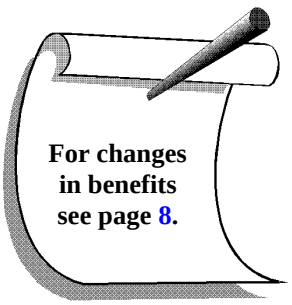
Health Plan of Nevada

http://www.healthplanofnevada.com

2003

A Health Maintenance Organization

Serving: The Las Vegas metropolitan area and surrounding communities



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

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.

- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

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. The address for Health Plan of Nevada's administrative offices is:

Health Plan of Nevada
PO Box 15645
Las Vegas, NV 89114-5645

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language 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.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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. The Plan is solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

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 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.

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 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 services (as described above). At the end of the year, that money may be paid to the doctor or medical group, depending up on the management and use of special services.

Your rights

OPM requires that all FEHB Plans 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 has operated as a mixed model HMO in Nevada for 20 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, effective August 2000, is for the commercial HMO, commercial point of service (POS) and Medicare HMO product lines in Nevada.
- 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. 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 by visiting our website at www.healthplanofnevada.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 and Nye.

Ordinarily, you must get 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 2003

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.

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 0.0% for Self Only or 0.0% for Self and Family.
- We eliminated the Point of Service (POS) benefit.
- We no longer service Lyon, Mineral and Washoe counties.
- You no longer have a copayment for physician visits during a hospital stay.
- The routine laboratory and diagnostic test copayment is $5, in addition to an office visit copayment.
- The complex imaging and diagnostic test copyament increases from $5 to $10.
- The sigmoidoscopy and colonoscopy cancer screening copayment increases from $10 to $50 per procedure.
- The maternity care copayment increases from $10 to $15 per visit.
- The physical and occupational therapy copayment decreases from $10 to $5 per visit.
- The speech therapy copayment decreases from $10 to $5 per visit.
- The orthopedic and prosthetic devices coverage is expanded to include more items. (Section 5(a))
- The orthopedic and prosthetic device coinsurance is 50% of the total cost, not to exceed $200 per device.
- The temporomandibular joint (TMJ) pain dysfunction syndrome copayment changes from $10 to 50% of eligible medical expense (EME).
- Temporomandibular joint (TMJ) pain dysfunction syndrome is no longer limited to $2,500 per member per year with a lifetime maximum per member.
- The durable medical equipment coinsurance is eliminated.
- Diabetes supplies (syringes, needles, blood glucose measuring strips and urine checking reagents) and diabetes equipment (blood glucose monitor and lancet device) are covered under the "Educational classes and programs benefit" instead of "Prescription drug benefits."
- The diabetes supplies copayment is reduced from $20 to $5 per 30-day therapeutic supply.
- The diabetes equipment coinsurance is changed to a $20 copayment per unit.
- We no longer charge for physician surgical services that are performed inpatient or in an outpatient facility.
- The organ/tissue transplant coverage is expanded. (Section 5(b))
- The copayment decreases from $200 per admission to $100 per admission for the following:
  - inpatient hospital services
  - extended care/skilled nursing care facility benefits
  - inpatient hospice services
  - inpatient respite services
- The outpatient respite services copayment decreases from $10 per visit to $5 per visit.
- The bereavement services copayment is $20 per visit.
- The professional ambulance service copayment increases from $25 per trip to $50 per trip.
- The emergency care at an urgent care facility within the Plan's service area copayment increases from $15 per visit to $20 per visit.
- The emergency care at a hospital emergency room within the Plan's service area copayment increases from $25 per visit to $50 per visit.
- The emergency care at a physician's office outside of the Plan's service area copayment increases from $25 per visit to $50 per visit.

- The emergency care at an urgent care facility outside of the Plan's service area copayment increases from $15 per visit to $40 per visit.
- The emergency care at a hospital emergency room outside the Plan's service area copayment increases from $25 per visit to $75 per visit.
- The mental health and substance abuse diagnostic test copayment is decreased from $10 to $5 per procedure, in addition to an office visit copayment.
- The Special features benefit is expanded to include more disease management and preventive health programs. (Section 5(g))
- The accidental dental injury copayment increases from $25 per outpatient visit to $50 per outpatient visit.

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) 777-1840 or write to us at PO Box 15645, Las Vegas, NV 89114-5645. You may also request replacement cards through our website at www.healthplanofnevada.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and coinsurance, and you will not have to file claims.

