

# NevadaCare, Inc.

<http://www.nevadacare.com>



## 2005

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### A Health Maintenance Organization with a point of service product

**Serving:** Clark County, Nevada

**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 received full compliance accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). See the 2005 Guide for more information on accreditation.

**Enrollment code for this Plan:**

**IF1 Self Only**

**IF2 Self and Family**

**Special notice:** This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2004 Open Season.

Authorized for distribution by the:



**United States  
Office of Personnel Management**

Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>

**RI 73-830**



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at [www.healthierfeds.opm.gov](http://www.healthierfeds.opm.gov) for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, [www.hhs.gov/safety/index.shtml](http://www.hhs.gov/safety/index.shtml), which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at [www.opm.gov/insure](http://www.opm.gov/insure). I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James  
Director



## Notice of the United States 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 United States 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 health care 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](http://www.opm.gov/insure) on the Web. You may also call 202-606-0745 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  
United States 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 United States 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 are effective April 19, 2003.

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## Introduction

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This brochure describes the benefits of NevadaCare under our contract (CS 2895) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the NevadaCare administrative offices is:

NevadaCare, Inc.  
10600 West Charleston Blvd.  
Las Vegas, NV 89135

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.

OPM negotiates benefits and rates with each plan annually. Rates are shown at the end of this brochure.

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## Plain Language

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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 NevadaCare, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States 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](http://www.opm.gov/insure) or e-mail OPM at [fehbwebcomments@opm.gov](mailto:fehbwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits 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 that 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 the NevadaCare Special Investigation Unit at (702) 304-5500 or 1 (800) 447-9834 and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE  
202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street NW Room 6400  
Washington, DC 20415-1100**

- 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, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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.

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## Preventing medical mistakes

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An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

### 1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery?
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- [www.ahrq.gov/consumer/pathqpack.htm](http://www.ahrq.gov/consumer/pathqpack.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- [www.talkaboutrx.org/consumer.html](http://www.talkaboutrx.org/consumer.html). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## Section 1. Facts about this HMO plan

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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 the Plan for a copy of their 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 pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

**You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. For the HMO in-network benefit it is your responsibility to verify that the provider you use is a Plan provider.**

### **We also have Point of Service (POS) benefits**

Our HMO offers POS benefits. This means you can receive covered services from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits. You are responsible for the calendar year deductible, copayments, coinsurance, and any difference between our payment and the actual charge.

### **How we pay providers**

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

We have the following types of payment arrangements with our contracted providers:

- Arrangement A: Your doctor may receive a fixed amount of money each month (called a "capitation") to provide services to all Plan patients they see.
- Arrangement B: Your doctor may be paid a pre-determined amount for each service he/she provides.

### **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 Web site ([www.opm.gov/insure](http://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.

- NevadaCare is a State of Nevada domiciled Health Maintenance Organization (HMO) with its offices located in Las Vegas
- NevadaCare received its HMO Certificate of Authority in the State of Nevada in 1995
- NevadaCare is a private, for-profit corporation
- NevadaCare has operated as a mixed-model pre-payment plan in Nevada since 1992
- NevadaCare achieved "full standards compliance" accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in November of 2003

If you want more information about us, call (702) 304-5500 or 1 (800) 447-9834, or write to NevadaCare, Inc., P.O. Box 379020, Las Vegas, NV, 89137. You may also contact us by fax at 1 (866) 823-3775 or visit our Web site at <http://www.nevadacare.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: Clark County, Nevada

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.

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## **Section 2. We are a new plan**

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This Plan is new to the FEHB Program. We are being offered for the first time during the 2004 open season.

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## Section 3. How you get care

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### 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) 304-5564 or 1 (800) 447-9834 or write to us at NevadaCare, Inc., P.O. Box 379020, Las Vegas, NV, 89137. You may also request replacement cards through our Web site at <http://www.nevadacare.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. If you use our point-of-service (POS) program, you can also get care from non-Plan providers but it will cost you more. You are responsible for the calendar year deductible, copayments, coinsurance, and any difference between our payment and the actual charge. You are responsible for verifying that required prior authorization is given by the Plan for certain procedures. Please refer to “Services Requiring our Prior Approval” in Section 3 and also in Section 5(i). If you get your care from a non-Plan provider you may need to file a claim. If you need to file a claim please refer to Section 7 or contact us at (702) 304-5500 or 1 (800) 447-9834.

- **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 Web site. 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 also on our Web site. If you have questions about Plan providers, please call us at (702) 304-5564 or 1 (800) 447-9834, or visit our website at <http://www.nevadacare.com>.

### What you must do to get covered care

Each member should select a Primary Care Physician (PCP) from a list of General Practice Physicians, Family Practice Physicians, Internal Medicine Physicians, and Pediatricians in the HMO Provider Directory. Choosing a PCP is beneficial since your PCP can provide and help coordinate your health care. Your PCP will know your overall medical history, help you to make informed decisions, and focus on preventative care to help you stay healthy. Each family member may select a different PCP. This selection is to be made during the enrollment period. However, if the member finds it necessary to change PCPs, this may be done at any time during the Plan year by contacting the NevadaCare Member Services Department at (702) 304-5564 or 1 (800) 447-9834.

- **Primary care**

Your PCP can be a general practitioner, family practitioner, internist, or pediatrician. Your PCP will provide most of your health care, or recommend that you see a specialist, or refer you to a specialist. If you want to change PCPs 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, or you may self-refer to a specialist. In either case, we suggest that you return to the PCP after the consultation unless your PCP recommended a certain number of visits to the specialist.

Here are some 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 can work with your specialist to develop a treatment plan. Your Plan provider will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your PCP. Your PCP can help you decide what treatment you need. If he or she decides to refer you to, or recommends that you see a specialist, let him or her know that you would like to see your current specialist. If your current specialist does not participate with us you must receive treatment from a specialist who does.
- If you are seeing a specialist and your specialist leaves the Plan, call your PCP, who will arrange for you to see another specialist or contact Member Services who will be able to assist you with finding another contracted 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 and disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist other than for cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program 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 at (702) 304-5500 or 1 (800) 447-9834, 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) 304-5564 or 1 (800) 447-9834. 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 92<sup>nd</sup> day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM 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.

## **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**

For certain services, 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 and supplies:

- Ambulance non-emergencies
- Arthroplasty of Hip/Knee (at least two weeks notice)
- Blepharoplasty (upper eyelid surgery for visual impairment)
- Breast Reduction Surgery
- Care related to complications resulting from non-covered cosmetic procedures
- Cochlear Implants
- Durable Medical Equipment (DME) items adding up to \$1,000 or more during an interval of 30 days on one invoice
- Dental Care Facility, Hospital Outpatient Surgery Center & Anesthesia for children ages 6 and under, or under limited circumstances (See Section 5(c))
- Dialysis (end stage renal disease) (applies to initial visit only)
- ESI (Epidural Steroid Injections)
- Enteral Formulas for the Treatment of Inherited Metabolic Disease
- Eyeglasses or contact lenses for vision impairment caused by ocular injury or intraocular surgery
- Gastric Restrictive Procedures
- Gynecomastia
- Hearing Aids and testing for Hearing Aids
- Home healthcare services
- Hospice care
- Intravenous (IV) Infusion Therapy, Antibiotic Therapy, and Home IV Therapy
- Infertility services
- Inpatient Hospital Admissions, Inpatient Skilled Nursing Facility Admissions, Inpatient Rehabilitation Facility
- Intrathecal (IT) Pumps (for pain therapy)
- Ligation, Vein Stripping, and Sclerotherapy
- Mental Health and Substance Abuse services
- Neurological Testing
- Orthotic Appliances for TMJ (Temporomandibular Joint)
- Orthotic and Prosthetic devices for metabolic or peripheral vascular disease
- Orthognatic Surgery
- Panniculectomy (Abdominoplasty)

