



## A Health Maintenance Organization with a Point of Service product

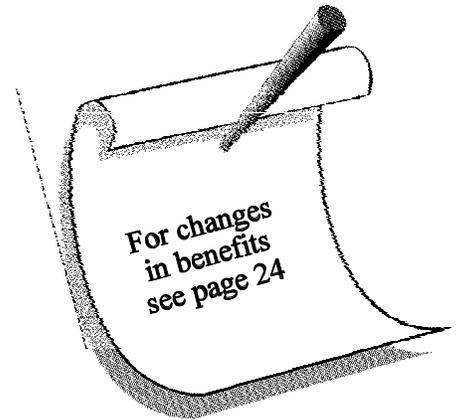
**Serving:** Clark, Nye, Mineral and Lyon Counties and parts of Washoe County in Nevada and Mohave County, Arizona.

Enrollment in this Plan is limited; see page 9 for requirements.

**Enrollment code:**

**NM1 Self Only**

**NM2 Self and Family**



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

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**United States  
Office of  
Personnel  
Management**



# Health Plan of Nevada, Inc.

Health Plan of Nevada, Inc., 2720 North Tenaya, Las Vegas, NV 89128, has entered into a contract (CS 1942) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Health Plan of Nevada, Health Plan, or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 24 of this brochure.

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# Inspector General Advisory: Stop Health Care Fraud!

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Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at (800) 777-1840 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

**THE HEALTH CARE FRAUD HOTLINE  
202/418-3300**

The Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street, N.W., Room 6400  
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

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## General Information

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### Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

### If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, **you will be covered only for services provided or arranged by a Plan doctor** except in the case of emergency as described on page 14, or when you self-refer for point of service, or POS, benefits as described on page 18. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

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## General Information *continued*

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### **If you are a new member** *continued*

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

### **If you are hospitalized**

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

### **Your responsibility**

**It is your responsibility to be informed about your health benefits.** Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

### **Things to keep in mind**

- The **benefits** in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency or POS benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions, including divorces, of covered family members to the Plan promptly.

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## General Information *continued*

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### Things to keep in mind

*continued*

- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

### Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

#### Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

#### Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

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## General Information *continued*

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### Temporary continuation of coverage (TCC) *continued*

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

### Notification and election requirements

**Separating employees** — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

**Children** — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

**Former spouses** — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

### Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

### Certificate of creditable coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

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## Facts about this Plan

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This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO) that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are required to select a personal doctor who will provide or arrange for your care and you will pay minimal amounts for comprehensive benefits. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See page 18 for more information.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

You have the right to be allowed to review and/or obtain a copy of your medical record upon request to your provider. To review or receive a copy of your medical record, contact your provider for these arrangements. You might be charged a nominal amount for the copy.

### **Information you have a right to know**

All carriers in the FEHB program must provide certain information to you. If you wish to receive information about this plan, you can obtain it by calling the Carrier at (800) 777-1840 or you may write the Carrier at P.O. Box 15645, Las Vegas, NV 89114-1531.

### **Information that must be made available to you includes:**

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If non compliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical record.

### **Who provides care to Plan members?**

This Plan has been approved as a mixed model prepayment plan. This means care is provided through Plan doctors who practice in medical centers (groups) or in individual (private) offices. As discussed below you must choose a primary care doctor. You may select any one of the Plan's primary care doctors whether that doctor practices in a group or individual setting. The Plan also contracts with certain area hospitals.

### **Role of a primary care doctor**

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the member's primary care doctor or when you use POS benefits, with the following exception: A woman may see her Plan Obstetrician/Gynecologist directly, with no need to be referred by her Primary Care Doctor.

### **Choosing your doctor**

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, OB-GYNs and internists) with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at (800) 777-1840. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits or POS benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

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## **Facts about this Plan** *continued*

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### **Choosing your doctor** *continued*

If you enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s) you selected for you and each member of your family. Members may change their doctor selection by notifying the Plan 30 days in advance.

In the event a member is receiving services from a doctor who terminates a participation agreement, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by a participating doctor.