· **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.

You should join our Plan because you prefer the 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.

· **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 available 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 (PCP). This decision is important since your PCP provides or arranges for most of your health care. This plan has a provider directory, which we urge you to review before choosing your PCP.

· **Primary care**

Your PCP can be a family practitioner, pediatrician, or internist who practices as a PCP. Women may also select an Obstetrician/Gynecologist. Your PCP will provide most of your health care, or give you a referral to see a specialist.

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

· **Specialty care**

Your PCP will refer you to a specialist for needed care. When you receive a referral from your PCP, you must return to the PCP after the consultation, unless your PCP authorized a certain number of visits without additional referrals. The PCP must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your PCP 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 PCP 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 PCP will use our criteria when creating your treatment plan (the physician may have to get Plan approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to PCP. Your PCP 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 PCP, 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 PCP 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 provider (PCP) 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 procedures
- Physical, occupational and speech therapy
- Inpatient and outpatient mental health and substance abuse treatment
- Home health
- Prosthetic devices and durable medical equipment

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

Contact our member 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 provider (PCP) you pay a copayment of $10 per office visit, and when you go to the hospital you pay $100 per admission.

- **Deductible**

  We do not have a deductible.

- **Coinsurance**

  Coinsurance is the percentage of our negotiated fee that you must pay for your care.

  Example: In our Plan, you pay 50% of our allowance for costs associated with vision supplies and non-dental treatment of temporomandibular joint pain dysfunction syndrome.

- **Eligible Medical Expense (EME)**

  Charges up to the Plan reimbursement schedule amount, incurred by you while covered under this Plan for covered services. Plan providers have agreed to accept the Plan's reimbursement schedule amount as payment in full for covered services, plus your payment of any applicable copayment or coinsurance. Non-Plan providers have not. If you use the services of non-Plan providers, you will receive no benefit payments or reimbursement for charges for the service, except in the case of emergency services, urgently needed services, or other covered services provided by a non-Plan provider that are prior authorized by the Plan. In no event will the Plan pay more than the applicable Plan reimbursement schedule amount for such services.

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

After your copayments and coinsurance total $2,000 per person or $5,000 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 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 52 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 claim 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.healthplanofnevada.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 year deductible.
- 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 • Office medical consultations	$10 per office visit
Professional services of physicians • In an urgent care center • House calls by physician	$20 per office visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Second surgical opinion	Nothing
Lab, X-ray and other diagnostic tests	
• Laboratory services	$5 plus office visit copayment
• Routine, such as: – EKG – X-ray	$5 per test plus office visit copayment
• Complex diagnostic imaging services, such as nuclear medicine, CT scan, cardiac ultrasonography, MRI and arthrography • Complex vascular diagnostic and therapeutic services including Holter monitoring, treadmill stress testing, and impedance venous plethysmography • Complex neurological diagnostic services including EEG, EMG and evoked potential • Complex pulmonary diagnostic services including pulmonary function testing and apnea monitoring • Otologic Evaluation	$10 per test or procedure

Preventive care, adult	You pay
Routine screenings, such as: • Total blood cholesterol – once every three years • Cholorectal Cancer Screening, including fecal occult blood test • Double contrast barium enema – once every 5-10 years beginning at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Screening for Chlamydial infection • Routine mammogram – covered for women age 35 and older as follows: – From age 35 through 39, one during this five year period – Age 40 and older, one every calendar year • Routine Pap test Note: The office visit is covered if the Pap test is received on the same day; see *Diagnostic and treatment services*, above.	$5 per test plus office visit copayment
• Sigmoidoscopy – one every five years starting at age 50; or • Colonoscopy – one every 10 years starting at age 50	$50 per procedure
• Routine immunizations, limited to: – Tetanus-diphtheria (Td) booster, once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) – Influenza vaccine, annually – Pneumococcal vaccine, age 65 and older	$10 per office visit No charge at immunization clinics
Not covered: • *Physical exams required for obtaining or continuing employment, licensing, insurance, attending schools or camp, travel, sports, or adoption purposes* • *Exams or treatment ordered by a court, or in connection with legal proceedings* • *Immunizations related to foreign travel*	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (through 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 (through age 22)	$10 per office visit
Not covered: • *Physical exams required for obtaining or continuing employment, licensing, insurance, attending schools or camp, travel, sports, or adoption purposes* • *Exams or treatment ordered by a court, or in connection with legal proceedings* • *Immunizations related to foreign travel*	*All charges*