*Services requiring our prior approval – continued on next page*

**Services requiring our  
prior approval**  
*(continued)*

- Positron Emission Tomography (PET) Scans
- Certain Prescription Drugs
- Sleep studies
- Surgery to correct sexual dysfunction, sexual inadequacy
- Surgical placement of Spinal Neurostimulator
- TMJ related services
- Transplant services, Inpatient/Outpatient (must use a designated transplant facility)
- Uvulo-Palatopharyngoplasty (UPPP)
- Ventral/Umbilical Hernia repair
- All covered services from non-Plan providers/facilities (except emergencies) at Plan HMO benefit level

Prior Authorization is an evaluation process that assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care. Prior Authorization does not guarantee payment. We will not pay if on the date you receive services:

- You are not eligible for benefits, or
- You have used up a limited benefit, or
- Your Plan has changed (January 1, new Plan year) and we no longer cover the service.

Your Plan PCP or specialist is responsible for obtaining Prior Authorization from the Plan for medically necessary treatment, services, and supplies. The Plan may not pay for services that have not been Prior Authorized.

It is your responsibility to verify that the required Prior Authorization has been given by the Plan for POS services. If Prior Authorization is not given, eligible charges will be subject to the non-compliance reduction and the amount of the reduction will not apply toward your out-of-pocket maximum or deductible. (See Section 5(i)).

We do not require Prior Authorization for inpatient maternity admissions in a Plan facility. However, we do require Prior Authorization if your provider plans to provide other medical or surgical care while you are in the hospital. We should be notified as soon as reasonably possible if either you or your baby needs to stay longer than 48 hours after a regular delivery, or 96 hours after a cesarean delivery. We will review all extended hospital stays for medical necessity.

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## Section 4. Your costs for covered services

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You must share the costs 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 PCP or a specialist you pay a copayment of \$20 per office visit and when you go in the hospital, you pay \$250 per admission per day not to exceed \$750.

### **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

We do not have a HMO in-network deductible.

We do have a POS out-of-network deductible. The POS deductible is \$500 per person, not to exceed three (3) deductibles per family.

### **Coinsurance**

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

### **Your catastrophic protection out-of-pocket maximum**

HMO In-Network: After your copayments and/or coinsurance, total \$1,500 per person or \$3,000 per family in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription Drugs
- Transportation, lodging, and meal allowance for patient and companion when receiving Organ/Tissue Transplant services.

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

POS Out-of-Network: After your deductible, coinsurance and/or copayment for out-of-network services total \$6,000 (including deductible) per person or \$12,000 (including deductible) per family, you do not have to pay copayments or coinsurance for covered services. However, you are still responsible for paying the difference between our payment and the actual charge. The difference between what our Plan pays and the actual medical charge does not apply to your catastrophic protection out-of-pocket maximum. Accidental dental injury services, prescription drugs and organ/tissue transplant services are not covered under the POS out-of-network option.

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## Section 5. Benefits – OVERVIEW

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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) 304-5564 or 1 (800) 447-9834, or at our Web site at <http://www.nevadacare.com>.

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

**Here are some important things you should keep in mind about these benefits:**

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- 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.
- You are responsible for verifying that your provider is a Plan provider.
- We have no HMO in-network Calendar Year Deductible.
- Your physician must get Prior Authorization for some HMO in-network services and supplies.
- 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.
- POS Out-of-Network services are subject to a Calendar Year Deductible, copayment, coinsurance, and any difference between our payment and the actual charge. POS benefits and services are limited. You are responsible for obtaining Prior Authorization for those services requiring prior approval. Please see Section 3 and Section 5(i) for details.
- The POS out-of-network Calendar Year Deductible does not apply to the following services: Preventative Care, adult and children, Treatment Therapies, Vision Services, Orthopedic and Prosthetic Devices, DME, Home health care.

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Benefit Description	In-Network You pay	Out-of-Network You pay
<b>Diagnostic and treatment services</b>		
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> <li>• At home</li> </ul>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
Professional services of physicians <ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> </ul>	Nothing	30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• In an urgent care center</li> </ul>	\$35 per visit	\$35 per visit, plus 30% of Plan allowance and any difference between our payment and the actual charge

<b>Lab, X-ray and other diagnostic tests</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<p>Tests, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• CAT Scans/MRI</li> <li>• PET Scans</li> </ul> <p>Note: Contact our Member Services Department at (702) 304-5564 or 1 (800) 447-9834 for the name and locations of our exclusive lab and exclusive radiology providers.</p>	<p>\$15 per visit, plus office visit copayment when tests are received from our exclusive lab and radiology providers</p>	<p>\$15 per visit, plus \$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge</p>
<ul style="list-style-type: none"> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	<p>Covered under office visit copayment No additional charge applies</p>	<p>30% of Plan allowance and any difference between our payment and the actual charge</p>
<b>Preventive care, adult</b>		
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Total Blood Cholesterol</li> <li>• Colorectal Cancer Screening, including <ul style="list-style-type: none"> <li>– Fecal occult blood test</li> <li>– Sigmoidoscopy, screening – every five years starting at age 50</li> </ul> </li> <li>• Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</li> <li>• Routine PAP test</li> </ul> <p>Note: The lab copayment does not apply when the routine PAP is received on the same day as the office visit</p> <ul style="list-style-type: none"> <li>• Routine Mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>– From age 35 through 39, one during this five year period</li> <li>– From age 40 through 64, one every calendar year</li> <li>– At age 65 and older, one every two consecutive calendar years</li> </ul> </li> <li>• Osteoporosis screening <ul style="list-style-type: none"> <li>– For women age 65 and older</li> <li>– For women age 60 through 64 who are at risk for osteoporosis</li> </ul> </li> </ul>	<p>\$15 per visit, plus office visit copayment</p>	<p>\$15 per visit, plus \$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or for travel</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

*Preventative care, adult – continued on next page*

<b>Preventive care, adult</b> <i>(continued)</i>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and over</li> </ul>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<i>Not covered: Immunizations exclusively for travel</i>	<i>All charges</i>	<i>All charges</i>
<b>Preventive care, children</b>		
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> </ul>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>– Eye exams through age 17 to determine the need for vision correction</li> <li>– Ear exams through age 17 to determine the need for hearing correction</li> <li>– Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> </ul>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<i>Not covered: Immunizations exclusively for travel</i>	<i>All charges</i>	<i>All charges</i>
<b>Maternity care</b>		
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> Note: Here are some things to keep in mind: <ul style="list-style-type: none"> <li>• You do not need prior authorization for your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment</li> </ul> Note: for newborn circumcision, see Surgery Benefits (Section 5(b)) <ul style="list-style-type: none"> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b))</li> </ul>	A one-time copayment of \$20 for the entire pregnancy	30% of Plan allowance and any difference between our payment and the actual charge for all maternity care charges  Note: A \$20 copayment per pregnancy applies