### **Referrals for specialty care**

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, or when you choose to use the Plan's POS benefits, you must receive a referral from your primary care doctor referral before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those participating in the Plan, the primary care doctor will make arrangements for appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation. All follow-up care must be provided or authorized by the primary care doctor. On referrals, the primary care doctor will give specific instructions to the consultant as to what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for and the Plan has issued an authorization for the referral in advance.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

### **Authorizations**

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care, receive a prescription for a non-formulary drug or obtain follow-up care from a specialist.

### **For new members**

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you prior to your joining this Plan is now your Plan primary care doctor, you need only call to explain that you now belong to this Plan and ask that a "referral form" be sent to the specialist for your next appointment.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

### **Hospital care**

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care. Outpatient surgical services will be provided in a hospital, outpatient surgical facility or other surgical facility, as appropriate.

### **Out-of-pocket maximum**

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach \$3,320 per Self Only enrollment or \$7,804 per Self and Family enrollment. This copayment maximum does not include the costs of prescription drugs. If you elect to use the POS Benefit, the out-of-pocket maximum is \$1,500 per member, \$4,500 per family.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

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## Facts about this Plan *continued*

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### **Deductible carryover**

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

### **Submit claims promptly**

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

### **Experimental/ investigational determinations**

A drug, device or medical treatment or procedure is experimental or investigational if it is unproven or not recognized as acceptable medical practice. Health Plan of Nevada conducts experimental or investigational assessments both in response to requests from appropriate parties and in a proactive manner by annual evaluation of several new medical technologies appropriate to its membership. Clinically urgent expedited and clinically non-urgent routine requests for experimental or investigational assessments are accepted and evaluated by submitting a request to the Health Plan of Nevada, Inc. Office of the Vice President Health Care Quality and Education for processing.

### **Other considerations**

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

### **The Plan's service area**

The service area for this Plan, where Plan providers and facilities are located, is described below. You must live or work in the service area to enroll in this Plan.

The service area for this Plan includes the following areas:

The Nevada counties of Clark, Nye, Mineral, and Lyon and the Arizona county of Mohave. Portions of Washoe county in Nevada are also within the service area, as indicated by the zip codes: 89442, 89431, 89433, 89434, 89436, 89501, 89502, 89503, 89506, 89509, 89510, 89511, 89512, 89523.

Benefits for care outside the service area are limited to emergency services, as described on page 14, and to services covered under Point of Service Benefits, as described on page 18.

If you or a covered family member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

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## **General Limitations**

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### **Important notice**

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan. This brochure is the official statement of benefits on which you can rely.

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## General Limitations *continued*

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### **Circumstances beyond Plan control**

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

### **Other sources of benefits**

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

#### **Medicare**

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers or the services are covered under this Plan's POS benefit. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

#### **Group health insurance and automobile insurance**

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

#### **CHAMPUS**

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care unless you use a non-Plan provider for POS benefits described on page 18. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

#### **Medicaid**

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

#### **Workers' compensation**

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

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## General Limitations *continued*

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### **DVA facilities, DoD facilities, and Indian Health Service**

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

### **Other Government agencies**

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

### **Liability insurance and third party actions**

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the plan will provide you with its subrogation procedures.

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## General Exclusions

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All benefits are subject to the limitations and exclusions in this brochure. Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition as discussed under Authorizations on page 8.

### **The following are excluded:**

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services obtained under Point of Service Benefits;
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term.

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## Medical and Surgical Benefits

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### **What is covered**

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a \$5 office visit copay, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; **you pay** a \$20 copay for a doctor's house call, nothing for home visits by nurses and health aides.

Copayments for surgery are as shown under Limited benefits.

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through age 49, one mammogram every one or two years; for women age 50 through age 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.

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## Medical and Surgical Benefits *continued*

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### What is covered

*continued*

- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, kidney and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE  
STANDARD HMO BENEFITS

- Surgical treatment of morbid obesity
- Prosthetic devices, such as artificial limbs and lenses following cataract removal (initial device covered only)
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.
- Chiropractic services
- Blood and blood derivatives

### Limited benefits

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

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

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## Medical and Surgical Benefits *continued*

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### Limited benefits *continued*

**Reconstructive surgery** will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

**Short-term rehabilitative therapy** (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living; **you pay** nothing for inpatient sessions and a \$5 copay per outpatient session.