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 have your normal delivery prior authorized; see page 10 for other circumstances, such as extended stays for you and your baby. • You may remain in the hospital up to 48 hours after a vaginal 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 the infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Circumcision is covered under the *Surgical benefits (Section 5(b))*. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits (Section 5(c))* and *Surgical benefits (Section 5(b))*.	$15 per office visit
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Amniocentesis, except when medically necessary under the guidelines of the American College of Obstetrics and Gynecology*	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • 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 copayments may apply for surgical services. See *Section 5(b)*.	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Voluntary abortions*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: – Intracervical insemination (ICI) – Intrauterine insemination (IUI)	$10 per office visit

Infertility services – continued on next page.

Infertility services *(continued)*	**You pay**
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* • *Low tubal transfers*	*All charges*
Allergy Care	
• Testing and treatment • Allergy injection	$10 per office visit
• Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 25. • 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 *(Section 5(f))*. 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 and prior authorization is given. If you do not request prior authorization 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 intended to primarily improve athletic ability.	*All charges*

Physical and occupational therapies	You pay
• Two 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. Note: Cardiac rehabilitation services must be provided on a monitored basis.	$5 per office visit
Not covered: – *Long-term rehabilitative therapy* – *Exercise programs* – *Milieu therapy, biofeedback, behavior modification, sensitivity training, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolfing, residential treatment, vocational rehabilitation and wilderness programs.* – *Treatment for mental retardation*	*All charges*
Speech therapy	
• Two consecutive months per condition for the services of a speech therapist	$5 per office visit
Hearing services (testing, treatment, and supplies)	
• 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 tests* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Annual eye refraction Note: See *Preventive care, children* for eye exams for children.	$10 per office visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental injury or intraocular surgery (such as for cataracts)	50% of costs
Not covered: • *Eye examination required as a condition of employment or by a government body* • *Low vision aids* • *Orthoptics or vision training and exercises* • *Medical or surgical treatment of the eyes* • *Any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses*	

Foot care	You pay
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: 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	
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants and surgically implanted breast implants following mastectomy Note: See *5(b)* for coverage of the surgery to insert the device. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Terminal devices, such as hand or hook • Artificial limbs and eyes; stump hose • Braces which include only rigid and semi-rigid devices used for supporting a weak or deformed body member or restricting or eliminating motion of a diseased or injured part of the body • Foot orthotics when part of a lower body brace • Lumbosacral supports • Adjustment of an initial Prosthetic or Orthotic Device required by wear or by change in the patient's condition when ordered by a Plan provider	50% of cost, not to exceed $200 per device
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	50% of eligible medical expense
Not covered: • *Arch supports* • *Special shoe accessories or corrective shoes unless they are an integral part of a lower body brace* • *Heel pads and heel cups* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than three years after the last one we covered*	*All charges*

Durable medical equipment (DME)	You pay
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: • Wheelchairs – limited to coverage of single standard manual wheelchair as deemed medically necessary and appropriate • Hospital beds • Traction equipment • Walkers • Crutches • Insulin pumps Note: Call us at (702) 242-7300 or (800) 777-1840 as soon as your Plan physician prescribes this equipment.	Nothing
Not covered: • *Motorized wheelchairs* • *Custom wheelchairs* • *More than one piece of equipment serving essentially the same function except for replacements as authorized by the Plan. Coverage for alternate or spare equipment is not provided.*	*All charges*
Home health services	
Covered services and supplies provided by a Home Health Care agency include: • Professional services of a registered nurse, licensed practical nurse, licensed vocational nurse or a health aide on an intermittent basis. • Physical therapy, speech therapy and occupational therapy by licensed therapists. • Medical and surgical supplies that are customarily furnished by the Home Health Care agency or program for its patients. • Prescribed drugs furnished and charged for by the Home Health Care agency or program. Prescribed drugs under this provision do not include self-injectable prescription drugs. • Health aid services furnished to member only when receiving nursing services or therapy.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Housekeeping or meal service*	*All charges*
Chiropractic	
• Chiropractic services for manual manipulation of the spine (except for reductions of fractures or dislocations) Note: Limited to 60 consecutive calendar days per condition.	$10 per office visit
Alternative treatments	
No benefit	*All charges*