*Maternity care – continued on next page*

<b>Maternity care (continued)</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Routine sonograms to determine fetal age, size or sex when not medically necessary</li> <li>• Scheduled home delivery</li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Family planning</b>		
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>• Surgically implanted contraceptives</li> <li>• Injectable contraceptive drugs (such as Depo Provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Reversal of voluntary surgical sterilization</li> <li>• Predictive genetic testing and/or counseling</li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Infertility services</b>		
<p>Diagnosis and treatment of infertility, limited to:</p> <ul style="list-style-type: none"> <li>• Diagnosis and initial evaluation to establish presence of infertility</li> <li>• Artificial insemination services, up to four attempts per member per lifetime <ul style="list-style-type: none"> <li>– intravaginal insemination (IVI)</li> <li>– intracervical insemination (ICI)</li> <li>– intrauterine insemination (IUI)</li> </ul> </li> </ul>	<p>\$50 copayment for initial infertility evaluation</p> <p>\$20 per subsequent office visits</p>	<p>\$75 for initial evaluation/\$20 per subsequent office visits, plus 30% of Plan allowance and any difference between our payment and the actual charge</p>
<p>Diagnostic and therapeutic infertility services determined to be medically necessary and prior authorized by the Plan.</p> <ul style="list-style-type: none"> <li>• Laboratory studies received from our exclusive lab provider</li> <li>• Diagnostic procedures</li> </ul> <p>Note: Contact our Member Services Department at (702) 304-5564 or 1 (800) 447-9834 for the name and locations of our exclusive lab provider.</p>	\$15 per visit , plus office visit copayment	\$15 per visit, plus office visit copayment, plus 30% of Plan allowance and any difference between our payment and the actual charge

*Infertility services – continued on next page*

<b>Infertility services (continued)</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> <li>– in vitro fertilization</li> <li>– embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</li> </ul> </li> <li>• Services and supplies related to ART procedures</li> <li>• Cost of donor sperm</li> <li>• Cost of donor egg</li> <li>• Fertility drugs</li> <li>• Low tubal transfers</li> <li>• Services and supplies not listed as covered</li> <li>• Services and supplies rendered in connection with member acting as, or utilizing the services of a surrogate mother</li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Allergy care</b>		
<ul style="list-style-type: none"> <li>• Testing and treatment</li> </ul>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Allergy injections</li> </ul>	\$7 per visit	\$7 per visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Allergy serum</li> </ul>	Nothing	30% of Plan allowance and any difference between our payment and the actual charge
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>
<b>Treatment therapies</b>		
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 29.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> </ul>	\$50 per office visit	\$50 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge

*Treatment therapies – continued on next page*

Treatment therapies <i>(continued)</i>	In-Network You pay	Out-of-Network You pay
<ul style="list-style-type: none"> <li>Dialysis – hemodialysis and peritoneal dialysis</li> </ul>	\$50 per office visit	\$50 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> </ul>	Nothing	30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit for HMO in-network benefits. There are no POS out-of-network benefits for prescription drugs, including GHT. (See Section 5(f))</p>	See Prescription Drug Benefits Section 5(f)	All charges
Physical and occupational therapies		
<ul style="list-style-type: none"> <li>A combined maximum benefit for both HMO in-network and POS out-of-network of 60 consecutive days per year for the services of each of the following: <ul style="list-style-type: none"> <li>qualified physical therapists, and</li> <li>occupational therapists</li> </ul> </li> </ul> <p>Note: This maximum includes adjunctive procedures by a chiropractor. (See Chiropractic in Section 5(a))</p> <p>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.</p> <ul style="list-style-type: none"> <li>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 30 sessions</li> </ul>	<p>\$20 per office visit</p> <p>No copayment per visit during covered inpatient admission</p>	<p>\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge</p> <p>30% of Plan allowance and any difference between our payment and the actual charge during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Long-term rehabilitative therapy</li> <li>Exercise programs</li> </ul>	<i>All charges</i>	<i>All charges</i>
Speech therapy		
<p>A combined maximum benefit for both HMO in-network and POS out-of-network of 60 visits per year per condition</p>	<p>\$20 per office visit</p> <p>No copayment per visit during covered inpatient admission</p>	<p>\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge</p> <p>30% of Plan allowance and any difference between our payment and the actual charge during covered inpatient admission</p>

Hearing services (testing, treatment, and supplies)	In-Network You pay	Out-of-Network You pay
<ul style="list-style-type: none"> <li>• First hearing aid and testing only when necessitated by accidental injury</li> </ul>	\$100 per hearing aid, plus \$20 per office visit	\$150 per hearing aid, plus \$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Hearing testing for children through age 17 (see Preventative care, children)</li> </ul>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• All other hearing testing</li> <li>• Hearing aids, testing and examinations for them</li> </ul>	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul>	\$50 per item	\$50 per item, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children)</li> </ul>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Eyeglasses or contact lenses and after age 17, examinations for them</li> <li>• Eye exercises and orthoptics</li> <li>• Radial keratotomy and other refractive surgery</li> </ul>	<i>All charges</i>	<i>All charges</i>
Foot care		
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge

*Foot care – continued on next page*

<b>Foot care (continued)</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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)</li> </ul>	All charges	All charges
<b>Orthopedic and prosthetic devices</b>		
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> </ul> <p>Note: A combined maximum benefit for both HMO in-network and POS out-of-network of \$15,000 per member, per calendar year applies. You pay all charges in excess of the \$15,000 maximum.</p>	\$1,000 per initial prosthesis	\$1,000 per initial prosthesis, plus 30% of Plan allowance and any difference between our payment and actual charge
<ul style="list-style-type: none"> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> </ul> <p>Note: A combined maximum benefit for both HMO in-network and POS out-of-network of \$1,500 per member, per year applies. You pay all charges in excess of the \$1,500 maximum.</p>	\$100 per device or replacement	\$100 per device or replacement, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Cochlear Implants</li> </ul>	\$1,500 copayment for entire cochlear implant or any major component	\$2,500 copayment for entire cochlear implant or any major component, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy</li> </ul> <p>Note: For HMO in-network benefits, we pay internal prosthetic devices (except cochlear implants) as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.</p>	Nothing	30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Corrective orthopedic braces or supports that are prescribed and custom made for the member.</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul> <p>Note: A combined maximum benefit for both HMO in-network and POS out-of-network of \$1,500 per member, per year applies. You pay all charges in excess of the \$1,500 maximum.</p>	\$100 per appliance	\$150 per appliance, plus 30% of Plan allowance and any difference between our payment and the actual charge