**Diagnosis and treatment of infertility** is covered; **you pay** \$5 per visit. The following types of artificial insemination are covered: intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay** \$5 per visit; cost of donor sperm is not covered. Fertility drugs are not covered. Other **assisted reproductive technology** (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

**Cardiac rehabilitation** following a heart transplant, bypass surgery or a myocardial infarction is provided "at a Plan facility" for up to 30 days; **you pay** \$5 per visit.

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

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

Durable Medical Equipment is covered at 50% of eligible medical expenses and limited to a maximum benefit of \$4,000 per member per calendar year.

### What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE  
STANDARD HMO BENEFITS

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## Hospital/Extended Care Benefits

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### What is covered

#### Hospital care

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

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

#### Extended care

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

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

#### Hospice care

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

#### Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay** a \$25 copay per trip.

### Limited benefits

#### Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for nonmedical substance abuse benefits.

### What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE STANDARD HMO BENEFITS

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## Emergency Benefits

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### 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

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## Emergency Benefits *continued*

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### **What is a medical emergency?** *continued*

potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

### **Emergencies within the service area**

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

To be covered by this Plan, any follow up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers except as covered under POS benefits.

#### **Plan pays...**

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

#### **You pay...**

\$25 per hospital emergency room visit (waived if admitted as an inpatient) or \$15 per urgent care center visit for emergency services that are covered benefits of this Plan. \$25 per ambulance trip, copayments as shown on page 12 for outpatient/inpatient surgical procedures and outpatient surgical facility visits and inpatient admissions, \$25 per non-Plan doctor's office visit (except \$15 per urgent care center), and all charges for services which are not a covered benefit of this Plan.

### **Emergencies outside the service area**

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers except as covered under POS benefits.

#### **Plan pays...**

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

#### **You pay...**

\$25 per hospital emergency room visit (waived if admitted as an inpatient) or \$15 per urgent care center visit for emergency services that are covered benefits of this Plan. \$25 per ambulance trip, copayments as shown on page 12 for outpatient/inpatient surgical procedures and outpatient surgical facility visits and inpatients admissions, \$25 per non-Plan doctor's office visit (except \$15 per urgent care center), all charges for services which are not a covered benefit of this Plan.

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## Emergency Benefits *continued*

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### What is covered

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

### What is not covered

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

### Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 22.

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## Mental Conditions/Substance Abuse Benefits

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### Mental conditions

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

### What is covered

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

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

### Outpatient care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** a \$20 copay per visit for each covered visit; **you pay** \$10 copay per group therapy visit - all charges thereafter.

### Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing for the first 30 days - all charges thereafter.

### What is not covered

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

### Substance abuse

### What is covered

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

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## Mental Conditions/Substance Abuse Benefits *continued*

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**Outpatient care** Treatment for individual, group and family counseling is covered to a maximum of \$2,500 per calendar year and **you pay** a \$20 copay per visit; **you pay** \$10 per group therapy visit.

**Inpatient care** Treatment is covered up to \$9,000 per calendar year and **you pay** nothing.

**What is not covered** • Treatment that is not authorized by a Plan doctor.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE STANDARD HMO BENEFITS

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## Prescription Drug Benefits

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**What is covered** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. **You pay** a \$5 copay per prescription unit or refill for generic. If a name brand is chosen but is not required/specified by your doctor, **you pay** the **\$10 copay** and the difference in cost between the name brand and the generic. If a name brand is **required/specified by your doctor, you pay a \$10 copay**. **You pay** a \$10 copay per prescription unit or refill for name brand drugs; and **you pay** a \$15 copay per prescription unit or refill for non-formulary drugs.

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

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

**Covered medications and accessories include:**

- Drugs for which a prescription is required by law
- Insulin, with a copay charge applied to each whole vial up to 40 ml
- Diabetic supplies, including insulin syringes, needles, blood glucose measuring strips, and urine checking reagents
- Nitroglycerin, phenobarbital or Thyroid U.S.P. When prescribed in quantities of 100, a single copay charge will apply.
- Vitamins which require a prescription
- Disposable needles and syringes needed to inject covered prescribed medication
- Contraceptive devices, injectable and oral contraceptive drugs which require a prescription; contraceptive diaphragms
- Implanted contraceptive drugs such as Norplant are covered when other contraceptives have failed or are contraindicated. **You pay** 50% coinsurance for charges related to the device, implantation, and removal. There will be no refund of any portion of these copays if the implanted time-release medication is removed before the end of its expected life.
- Smoking cessation drugs and medication, including nicotine patches.

Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits.

**Limited benefits** • Sexual dysfunction drugs have dispensing limitations. Contact the Plan for details.

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## Prescription Drug Benefits *continued*

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### What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE STANDARD HMO BENEFITS

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## Other Benefits

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### Dental care

#### What is covered

#### Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound, natural teeth. The need for these services must directly result from an accidental injury. **You pay** \$25 per emergency room visit and \$5 per doctor's office visit. The outpatient/inpatient surgery/admissions copayments noted on pages 12 and 14 also apply.

#### What is not covered

- Other dental services not shown as covered

### Vision care

#### What is covered

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

#### What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE STANDARD HMO BENEFITS

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## Point of Service (POS) Benefits

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

At your option, you may choose to obtain services from non-Plan doctors and hospitals, except for the benefits listed below under "What is not covered", and still be eligible for benefit payments. In order to be eligible for benefit payment, however, some services must be received from or arranged by Plan doctors. When you incur covered expenses for non-emergency medical services received from a non-Plan doctor without a referral from a Plan doctor, your benefits are subject to the deductible, coinsurance and maximum benefit stated below.

After the calendar year deductible is met (\$250 per member and \$750 per family), your coinsurance for most non-Plan covered services is 20% of the Plan's Eligible Medical Expense (EME). After satisfying the calendar year deductible, your coinsurance maximum is limited to \$1,500 of EME per member per calendar year or \$4,500 per family in any calendar year.

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## Point of Service (POS) Benefits *continued*

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### What is covered

#### After satisfying your deductible:

Physician Services (Non-specialist Office visit, Inpatient visit, Specialist visit):  
Preventive Healthcare (well child care, routine physical exams and pap smear, routine diagnostic) subject to a maximum benefit of \$100 per calendar year.  
Manual Manipulation (Chiropractor, D.O., Physical Therapist) subject to a maximum benefit of \$1000 per calendar year and \$5,000 maximum lifetime benefit.  
Physician Consultations (Non-specialist Office Visit, Specialist Office Visit)  
Inpatient Hospital Services  
Outpatient Hospital and Ambulatory Surgical Facility Services  
Skilled Nursing Services subject to a maximum benefit of 12 days per calendar year.  
Inpatient and Outpatient Physician Services  
Inpatient and Outpatient Oral Surgical Physician Services  
Surgical Assistant Services  
Anesthesia Services  
Ambulance Services (non-emergent)  
Laboratory Services  
Routine Radiological and Non-radiological Diagnostic Imaging Services - Outpatient  
Other Diagnostic and Therapeutic Services including Chemotherapy, Dialysis, Therapeutic Radiology, Allergy testing and Serum Injection, Otologic Evaluations, complex diagnostic imaging, vascular diagnostic and therapeutic services, pulmonary diagnostic services, neurological or psychiatric testing  
Home Health Care Services subject to a maximum benefit of 30 visits or \$5,000 per calendar year, whichever is less.  
Prescription Drugs (prescription drug fee)  
Durable Medical Equipment subject to a combined HMO/POS maximum benefit of \$4,000 per member per calendar year.  
Enteral Formulas and special food products, special food products are subject to a combined HMO/POS maximum benefit of \$2,500 per member per calendar year.  
Self Management and treatment of Diabetes  
Short Term Inpatient and Outpatient Rehabilitation Services subject to a combined HMO/POS calendar year maximum of two months per condition.  
Prosthetic and Orthotic Devices subject to a combined HMO/POS maximum benefit of \$10,000 (including repairs).  
Mental Health and Substance Abuse Services

### What is not covered

#### Examples Include:

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

\*\* Covered under the in-plan benefit

### Prior-Authorization

In order for expenses incurred for certain non-Plan services described in this plan to be covered, these services must be Prior-Authorized by the Plan when not of an emergency nature. Failure to comply with the requirements may result in the reduction of benefits. Benefits payable for services which are not properly authorized will be reduced to 50%, up to \$500, of what the member would have received if the services had been properly authorized.