Educational classes and programs	You pay
Coverage is limited to: • Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime Note: See *Prescription drug benefits (Section 5(f))* for coverage of smoking cessation medication.	$10 per office visit $5 per eductional site visit
• Diabetes self-management • Education – Includes coverage for education for treatment of diabetes. Covered services include medically necessary training and education for: – the care and management of diabetes, after initial diagnosis of diabetes, to include counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes – a subsequent diagnosis that indicates a significant change in the symptoms or condition which requires modification of the self-management program – the development of new techniques and treatment for diabetes	$10 per office visit $5 per educational site visit
• Diabetes supplies, including: – syringes – needles – blood glucose measuring strips – urine checking reagents • Disposable needles and syringes for the administration of covered medications	$5 per 30-day therapeutic supply
• Diabetes equipment, including: – blood glucose monitor – lancet device Note: See *Durable medical equipment (Section 5(a))* for coverage of insulin pumps. See *Prescription drug benefits (Section 5(f))* for coverage of diabetes medication.	$20 per unit (maximum one unit per year)

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 for your care.
- We have no calendar year deductible.
- 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 FOR SURGICAL PROCEDURES.** Please refer to the prior authorization information in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

IMPORTANT

Benefit Description	You pay
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 as a treatment of last resort. • Insertion of internal prosthetic devices. See *Orthopedic and prosthetic devices (Section 5(a))* for device coverage information. • Treatment of burns • Surgically implanted contraceptives • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) 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.	$5 plus office visit copayment in a physician's office Nothing in an outpatient facility Nothing for inpatient admissions
• Surgical Assistant Services	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot*	*All charges*

Reconstructive surgery	You pay
• Surgery to correct a function 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: cleft lip, cleft palate, birth marks, webbed fingers, and webbed toes.	$5 plus office visit copayment in a physician's office Nothing in an outpatient facility Nothing for inpatient admissions
• 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.	Nothing for inpatient admissions
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 • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Treatment of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth • Removal of teeth necessary in order to perform radiation therapy • Removal of stones from salivary ducts • Other surgical procedures that do not involve the teeth or their supporting structures	$10 in a physician's office Nothing in an outpatient facility Nothing for inpatient admissions
• Non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	50% of eligible medical expense
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes* • *Charges for dental services in connection with TMJ*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Kidney • Liver • Allogenic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute 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.	Nothing for inpatient admissions
• Transportation, lodging and meals Note: Prior authorization is required.	All costs exceeding $200 per day and $10,000 per transplant period
• Procurement	All costs exceeding $15,000 of eligible medical expense
• Retransplantation services	All costs exceeding 50% of eligible medical expense
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 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 for your care.
- We have no calendar year deductible.
- 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 services for your surgery or care. Any costs associated with the professional charge (e.g., physicians) are covered in Sections 5(a) or 5(b).
- **YOU 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 • 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. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Clinical pathology and laboratory services and supplies and x-rays • Dressing, splints, casts, and sterile tray services • Medical supplies including oxygen and its administration • Blood or blood plasma, if not donated or replaced • Intravenous injections and solutions • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	$100 per admission
Not covered: • *Custodial care* • *Non-covered facilities* • *Personal comfort items, such as telephone, television, barber services* • *Private nursing care*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Clinical pathology and laboratory services and supplies and x-rays • Dressing, splints, casts, and sterile tray services • Medical supplies including oxygen • Blood or blood plasma, if not donated or replaced • Pre-surgical testing • Intravenous injections and solutions 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
Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF): • Bed, board, and general nursing care • Prescribed drugs and medicines • Clinical pathology and laboratory services and supplies and x-rays • Dressing, splints, casts, and sterile tray services • Oxygen and its administration • Blood or blood plasma, if not donated or replaced • Intravenous injections and solutions Note: Maximum benefit of 100 days per member per calendar year.	$100 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:	
• Inpatient hospice services • Inpatient respite services	$100 per admission
• Outpatient respite services	$5 per visit
• Bereavement services Note: Limited to five (5) group therapy sessions or a maximum of $500, whichever is less, per event.	$20 per visit
Not covered: Independent nursing, homemaker services	*All charges*

Ambulance	You pay
Covered services include ambulance transportation to the nearest appropriate facility. Note: Ambulance services will be reviewed on a retrospective basis to determine medical necessity. The member will be fully liable for the cost of ambulance services that are not medically necessary. Note: Non-emergency medically necessary benefits are payable only upon prior authorization from the Plan.	$50 per trip

Section 5 (d). Emergency services/accidents

IMPORTANT		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.
- We have no calendar year deductible.
- 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.