*Orthopedic and prosthetic devices – continued on next page*

Orthopedic and prosthetic devices	In-Network You pay	Out-of-Network You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Orthopedic and corrective shoes</li> <li>• Arch supports</li> <li>• Foot orthotics</li> <li>• Heel pads and heel cups</li> <li>• Lumbosacral supports</li> <li>• Corsets, trusses, elastic stockings, support hose, and other supportive devices</li> <li>• Penile implants</li> <li>• Prosthetic replacements when the device has been abused or improperly cared for</li> </ul>	All charges	All charges
Durable medical equipment (DME)		
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment.</p> <p>Note: The DME combined maximum benefit for both HMO in-network and POS out-of-network of \$4,000 per member, per calendar year applies (except to motorized wheelchairs). You pay all charges in excess of the maximum.</p> <ul style="list-style-type: none"> <li>• Hospital beds;</li> <li>• Wheelchairs;</li> <li>• Crutches;</li> <li>• Walkers; and</li> <li>• Ostomy supplies</li> </ul>	<p>All DME items under \$1,000, you pay \$50 per item</p> <p>All DME items adding up to \$1,000 or more during an interval of 30 days, you pay \$150 per 30 day invoice</p>	<p>All DME items under \$1,000, you pay \$50 per item plus 30% of Plan allowance and any difference between our payment and the actual charge</p> <p>All DME items adding up to \$1,000 or more during an interval of 30 days, you pay \$150 per 30 day invoice, plus 30% of Plan allowance and any difference between our payment and the actual charge</p>
<ul style="list-style-type: none"> <li>• Blood glucose monitors; and</li> <li>• Insulin pumps</li> </ul> <p>Note: The DME combined maximum benefit for both HMO in-network and POS out-of-network of \$4,000 per member, per calendar year applies (except motorized wheelchairs). You pay all charges in excess of the maximum.</p>	\$20 per unit	\$20 per unit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul> <p>Note: The DME combined maximum benefit for both HMO in-network and POS out-of-network of \$4,000 per member, per calendar year applies (except motorized wheelchairs). You pay all charges in excess of the maximum.</p>	\$50 per item	\$50 per item, plus 30% of Plan allowance and any difference between our payment and the actual charge

*Durable medical equipment (DME) – continued on next page*

<b>Durable medical equipment (DME) (continued)</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<ul style="list-style-type: none"> <li>Motorized wheelchairs</li> </ul> <p>Note: Limited to a combined maximum benefit for both HMO in-network and POS out-of-network of \$5,000, one per lifetime. You pay all charges in excess of the maximum.</p>	\$150 copayment	\$150 copayment, plus 30% of Plan allowance and any difference between our payment and the actual charge
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Specialized wheelchairs for comfort and convenience</i></li> <li><i>Coverage for alternative or spare equipment</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Home health services</b>		
<ul style="list-style-type: none"> <li>Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.</li> <li>Self-injectable medication instruction</li> <li>Services include oxygen therapy, intravenous therapy and medications</li> <li>Home speech therapy</li> <li>Home rehabilitative therapy, including physical therapy and occupational therapy when significant improvement can be expected</li> </ul>	\$35 per visit	\$50 per home visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li><i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;</i></li> <li><i>Services primarily for hygiene, feeding, exercising, moving the patient, home making, companionship, or giving oral medication</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Chiropractic</b>		
<ul style="list-style-type: none"> <li>Manipulations of the spine and/or extremities</li> </ul> <p>Note: A combined maximum benefit of 15 visits for both HMO in-network and POS out-of-network applies per member, per calendar year.</p>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul> <p>Note: Adjunctive procedures are subject to the physical therapy/occupational therapy combined maximum benefit for both HMO in-network and POS out-of-network of 60 consecutive days per year, per member. See physical and occupational therapies in Section 5(a).</p>	\$20 additional office visit copayment	\$20 additional office visit copayment, plus 30% of Plan allowance and any difference between our payment and the actual charge

Alternative treatments	In-Network You pay	Out-of-Network You pay
<p>Acupuncture – by a doctor of medicine, osteopathy, or doctor of oriental medicine for:</p> <ul style="list-style-type: none"> <li>• anesthesia; and/or</li> <li>• pain relief</li> </ul> <p>Note: A combined maximum benefit of 5 visits for both HMO in-network and POS out-of-network applies per member, per calendar year.</p>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Naturopathic services</i></li> <li>• <i>Hypnotherapy</i></li> <li>• <i>Biofeedback</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Educational classes and programs		
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs</li> <li>• Asthma, diabetes, and pulmonary rehabilitation self-management classes</li> </ul> <p>Note: We cover educational classes provided by a hospital as an outpatient hospital benefit (See Section 5(c))</p>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge





Oral and maxillofacial surgery	In-Network You pay	Out-of-Network You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>\$20 per office visit</p> <p>Nothing for outpatient or inpatient surgery</p>	<p>\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge</p> <p>Outpatient or inpatient, 30% of Plan allowance and any difference between our payment and the actual charge</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Charges for dental services in connection with TMJ</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Organ/tissue transplants		
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single – Double</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• 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, and other conditions as determined appropriate by evidence-based medicine</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> </ul>	<p>\$75 pre-transplant evaluation</p> <p>\$20 per office visit</p> <p>Nothing for outpatient or inpatient surgery</p>	<p>The Plan specifically excludes coverage for any POS out-of-network transplant related services</p> <p>You pay all charges</p>

*Organ/tissue transplants – continued on next page*

Organ/tissue transplants <i>(continued)</i>	In-Network You pay	Out-of-Network You pay
<p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute or National Institutes of Health-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.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>Note: NevadaCare’s designated in-network Plan transplant facility network must be used.</p>	<p>\$75 pre-transplant evaluation</p> <p>\$20 per office visit</p> <p>Nothing for outpatient or inpatient surgery</p>	<p>The Plan specifically excludes coverage for any POS out-of-network transplant related services</p> <p>You pay all charges</p>
<ul style="list-style-type: none"> <li>Organ/tissue procurement</li> </ul>	<p>20% Coinsurance</p>	<p>The Plan specifically excludes coverage for any POS out-of-network transplant related services</p> <p>You pay all charges</p>
<ul style="list-style-type: none"> <li>Transportation, lodging, and meal allowance for patient and companion</li> </ul> <p>Note: The \$150 maximum daily allowance for lodging and meals is subject to the \$5,000 maximum benefit from pre-transplant evaluation through one year of follow-up.</p>	<p>Charges in excess of the daily and overall maximum</p>	<p>The Plan specifically excludes coverage for any POS out-of-network transplant related services</p> <p>You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li><i>Implants of artificial organs</i></li> <li><i>Transplants not listed as covered</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p><b>Anesthesia</b></p>		
<p>Professional services provided in;</p> <ul style="list-style-type: none"> <li>Hospital (inpatient)</li> <li>Hospital (outpatient)</li> <li>Skilled nursing facility</li> <li>Ambulatory surgical center</li> <li>Office</li> </ul>	<p>Nothing</p>	<p>30% of Plan allowance and any difference between our payment and the actual charge</p>

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- It is your responsibility to verify that your physician has arranged for your care in a Plan facility.
- We have no HMO in-network 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 service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR ALL HOSPITAL ADMISSIONS, SKILLED NURSING FACILITY ADMISSIONS, HOSPICE CARE AND NON-EMERGENCY AMBULANCE SERVICE.** Please refer to Section 3 to be sure which services require Prior Authorization.
- POS out-of-network services are subject to a calendar year deductible, copayment, coinsurance, and any difference between our payment and the actual charge. POS benefits and services are limited. You are responsible for obtaining Prior Authorization for those services requiring prior approval. Please see Section 3 and Section 5(i) for details.
- The POS out-of-network calendar year deductible does not apply to the services listed in this section except for hospice outpatient respite care and bereavement care.