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## Point of Service (POS) Benefits *continued*

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### **Prior- Authorization** *continued*

Benefits which require Prior-Authorization under the Point of Service benefits include all elective inpatient admissions and extensions of stay beyond the original certified length of stay to a Hospital or Skilled Nursing Facility; all outpatient surgery provided in any setting if the charges exceed \$200; all outpatient tests, including technical and professional services if the charges exceed \$200; all outpatient courses of treatment, including, for example, but not limited to: allergy testing/treatment; angioplasty; chemotherapy; dialysis; manual manipulation, radiation therapy; rehabilitation (physical, occupational, speech)

### **Eligible Medical Expenses (EME)**

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

### **Plan Reimbursement Schedule**

Means the level of payment for EME as defined by the Plan with reference to (1) the amount most consistently paid to the Provider; or (2) the amount paid to other Providers of similar qualifications; or (3) is relative to the value or worth of other allowances for similar services comparable in severity and nature as determined by the Plan with reference to other industry and governmental sources.

### **Lifetime Maximum**

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

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

## Non-FEHB Benefits Available to Plan Members

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

### **Supplemental Dental Care Services**

Health Plan of Nevada, Inc. is pleased to offer a Supplemental Dental program to FEHBP members with Dentists who have agreed under contract to participate in HPN's Dental Program and provide Dental Care Services to members. Procedures not listed are not covered. The maximum amount of benefits which HPN will provide under this benefit is \$1,500 per member per calendar year. You are required to re-enroll every year into the supplemental dental plan during the open enrollment period. Please refer to the supplemental dental information for further information on this program, including premiums, what is covered under the supplemental program and limitations and exclusions.

**Benefits on this page are not part of the FEHB contract**

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# How to Obtain Benefits

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## Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Office at (800) 777-1840, or you may write to the Plan at P.O. Box 15645, Las Vegas, NV 89114-5645.

## Disputed claims review Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

Initial decisions regarding payment of a claim are made by the Claims Processing Department by a Claims Analyst. If you request reconsideration by the Plan for denial of a claim for payment or service, this request is processed and researched by a Member Services Reconsideration Specialist or Claims Research Analyst. All benefit decisions associated with a reconsideration are made by the Member Services Reconsideration Specialist or Claims Research Analyst. All medical decisions associated with a reconsideration are sent to the Plan's Medical Director for determination.

## OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

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## How to Obtain Benefits *continued*

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### **OPM review** *continued*

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

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# How Health Plan of Nevada Changes January 1999

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Do not rely on this page; it is not an official statement of benefits.

## Program-wide Changes

Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.

- Women may see their Plan gynecologist for routine examinations without a referral from their primary care doctor (see page 7).
- If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals (See page 8 for details).
- A medical emergency is defined as 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 (See page 14).
- The medical management of certain mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 20 outpatient Mental Conditions visit limit.
- Coverage of drugs for sexual dysfunction are shown under the Prescription Drug Benefit. See page 17.

## Changes to this Plan

The copay structure for prescription drugs has changed to a three tier. Members will now pay a \$5 copay for generic drugs, a \$10 copay for name brand formulary drugs, and a \$15 copay for non-formulary name brand drugs. See page 17.

- This Plan no longer offers preventive dental care under the HMO benefits.
- Durable medical equipment is now covered under the HMO and POS benefits, payable at 50% of eligible medical expenses and subject to a \$4,000 maximum benefit per member per calendar year. See pages 13.
- Coverage for the dental related aspects of TMJ are covered under the HMO benefits, subject to a \$2,500 calendar year maximum. See page 12.
- Short-term inpatient and outpatient rehabilitation services are now covered under the POS benefits subject to a combined HMO and POS calendar year maximum of two months per condition. See pages 19.
- Enteral formulas and special food products are now covered under the HMO and POS benefits. See pages 13 and 19.
- Medication, equipment, supplies and appliances used for the treatment of diabetes is now covered under the HMO and POS benefits. See pages 13 and 19.
- Mental health and substance abuse services are now covered under the POS benefits. See page 19.
- Manual Manipulation under the POS benefits has increased from \$500 to \$1,000 per member per calendar year subject to a \$5,000 lifetime maximum. See page 19.
- Prosthetic and Orthotic Devices are now covered under the POS benefits subject to a \$10,000 lifetime maximum benefit. See page 19.
- The Plan's payment maximum under POS benefits has increased from \$1,000,000 to \$2,000,000 per member per lifetime. See page 20.