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 the 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 PCP. 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 Urgent Care Centers (see Provider Directory). 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.

We pay up to the eligible medical expense (EME) 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 services that are 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.

We pay up to the eligible medical expense (EME) 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 physician's office	$25 per visit plus amount exceeding EME
• Emergency care at an urgent care facility	$20 per visit plus amount exceeding EME
• Emergency care in a hospital emergency room	$50 per visit plus amount exceeding EME Waived if admitted
Emergency outside our service area	
• Emergency care at a physician's office	$50 per visit plus amount exceeding EME
• Emergency care at a non-plan urgent care facility	$40 per visit plus amount exceeding EME
• Emergency care in a hospital emergency room	$75 per visit plus amount exceeding EME Waived if admitted
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	
Covered services include ambulance services to the nearest appropriate hospital. See *5(c)* for non-emergency ambulance services. Note: Ambulance services will be reviewed on a retrospective basis to determine medical necessity. The member will be fully liable for the cost of ambulance services that are not medically necessary.	$50 per trip
Not covered: Air ambulance unless medically necessary	*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:

- 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.
- We have no calendar year deductible.
- 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 PRIOR AUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
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 service, 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 not 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
• Diagnostic tests	$5 per procedure plus office visit copayment
• 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 admission
Not covered: • *Services we have not approved* • *Marital or family counseling* *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*

Prior authorization

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.behavioralhealthcareoptions.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 have no calendar year deductible.
- 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, 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 order 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 use a formulary (also referred to as a "Preferred Drug List") to serve as a guide for providers in the selection of cost-effective drug therapy and to help maximize the value of our members' prescription drug coverage. 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. If your physician believes a brand-name product is necessary or there is no generic available, your physician may prescribe a brand name drug from the formulary. Inclusion of drugs on the formulary does not guarantee that your provider will prescribe that medication.

  Your copayment is lower when formulary drugs are prescribed for you. However, your benefit also includes coverage for non-formulary drugs. Non-formulary drugs are available for the higher non-formulary copayment. Prior authorization may be required.

  To obtain a copy of our Preferred Drug List, contact Member Services at (702) 242-7300 or (800) 777-1840, or visit our web site at www.healthplanofnevada.com.

  A "maintenance drug" is a preferred covered drug prescribed to treat certain chronic or life-threatening long-term conditions as determined by the Plan, such as diabetes, arthritis, heart disease and high blood pressure.

  "Therapeutic supply" is the quantity of a covered drug for which benefits are available for a single applicable copayment and may be less than but shall not exceed a 30-day supply.

- **These are the dispensing limitations.** A dispensing limitation is the quantity of a medication for which benefits are available for a single applicable copayment, or in the case of maintenance drugs, two copayments. Dispensing limitations may include, but are not limited to
  - a period of time that a specific medication is recommended by the manufacturer and/or the FDA to be an appropriate course of treatment when prescribed for a particular condition, or
  - a predetermined period of time established by the Plan, or
  - the FDA-approved dosage of a medication when prescribed for 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 are available 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 brand name. If you receive a brand-name drug when a Federally-approved generic drug is available, and your physician has not specified "Dispense as Written" for the brand-name drug, you have to pay the difference in cost between the brand-name drug and the generic, in addition to the generic drug copayment.

- **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. 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.

- **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 and receipts) 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.: Correspondence/CRR, P.O. Box 15645, Las Vegas, NV 89114-5645.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a 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 (See *Educational classes and programs (Section 5(a))* for coverage of diabetes supplies.) • Drugs for sexual dysfunction. Sexual dysfunction drugs have specific dispensing limitations and require prior authorization by the Plan. Contact the plan for details. • Oral contraceptive drugs • Smoking cessation drugs (e.g., nicotine patches) • Growth hormone • Orphan drugs • Self-injectable drugs • Pediatric and prenatal vitamins Note: A "self-injectable" is to be administered subcutaneously or intramuscularly and does not require administration by a licensed practitioner.	$5 per generic prescription $20 per brand-name prescription $35 per non-formulary drug You pay two applicable copayments for a 90-day therapeutic supply of maintenance medication obtained through our mail-order program.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription medicines (except insulin)* • *Anorexic agents* • *Injectable and oral drugs to treat fertility* • *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.
Telephone Advice Nurse	For any of your health concerns you may call 242-7330 or (800) 288-2264 and talk with a registered nurse who will answer your health questions and discuss treatment options.
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 (HPN) offers numerous preventive health management programs to assist members with early detection and prevention of serious illnesses. These programs may include childhood immunizations, breast and cervical cancer screenings, nutrition and fitness, smoking cessation, prenatal care, stress management, weight management for adults and children, and women's health issues. • HPN also offers disease management programs and other health promotion activities to assist members with chronic conditions such as arthritis, adult and childhood asthma, back care, carpal tunnel syndrome, cholesterol reduction, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and hypertension.