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Benefit Description	In-Network You pay	Out-of-Network You pay
<p><b>Inpatient hospital</b></p> <p>Room and board, such as</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> <p>Note: There is no additional copayment applied if you are readmitted within 48 hours of discharge.</p> <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>\$250 per day, per inpatient admission up to \$750</p>	<p>\$250 per day, per inpatient admission up to \$750, plus 30% of Plan allowance and any difference between our payment and the actual charge</p>

*Inpatient hospital - continued on next page*

<b>Inpatient hospital</b> <i>(continued)</i>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul> <p>Note: For HMO in-network benefits, 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.</p>	Nothing	30% of Plan allowance and any difference between our payment and the actual charge
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Outpatient hospital or ambulatory surgical center</b>		
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> <li>• 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.</li> </ul>	\$150 per outpatient admission	\$150 per outpatient admission, plus 30% of Plan allowance and any difference between our payment and the actual charge

*Outpatient hospital or ambulatory surgical center – continued on next page*

<b>Outpatient hospital or ambulatory surgical center (continued)</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
Educational Self-Management classes	\$20 per visit	\$20 per visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
Major diagnostic tests, such as: <ul style="list-style-type: none"> <li>• Angiography</li> <li>• CAT Scans and MRIs</li> <li>• Neurological testing</li> <li>• Psychiatric testing</li> </ul>	\$50 per visit	\$50 per visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
PET and SPECT Scans	\$100 per visit	\$100 per visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<i>Not covered: Personal comfort items</i>	<i>All charges</i>	<i>All charges</i>
<b>Extended care benefits/Skilled nursing care facility benefits</b>		
Skilled Nursing Facility (SNF)/ Extended care benefits: A combined maximum benefit for both HMO in-network and POS out-of-network of 100 days per member per calendar year. <ul style="list-style-type: none"> <li>• Professional services – physicians and general nursing care</li> <li>• Medical supplies and medications</li> <li>• Medical equipment ordinarily provided by a skilled nursing facility</li> <li>• Room and board</li> </ul>	\$125 per day, per inpatient admission up to \$375	30% of Plan allowance and any difference between our payment and the actual charge
<i>Not covered: Custodial care, personal comfort or convenience items</i>	<i>All charges</i>	<i>All charges</i>
<b>Hospice care</b>		
Supportive and palliative care for terminally ill members with an approximate life expectancy of 6 months or less is covered in the home or in a hospice facility.		
Inpatient services	\$125 per day, per inpatient admission up to \$375	30% of Plan allowance and any difference between our payment and the actual charge

*Hospice care – continued on next page*

<b>Hospice care (continued)</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
Outpatient services	\$20 per visit	\$20 per visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
Inpatient respite care Note: A combined maximum benefit for both HMO in-network and POS out-of-network of 15 days per member, per calendar year applies	\$125 per day, per inpatient admission up to \$375	30% of Plan allowance and any difference between our payment and the actual charge
Outpatient respite care Note: A combined maximum benefit for both HMO in-network and POS out-of-network of 15 visits per member, per calendar year applies	\$20 per visit	\$20 per visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
Bereavement care Note: A combined maximum benefit for both HMO in-network and POS out-of-network of 6 sessions per member, per calendar year applies	\$20 per visit	\$20 per visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>	<i>All charges</i>
<b>Ambulance</b>		
Local professional ambulance service when determined medically necessary by the Plan	\$100 per trip	\$100 per trip, plus 30% of the Plan allowance and any difference between our payment and the actual charge
Ground or air ambulance between facilities when determined medically necessary by the Plan	Nothing	30% of the Plan allowance and any difference between our payment and the actual charge
<i>Not covered: Medical transportation for the convenience of you or your family</i>	<i>All charges</i>	<i>All charges</i>

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## Section 5(d) Emergency services/accidents

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### 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.

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

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### What to do in case of emergency:

#### Emergencies within our service area:

If you have an emergency situation, please call your PCP. 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 should notify the Plan within 48 hours (unless it is not reasonably possible to do so). It is your responsibility to notify us in a timely manner. 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. 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 us you must get all follow-up care from Plan providers or follow-up care must be approved by us. The emergency room copayment is waived if you are admitted to the hospital from the emergency room.

#### Emergencies outside our 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 you are hospitalized in a non-Plan facility 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. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan for in-network benefits. The emergency room copayment is waived if you are admitted to the hospital from the emergency room.

#### Contacts for questions:

If you have any questions about what to do in case of emergency within or outside of our service area, please contact us at: (702) 304-5500 or 1 (800) 447-9834

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Benefit Description	In-Network You pay	Out-of-Network You pay
<b>Emergency within our service area</b>		
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$20 per office visit	\$20 per office visit
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$35 per visit	\$35 per visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient or inpatient at a hospital, including doctors' services</li> </ul> <p>Note: If you are admitted as an inpatient following a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.</p>	\$75 per emergency room visit	\$75 per emergency room visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>
<b>Emergency outside our service area</b>		
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$20 per office visit	\$20 per office visit
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$35 per visit	\$35 per visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient or inpatient at a hospital, including doctors' services</li> </ul> <p>Note: If you are admitted as an inpatient following a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.</p>	\$75 per emergency room visit	\$75 per emergency room visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Benefits may be limited if you deliver a baby outside of the service area</i></li> </ul>	<p><i>All charges</i></p> <p><i>See Out-of-Network Benefit, Section 5(i)</i></p>	<p><i>All charges</i></p> <p><i>See Out-of-Network Benefit, Section 5(i)</i></p>
<b>Ambulance</b>		
<p>Professional ambulance, air ambulance, and/or paramedic services when medically necessary.</p> <p>Note: See 5(c) for non-emergency service.</p>	\$100 per trip	\$100 per trip
<i>Not covered: Medical transportation for the convenience of you or your family</i>	<i>All charges</i>	<i>All charges</i>

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

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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 HMO in-network 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 PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.
- POS out-of-network services are subject to a calendar year deductible, copayment, coinsurance, and any difference between our payment and the actual charge. These services require Prior Authorization from our exclusive Behavioral Health vendor. You are responsible for obtaining Prior Authorization for those services requiring prior approval. Please see the preauthorization section on the following page and Sections 3 and 5(i) for details.
- The POS out-of-network calendar year deductible does not apply to the following services: Inpatient hospitalization, Partial hospitalization and Facility-based intensive outpatient treatment.