# Summary of Benefits for Health Plan of Nevada - 1999

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

	<b>Benefits</b>	<b>Plan pays/provides</b>	<b>Page</b>
<b>Inpatient care</b>	<b>Hospital</b>	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. <b>You pay</b> \$100 per day not to exceed \$200 per admission; \$100 per surgical procedure . . . . .	14
	<b>Extended care</b>	All necessary services, no dollar or day limit. <b>You pay</b> \$100 per day not to exceed \$200 per admission . . . . .	14
	<b>Mental conditions</b>	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. <b>You pay</b> nothing . . . . .	16
	<b>Substance abuse</b>	Coverage under mental conditions benefits and in addition rehabilitative care up to \$9,000 per calendar year. <b>You pay</b> nothing . . . . .	17
<b>Outpatient care</b>		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. <b>You pay</b> a \$5 copay per office visit; \$20 per house call by a doctor; \$50 per surgical procedure; \$50 per outpatient surgical facility visit . . . . .	11, 12
	<b>Home health care</b>	All necessary visits by nurses and health aides. <b>You pay</b> nothing . . . . .	11, 12
	<b>Mental conditions</b>	Up to 20 outpatient visits per year. <b>You pay</b> a \$20 copay per visit; <b>you pay</b> \$10 copay per group therapy visit . . . . .	16
	<b>Substance abuse</b>	Coverage under mental conditions benefits and in addition counseling up to \$2,500 per calendar year. <b>You pay</b> a \$20 copay per visit; <b>you pay</b> \$10 per group therapy visit . . . . .	17
<b>Emergency care</b>		Customary and reasonable charges for services and supplies required because of a medical emergency. <b>You pay</b> a \$25 copay to the hospital for each emergency room visit and any non-Plan doctor's office visit and ambulance trip, \$15 per urgent care center visit, surgery/admission copayments as shown, and any charges for services that are not covered by this Plan . . . . .	15
<b>Prescription drugs</b>		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. <b>You pay</b> a \$5 copay per prescription unit or refill. If a name brand is chosen but is not required/specified by your doctor, <b>you pay</b> the <b>\$10 copay</b> and the difference in cost between the name brand and the generic. If a name brand is required/specified by your doctor, <b>you pay</b> a \$10 copay. If a non-formulary drug is prescribed by a Plan doctor and obtained at a Plan pharmacy, <b>you pay</b> a \$15 copay per prescription unit or refill. A Mail Order is available for up to a 90 day supply of maintenance medications. <b>You pay</b> two prescription copayments . . . . .	17
<b>Dental care</b>		Accidental injury benefit. <b>You pay</b> \$5 per doctor's visit and \$25 for an emergency room visit and surgery/admission copayments as shown . . . . .	18
<b>Vision care</b>		One refraction annually. <b>You pay</b> \$10 copay per visit . . . . .	18
<b>Point of Service Benefits</b>		Services of non-Plan doctors and hospitals. Not all benefits are covered. <b>You pay</b> deductibles and coinsurance and a maximum benefit applies . . . . .	18
<b>Out-of-pocket maximum</b>		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$3,320 per Self Only or \$7,804 per Self and Family enrollment per calendar year under standard HMO benefits; \$1,500 per member or \$4,500 per family for POS benefits; benefits will be provided at 100%. This copay maximum does not include prescription drugs . . . . .	8

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## Notes

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# 1999 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 most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	NM1	\$55.46	\$18.49	\$120.17	\$40.06	\$65.63	\$8.32
Self and Family	NM2	\$127.53	\$42.51	\$276.32	\$92.10	\$150.91	\$19.13