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 have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See *Section 5 (c)* for inpatient hospital benefits. 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

Benefit Description	You pay
Accidental injury benefit	
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. • Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an injury (not to include chewing) when the treatment starts within the first 10 days after the injury and ends within 60 days, such as: – Root canal therapy, post and build up – Temporary crowns – Temporary partial bridges – Temporary and permanent fillings – Pulpotomy – Extractions of broken teeth – Incision and drainage – Tooth stabilization through splinting	
• Emergency dental care in a physician's office	$10 per office visit
• Emergency dental care in an emergency room	$50 per outpatient facility
Dental benefits	
We have no other dental benefits.	

Section 5 (i). 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 FEHB 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 FEHB, have Medicare Part A coverage and have purchased Part B coverage, you may also enroll in the Plan's Senior Dimensions Medicare + Choice program. The Senior Dimensions program 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 FEHB 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 + Choice program sponsored by this Plan without dropping your enrollment in this Plan's FEHB, call (702) 242-7300 or (800) 777-1840 for information on the benefits available under the Medicare + Choice program.

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 12.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies. See Emergency benefits 5(d);
- 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 participation in the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

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 or coinsurance.

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) 777-1840.

When you must file a claim -- such as for services you receive outside of the Plan's service area -- 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) 777-1840. We will assist you in completing a Direct Member Reimbursement form and help you process your claim.

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 prior authorization:

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 more than one claim, 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.

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 prior authorization. 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 prior authorization/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 prior authorization/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 may 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 or a covered family member have coverage 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.

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 claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, 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.healthplanofnevada.com.

We do not waive any costs if the Original Medicare Plan is your primary payer.

[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)		✓
1) 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),	✓	
2) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
3) 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		✓

· **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from 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. If you are a FEHB annuitant and enrolled in our Medicare managed care plan, we waive the copayments for your FEHB coverage. If you are an active FEHB employee and enrolled in our Medicare managed care plan, we do not waive cost-sharing 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 or coinsurance. 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 and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under the program.

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.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these State programs, eliminating your FEHB 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 under the State program.

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 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

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. Custodial care that lasts 90 days or more is sometimes known as Long term care.

Eligible Medical Expense (EME)

Charges up to the Plan reimbursement schedule amount, incurred by you while covered under this Plan for covered services. Plan providers have agreed to accept the Plan's reimbursement schedule amount as payment in full for covered services, plus your payment of any applicable copyament. Non-plan providers have not. If you use the services of non-plan providers, you will receive no benefit payments or reimbursement for charges for the service, except in the case of emergency services, urgently needed services, or other covered services provided by a non-plan provider that are prior authorized by the Plan. In no event will the Plan pay more than the applicable Plan reimbursement schedule amount for such services.

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 (also “Medically Necessary”) 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.

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 your FEHB coverage. These materials tell you:

- 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.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,

- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact you employing office for further information.

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.

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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's website, www.opm.gov/insure.

· 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 Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

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 – 2003

- **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 copayment: $10 primary care; $10 specialist	15
Services provided by a hospital: • Inpatient ..... • Outpatient.....	 $100 per admission $50 per visit	26 27
Emergency benefits: • In-area ..... • Out-of-area	 $25 per visit $50 per visit	30 30
Mental health and substance abuse treatment.....	Regular cost sharing.	31
Prescription drugs	$5 generic preferred $20 brand preferred $35 non-preferred	32
Dental Care	No benefit	35
Vision Care	$10 per visit for one refraction annually and 50% of costs associated with vision supplies	19
Special features: Flexible benefits option, Telephone Advice Nurse, Services for the deaf and hearing-impaired, Preventive Health/Disease Management		34
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $2,000/Self Only or $5,000/Family enrollment per year Some costs do not count toward this protection	13

2003 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 a special FEHB guide is published 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 who are not career postal employees. 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**
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**	**$407.02**	**$135.67**	**$222.29**	**$28.18**

Location Information