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Benefit Description	In-Network You pay	Out-of-Network You pay
<b>Mental health and substance abuse benefits</b>		
<p>All diagnostic and treatment services recommended by a provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan HMO in-network or POS out-of-network 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.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions	Your cost sharing responsibilities are no greater than for other illnesses or conditions
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> <li>• Psychological evaluations</li> </ul>	\$20 per office visit	\$20 per office visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul> <p>Note: Contact our Member Services department at (702) 304-5564 or 1 (800) 447-9834 for the name and locations of our exclusive lab and exclusive radiology providers.</p>	\$15 per visit, plus office visit copayment when tests are received from our exclusive lab and radiology providers	\$15 per visit, plus office visit copayment, plus 30% of Plan allowance and any difference between our payment and the actual charge

*Mental health and substance abuse benefits – continued on next page.*

Mental health and substance abuse benefits <i>(continued)</i>	In-Network You pay	Out-of-Network You pay
Major diagnostic tests, such as: <ul style="list-style-type: none"> <li>• Angiography</li> <li>• CAT Scans and MRIs</li> <li>• Cognitive interviews</li> <li>• Neurological testing</li> <li>• Psychiatric testing</li> </ul>	\$50 per visit	\$50 per visit, plus 30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> </ul>	\$250 per day, per admission up to \$750	\$250 per day, per admission up to \$750, plus 30% of Plan allowance and any difference between our payment and the actual charge
Electroconvulsive Therapy (ECT) <ul style="list-style-type: none"> <li>• Hospital (outpatient)</li> </ul>	\$150 per outpatient admission	30% of Plan allowance and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, and facility based intensive outpatient treatment</li> </ul>	\$125 per day, per admission up to \$375	\$125 per day, per admission up to \$375, plus 30% of Plan allowance and any difference between our payment and the actual charge
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<i>All charges</i>	<i>All charges</i>

**Preauthorization**

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

You must contact Human Behavioral Institute (HBI) at (702) 248-8866 or 1 (800) 441-4483 for Prior Authorization of all inpatient and outpatient mental health/substance abuse services, information about contracted mental health providers and/or immediate access to care. You may call 24 hours a day, seven days a week.

**Limitation**

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

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## Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart in this section.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your physician must get Prior Authorization for some drugs.
- 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.
- There are no Point of Service (POS) benefits for Prescription Drugs.

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

- **Who can write your prescription.** A licensed physician or dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication  

A “maintenance medication” is a drug prescribed to treat certain chronic or life-threatening long term conditions as determined by the Plan, such as Diabetes, Arthritis, Heart Disease, or High Blood Pressure.

The mail order option is a convenient and affordable way to obtain your maintenance medications. It takes approximately ten (10) days to receive your mail order supply from the mail service program. Self-injectable medications are not available through mail order. To enroll in the mail order drug program contact, Walgreens Healthcare Plus at 1 (800) 635-3070 or visit the website at <http://www.rxxpbm.com> and choose the On-line Forms and Services.

If you need self-injectable medications for conditions such as Hepatitis C, Hemophilia, Multiple Sclerosis, or Arthritis, your physician will contact R/x<sup>x</sup> Pharmacy Solutions to enroll you with our exclusive provider, BioSource. These medications will be delivered to either your physician’s office or your house as needed. Your physician can call R/x<sup>x</sup> Pharmacy Solutions at 1 (866) 251-3317 to start this process. Certain self-injectable medications may require Prior Authorization.
- **We use a formulary.** NevadaCare covers most FDA approved generics and a broad selection of brand medications for patients. We use a formulary that is described as a “Preferred Drug List” or PDL. It is used to help provide safe, effective, and affordable prescription drugs. The PDL is a guide for physicians to help them select preferred brand drugs. We work with the physician and pharmacist to make sure you are getting the appropriate drug therapy. A Pharmacy and Therapeutics Committee evaluates prescription drugs for safety, effectiveness, quality treatment, and overall value. The PDL is reviewed on a regular basis and may change at the sole discretion of the Plan. Your copayment is lower when drugs listed on the PDL are prescribed. We also cover drugs not on our PDL at a higher copayment when prescribed by your physician.  

To obtain a copy of the PDL, contact [RxxHelpDesk@mxinc.com](mailto:RxxHelpDesk@mxinc.com), visit our website at <http://www.nevadacare.com>, or call R/x<sup>x</sup> Pharmacy Solutions at 1 (866) 251-3317.
- **These are the dispensing limitations.** A dispensing limitation is the quantity of a medication for which benefits are available for a single copayment at a Plan retail pharmacy, or in the case of mail order medications, two copayments. Dispensing limitations may be less than, but shall not exceed either a 30-day supply for drugs obtained at a Plan pharmacy or a 90-day supply for drugs obtained through our mail order drug program. Dispensing limitations may include, but are not limited to:
  - Medications with quantities that may be set at a smaller amount to promote appropriate medication use and patient safety,
  - Pre-packaged medications such as inhalers, eye drops, creams or other types of medications that are normally dispensed in pre-packaged units of 30-days or less will be considered one prescription unit,
  - A period of time that a specific medication is recommended by the manufacturer and/or the FDA can be an appropriate course of treatment when prescribed for a particular condition,
  - An FDA approved dosage of a medication when prescribed for a particular condition, or
  - Mail order medications that are available for up to a 90-day supply, such as medications for Heart Disease, High Blood Pressure, or Arthritis. This does not include self-injectable medications.

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- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified “Dispense as Written” for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic in addition to the brand drug copayment or coinsurance.
  - **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name products. Under Federal Law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you and us less than a name brand prescription.
  - **When you have to file a claim.** Normally, you will not have to submit claims to us. However, you may need to submit claims when:
    - You have a prescription filled at an out of area pharmacy, or
    - You fill a prescription for immediate use because of medical necessity and no Plan-participating pharmacy was open for business at that time.

If you need to submit a claim for medications, contact:

Mailing Address: R/x<sup>x</sup> Pharmacy Solutions, Inc.  
1600 Broadway, Suite 300  
Tempe, AZ 85282

Telephone Contact: 1 (866) 251-3317

Email Address: [RxxHelpDesk@imxinc.com](mailto:RxxHelpDesk@imxinc.com)

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*Prescription drug benefits begin on the next page*

Benefit Description	In-Network You pay	Out-of -Network You pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction (limited to 6 pills per month)</li> <li>• Contraceptive drugs and devices</li> <li>• Smoking cessation drugs (such as nicotine patches)</li> <li>• Pharmaceutical compounds (when medically necessary)</li> </ul> <p>Note: You pay two applicable copayments for maintenance medication ordered through our mail order program.</p> <p>If there is no generic equivalent available, you will still have to pay the brand-name copayment.</p>	<p>\$15 per generic prescription at a plan pharmacy</p> <p>\$25 per preferred brand-name prescription at a plan pharmacy</p> <p>\$60 per non-preferred prescription at a plan pharmacy</p> <p>You pay two applicable copayments for maintenance medication ordered through our mail order program</p>	<p>The Plan has no POS out-of-network benefits</p> <p>You pay all charges</p>
<ul style="list-style-type: none"> <li>• Self-injectable drugs</li> </ul> <p>Note: Self-injectable drugs are not available through our mail order program.</p>	<p>12% coinsurance per preferred prescription</p> <p>18% coinsurance per non-preferred prescription</p>	<p>The Plan has no POS out-of-network benefits</p> <p>You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Anorexiant or weight loss medications</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy (except for out-of-area emergencies)</i></li> <li>• <i>Vitamins, nutrients, and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Non-prescription medicines</i></li> <li>• <i>Fertility drugs</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

## Section 5(g) Special features

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>• Alternative benefits are subject to our ongoing review.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<b>24 hour Plan representative line</b>	<p>For any of your benefit concerns, 24 hours a day, 7 days a week, you may call (702) 304-5500 or 1 (800) 447-9834 and talk with a Plan representative who will assist you with benefit questions that cannot wait until regular business hours of operation.</p>
<b>Services for deaf, hearing impaired, and non-English speaking members</b>	<p>For assistance call Relay Nevada (711) or 1 (800) 326-6868. En Español, Relay Nevada (711) or 1 (800) 877-1219.</p> <p>If you need interpreter service call us at (702) 304-5564 or 1 (800) 447-9834 and we will arrange for the service.</p>
<b>High risk pregnancies</b>	<p>High risk pregnancy case management.</p>
<b>Centers of excellence</b>	<p>We have a contract with United Resource Networks (URN) for transplant services, URN is a National Centers of Excellence program.</p>
<b>Patient Care Coordinator</b>	<p>When a member is discharged from the hospital, the Patient Care Coordinator provides services such as: contacting the member to ensure follow-up appointments are kept, prescriptions are filled, DME is delivered, and home health services are scheduled.</p>
<b>Home Health Safety Checks</b>	<p>Prior to all hip and knee replacement surgeries, Home Health Services does a safety check to ensure a safe post-operative environment and to prepare for post-operative physical therapy.</p>
<b>Social Workers</b>	<p>Our Social Workers provide support to our members for accessing services such as: admission to Hospice care, to facilitate a member's wish to leave Hospice care and return to their home, Social Security, counseling treatment referrals, child and senior protective services, disability programs, domestic violence programs, funeral and burial, support groups, VA benefits and victim services.</p> <p>Our Social Workers can be reached at (702) 304-5500 or 1 (800) 447-9834.</p>

## Section 5(h) Dental benefits

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

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- 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.
- We cover hospitalization for dental procedures only when a non-dental 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.
- There are no Point of Service (POS) out-of-network benefits for Dental.
- 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.

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<b>Accidental injury benefit</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<p>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 (not biting or chewing).</p> <ul style="list-style-type: none"> <li>• Treatment and repair must begin within fifteen (15) days of the date of documented injury.</li> </ul>	<p>\$20 per office visit \$150 per outpatient procedure \$250 per day, per inpatient admission up to \$750</p>	<p>The Plan has no POS out-of-network benefits You pay all charges</p>

### **Dental benefits**

We have no other dental benefits.

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## Section 5(i) Point of Service benefits

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### Point of Service (POS) Benefits

- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works.
- Point of Service (POS) out-of-network services are subject to a calendar year deductible, copayment, coinsurance, and any difference between our payment and the actual charge. Some services require prior authorization. POS benefits and services are limited. Please see Sections 3, 5(a-f), 5(h) and 5(i) for details.

### Facts about this Plan's POS option

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

### What is covered

- Medical services and supplies (Section 5(a))
- Surgical and anesthesia services (except organ/tissue transplants) (Section 5(b))
- Services provided by a hospital or other facility, and ambulance service (Section 5(c))
- Emergency services/accidents (Section 5(d))
- Mental health and substance abuse benefits (Section 5(e))

### Prior Authorization

For Prior Authorization of services call: (702) 304-5500 or 1 (800) 447-9834

You or your physician must obtain Prior Authorization for the services listed in Section 3. It is your responsibility to verify that the required Prior Authorizations have been given by the Plan for coverage. Please see Section 3 for details on Prior Authorization. If Prior Authorization is not given, or you fail to comply with the requirements, Plan allowance will be subject to Non-compliance Reduction. Non-compliance Reduction means the Plan allowance considered for payment are reduced to 50% as a result of your failure to comply with the Prior Authorization requirements. These Plan allowances will not be used to meet a deductible or out of pocket maximum. Prior Authorization of a service does not guarantee payment.

We will not pay if on the date you receive services:

- You are not eligible for benefits, or
- You have used up a limited benefit, or
- Your plan has changed (January 1, new plan year) and we no longer cover the services.

To verify if a service must be Prior Authorized please call Member Services at (702) 304-5564 or 1 (800) 447-9834.

To initiate the Prior Authorization process, call us at (702) 304-5500 or 1 (800) 447-9834. We will ask you for information such as:

- Your name
- ID Number
- Date of Birth
- Insurance Information
- Doctor's name
- Information about your medical condition, and
- Any other information that may be necessary to help us process your Prior Authorization

If we deny your request for Prior Authorization, see Section 8 for the Disputed Claims Process.

### Deductible

Deductible is the amount of money the member must pay for health care services before the Plan is responsible for providing any coverage. Under this Plan there is one deductible. Deductibles are calculated on a Calendar Year basis. Under this Plan the Calendar Year Deductible is \$500 per person, not to exceed three (3) deductibles per family. Copayments do not apply until the Calendar Year Deductible has been met.

### Coinsurance

Coinsurance is the percentage of our Plan allowance that you must pay for your care. You are responsible for 30% of Plan allowance and any difference between our payment and the actual charge.

### Catastrophic Protection Out-of-Pocket Maximum benefit

The catastrophic protection out-of-pocket maximum per person is \$6,000 (including the deductible) and \$12,000 per family (including deductible). Your out-of-pocket expenses under POS do not qualify for the Plan's HMO in-network out-of-pocket maximum.

### Maximum benefit

The lifetime maximum benefit is \$1,000,000 per person.

### Hospital/extended care

- Hospital: You are responsible for 30% coinsurance after the deductible, plus any difference between our payment and the actual charge.
- Extended Care (Skilled Nursing Facility): You are responsible for 30% coinsurance after the deductible, plus any difference between our payment and the actual charge. A combined maximum benefit for both HMO in-network and POS out-of-network of 100 days per member, per calendar year applies.

### Emergency benefits

True emergency care is always payable as an in-Plan benefit.

You will pay a \$75 copayment per visit for services and supplies. When you are directly admitted to the hospital the copayment charge will be waived. You should notify us within 48 hours, or as soon as reasonably possible, after a hospital inpatient admission.

You should notify us within 48 hours, or as soon as reasonably possible, after a hospital inpatient admission resulting from an emergency room visit. The 48 hour notification applies to all inpatient services except maternity.

### What is not covered

The following are not covered under the POS out-of-network benefit:

- Any organ transplant surgery or procedures, including services rendered on behalf of an organ recipient or an organ donor; transportation, lodging and meal allowance for patient and companion (Section 5(b))
- Prescription drug benefits (Section 5(f))
- Dental benefits (Section 5(h))
- Charges in excess of the Plan allowance for the service provided as determined by us, or any charges which exceed a calendar year maximum, or other benefit maximum
- Any type of services, supplies, or treatment not specifically provided for herein

Please refer to the general exclusions listed in Section 6 and under "what is not covered" in sections 5(a-f) and 5(h-i) for additional information.

When you seek services, the providers and/or facilities are paid according to whether or not they are contracted with the Plan. For example, if you see a Plan provider at a non-Plan hospital the Plan provider is paid at the HMO in-network level and the non-Plan hospital is paid at the POS out-of-network level. You will be required to share a large part of the Plan allowance by satisfying the annual deductible and paying the required coinsurance. Finally, when health care is received from a non-Plan provider, you will be responsible for submitting a completed claim form with an itemized bill.

Services do not need to be obtained within the service area to be eligible for coverage under POS.

### How to obtain benefits

Please see Section 3 for detailed information.

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## Section 6. General exclusions – things we don't cover

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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 doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services requiring our Prior Approval* beginning on page 11.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies 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 or supplies given by a health care provider who lives in the same household as the patient;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

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## Section 7. Filing a claim for covered services

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

You will need to file a claim when you receive emergency services from non-Plan providers or when you receive POS out-of-network 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. Your facility will file on the UB-92 form. For claims questions and assistance, call us at (702) 304-5564 or 1 (800) 447-9834.

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:** NevadaCare, Inc.  
10600 West Charleston Boulevard  
Las Vegas, NV 89135

### **Prescription drugs**

Call R/x<sup>x</sup> Pharmacy Solutions, Inc. Customer Service Department at 1(866) 251-3317 to get forms and instruction for reimbursement.

**Submit your claims to:** R/x<sup>x</sup> Pharmacy Solutions, Inc.  
1600 Broadway, Suite 300  
Tempe, AZ 85282

### **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.

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## Section 8. The disputed claims process

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

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: NevadaCare, Inc. 10600 West Charleston Boulevard Las Vegas, NV 89135; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>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.</li></ol>
<b>3</b>	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p>

## 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.

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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 preauthorization/prior approval, then call us at (702) 304-5568 or 1 (800) 447-9834 ext. 530 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### 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. We will not pay for any services that are not a covered Plan benefit.

### What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or 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.

### • Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don’t have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage Plan.

- **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, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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. Your care must be authorized or have prior authorization as required.

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare

**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) 304-5564 or 1 (800) 447-9834, or see our Web site at <http://www.nevadacare.com>.

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare 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.

<b>Primary Payer Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payer for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... <ul style="list-style-type: none"> <li>• You have FEHB coverage on your own or through your spouse who is also an active employee</li> <li>• You have FEHB coverage through your spouse who is an annuitant</li> </ul>	✓	✓
5) 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) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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	✓*	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and... <ul style="list-style-type: none"> <li>• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)</li> </ul>		✓
<ul style="list-style-type: none"> <li>• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD</li> </ul>	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... <ul style="list-style-type: none"> <li>• This Plan was the primary payer before eligibility due to ESRD</li> </ul>		✓ for 30-month coordination period
<ul style="list-style-type: none"> <li>• Medicare was the primary payer before eligibility due to ESRD</li> </ul>	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>	✓	

\*Workers' Compensation is primary for claims related to your condition under Workers' Compensation

## • Medicare Advantage

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

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

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

**Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

## 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 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.

## **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 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.

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## Section 10. Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Care or services that can be provided by a non-medically skilled person. Such services help the patient with daily living activities and include but are not limited to: walking, dressing, bathing, exercising, preparing meals, moving the patient, acting as a companion, administering medication which can usually be self-administered, and rest cures. Custodial care that lasts 90 days or more is sometimes known as long-term care.
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.
<b>Experimental or investigational services</b>	<p>A drug, device, or biological product is experimental or investigational if it cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Note: Approval means all forms of acceptance by the FDA.</p> <p>A drug, device, or biological product or medical treatment or procedure is experimental or investigational if:</p> <ul style="list-style-type: none"><li>• Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or</li><li>• Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.</li></ul> <p>Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.</p> <p>FDA-approved drugs, devices, or biological products used for their intended purposes and labeled indications and those that have received FDA approval subject to post-marketing approval clinical trials, and devices classified by the FDA as “Category B Non-experimental/investigational Devices” are not considered experimental or investigational when used for the intended purposes and labeled indications as approved by FDA, provided those purposes and indications would otherwise be eligible for Plan benefits.</p>
<b>Group health coverage</b>	A plan or contract that provides coverage for health care services to eligible employees and their dependents.

**Medical necessity**

Medical necessity refers to services, drugs, supplies, or equipment provided by a hospital or covered provider that are determined by us to be:

- Rendered for the treatment or diagnosis of an injury or illness; and
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and
- Consistent with standards of good medical practice in the United States; and
- In the case of inpatient care, cannot be provided safely on an outpatient basis.

**Plan allowance**

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

- In-Network HMO Plan Providers: Our allowance is the amount agreed upon between the Plan Provider and us. You are not liable for any amount above the Plan allowance for a Plan Provider.
- Out-of-Network POS Non Plan Providers: Our allowance for non-Plan Providers is based on 115% of the Medicare limiting charge. You are responsible for any charges above the Plan allowance in addition to any applicable copayments, deductibles, and coinsurance, except in an emergency.

**Us/We**

Us and We refer to NevadaCare.

**You**

You refers to the enrollee and each covered family member.

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## Section 11. FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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](http://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 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 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 cancel your coverage, change to Self Only, or change to a plan that doesn’t serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective 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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2004 benefits until the effective date of your coverage with your new plan. 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 (TCC), or a conversion policy (a non-FEHB individual policy.)

- **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 provide 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 Web site, [www.opm.gov/insure](http://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 Federal 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](http://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.

From more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at [www.opm.gov/insure/health](http://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 information about Federal and State agencies you can contact for more information.

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## Section 12. Two Federal Programs complement FEHB benefits

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### Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs that are not covered under the FEHB.

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### • What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!!*

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

#### Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

#### • Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit [www.fsafeds.com](http://www.fsafeds.com) and click on **Enroll**
- **Telephone:** call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337) Monday through Friday; from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

#### What is SHPS?

SHPS is a Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

## Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on to participate. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

## • How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30 following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example, if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

The FSAFEDS Calculator at [www.fsafeds.com](http://www.fsafeds.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

## • What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. The out of pocket costs are summarized on page 13 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse, and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out of pocket expenses include:

- Office visit copayments
- Eyeglasses and contact lenses
- Immunizations exclusively for travel
- Diagnostic Test copayments
- Pharmacy copayments

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at: [www.fsafeds.com/fsafeds/eligibleexpenses.asp](http://www.fsafeds.com/fsafeds/eligibleexpenses.asp). If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

<b>Annual Tax Savings Example</b>	<b>With FSA</b>	<b>Without FSA</b>
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
<b>Your tax savings:</b>	<b>\$576</b>	<b>-\$0-</b>

**Note:** This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

- Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal Tax Credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit [www.fsafeds.com](http://www.fsafeds.com) and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.fsafeds.com](http://www.fsafeds.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: [fsafeds@shps.net](mailto:fsafeds@shps.net)
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450

## **The Federal Long Term Care Insurance Program**

- **It's important protection** Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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

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## Summary of benefits for NevadaCare - 2005

- **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: \$20 primary care; \$20 specialist	16
Services provided by a hospital: • Inpatient .....	\$250 per day, per admission up to \$750	31
• Outpatient .....	\$150 per outpatient admission	32
Emergency benefits • In area .....	\$75 per visit	36
• Out-of-area .....	\$75 per visit	36
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Prescription drugs .....	\$15 per generic \$25 per brand name \$60 per non-preferred	41
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## 2005 Rate Information for NevadaCare

**Non-Postal rates** apply to most non-Postal employees. 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.

		<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
<b>Type of Enrollment</b>	<b>Code</b>	<b>Gov't Share</b>	<b>Your Share</b>	<b>Gov't Share</b>	<b>Your Share</b>	<b>USPS Share</b>	<b>Your Share</b>
<b>Self Only</b>	<b>IF1</b>	<b>\$124.10</b>	<b>\$41.36</b>	<b>\$268.88</b>	<b>\$89.62</b>	<b>\$146.85</b>	<b>\$18.61</b>
<b>Self &amp; Family</b>	<b>IF2</b>	<b>\$298.23</b>	<b>\$104.51</b>	<b>\$646.17</b>	<b>\$226.43</b>	<b>\$352.08</b>	<b>\$50.66</b>