

Health Plan of Nevada

[http:// fehbp.healthplanofnevada.com](http://fehbp.healthplanofnevada.com)

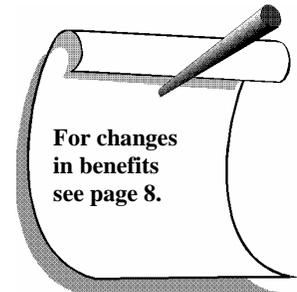


2006

A Health Maintenance Organization

Serving: The Las Vegas metropolitan area and surrounding communities and the Reno/Sparks metropolitan area

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 “Commendable” status from the National Committee for Quality Assurance (NCQA) for Commercial and Medicare Products. See the 2006 Guide for more information on accreditation.

Enrollment codes for Clark, Esmeralda and Nye Counties:

**NM1 Self Only
NM2 Self and Family**

Enrollment codes for Lyon, Mineral and portions of Washoe Counties:

**2L1 Self Only
2L2 Self and Family**

Authorized for distribution by the:



**United States
Office of Personnel Management**

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



RI73-129

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 Accountability 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 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 14, 2003.

Important Notice from Health Plan of Nevada About Our Prescription Drug Coverage and Medicare

OPM has determined that Health Plan of Nevada's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and Health Plan of Nevada will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Health Plan of Nevada under our contract (CS 1942) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Health Plan of Nevada's administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 68. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Health Plan of Nevada.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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 or e-mail OPM at fehwebcomments@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.

Stop Health Care Fraud!

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 us at 1-702-242-7300 or 1-800-777-1840 and explain the situation.

If we do not resolve the issue:

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

OR WRITE TO:
**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.

Preventing medical mistakes

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.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

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. 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. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- ▶ www.talkaboutrx.org/index.jsp. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- ▶ www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- ▶ www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- ▶ 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.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact 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 and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

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

When we contract with a doctor or medical group to provide health care services, the contract specifies the amount the doctor or medical group will be paid for providing services – either on a fixed monthly basis or as a payment per service provided.

We have several types of payment arrangements with our doctors:

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

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

Arrangement C: Your doctor may be paid a pre-determined amount for each service he/she provides.

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) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Health Plan of Nevada has operated as a mixed model HMO in Nevada for 23 years. Health Plan of Nevada has been awarded “Commendable” status by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to measuring the quality of America's healthcare. Accreditation, effective July 2003, is for the commercial HMO, commercial point-of-service (POS) and Medicare HMO product lines in Nevada.
- We understand the importance of getting your questions answered. Whether you need an answer to a benefit question or have a concern about a claim, or need help in selecting a provider, we are available Monday through Friday, 8 a.m. to 5 p.m. at 1-702-242-7300 or 1-800-777-1840.
- At times, services requested on your behalf by your provider may not be approved by Health Plan of Nevada. The decision to deny coverage for services requested, courses of treatment or inpatient care is made by a physician. These denials are based upon medical necessity, benefit coverage and your individual needs. Written notification of the denial will be sent to you, your primary care provider and the provider who requested the service. You have the right to appeal these decisions.

If you want more information about us, call 1-702- 242-7300 or 1-800-777-1840, or write to Health Plan of Nevada, P.O. Box 15645, Las Vegas, NV 89114-5645. You may also contact us by fax at 1-702-242-9350 or visit our Web site at <http://fehbp.healthplanofnevada.com>.

Service Area

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

Serving: Clark, Esmeralda and Nye counties

Enrollment Code:

NM1 Self Only

NM2 Self and Family

Serving: Lyon and Mineral counties and portions of Washoe County as defined by the towns listed below:

Sparks, Sun Valley, Wadsworth and Reno

Enrollment Code:

2L1 Self Only

2L2 Self and Family

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

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

Section 2 How we change for 2006

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

Changes to this Plan

- If you are enrolled in Code NM, your share of the non-Postal premium will increase by 4.4% for Self Only or 4.4% for Self and Family.
- If you are enrolled in Code 2L, your share of the non-Postal premium will increase by 7.4% for Self Only or 11.2% for Self and Family.
- You now pay \$7 for a 30-day therapeutic supply of generic drugs (see [page 46](#)).
- You now pay \$30 for a 30-day therapeutic supply of brand-name formulary drugs (see [page 46](#)).
- You now pay \$50 for a 30-day therapeutic supply of non-formulary drugs (see [page 46](#)).
- We added a benefit for medical treatment in a Phase I clinical trial for the treatment of cancer conducted in the state of Nevada with a \$10 office visit or specialist visit copayment (see [page 28](#)).

Section 3 How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as 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 1-702-242-7300 or 1-800-777-1840 or write to us at P.O. Box 15645, Las Vegas, NV 89114-5645. You may also request replacement cards through our Web site at <http://fehbp.healthplanofnevada.com>.

Where you get covered care

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

- **Plan providers**

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

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

What you must do to get covered care

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

- **Primary care**

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

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

- **Specialty care**

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

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 primary care provider will work with the plan and your specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care 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 primary care provider. Your primary care provider will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB 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, or if we drop out of the Program, contact your new plan.

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

- **Hospital care**

Your Plan primary care provider 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 1-702-242-7300 or 1-800-777-1840. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

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

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

- All non-emergency hospital admissions
- Admissions to skilled nursing facilities and inpatient hospice facilities
- All non-emergency inpatient and outpatient surgeries
- Many diagnostic procedures
- Physical, occupational and speech therapy
- Inpatient and outpatient mental health and substance abuse treatment
- Home health
- Prosthetic devices and durable medical equipment
- Certain prescription drugs
- Pharmaceutical compounds
- Genetic disease testing
- Clinical trials or studies for the treatment of cancer or chronic fatigue syndrome conducted in the state of Nevada
- Dental anesthesia for enrolled dependent children when determined to be medically necessary

It is best to contact your primary care provider before you seek any services. Failure to follow the requirements of the prior authorization process will result in higher out-of-pocket costs to you.

Contact our member services department at 1-702-242-7300 or 1-800-777-1840 for additional details.

Section 4 Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments

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

Example: When you see your primary care provider you pay a copayment of \$10 per office visit and when you go in the hospital you pay \$100 per admission.

Deductible

We do not have a deductible.

Coinsurance

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

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

Eligible Medical Expense (EME)

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

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total \$2,000 per person or \$5,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for prescription drugs do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for them.

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

Section 5 Benefits – Overview

See [page 8](#) for how our benefits changed this year. 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 your benefits, please contact us at 1-702-242-7300 or 1-800-777-1840 or at our website at <http://fehbp.healthplanofnevada.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:

- 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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.

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Specialty services and consultations 	\$10 per office visit Applicable facility copayment may apply. See <i>Section 5(c)</i> .
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • House calls by physician 	\$20 per office visit
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • Second surgical opinion 	Nothing Applicable facility copayment applies. See <i>Section 5(c)</i> .

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Lab, X-ray and other diagnostic tests	You pay
<ul style="list-style-type: none"> • Laboratory Services <p>Routine tests, such as:</p> <ul style="list-style-type: none"> • EKG • X-rays 	<p>\$5 plus office visit copayment</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>
<ul style="list-style-type: none"> • Complex diagnostic imaging services, such as nuclear medicine, CT scan, cardiac ultrasonography, MRI and arthrography • Complex vascular diagnostic and therapeutic services including Holter monitoring, treadmill stress testing, and impedance venous plethysmography • Complex neurological diagnostic services including EEG, EMG, and evoked potential • Complex pulmonary diagnostic services including pulmonary function testing and apnea monitoring • Otologic evaluation 	<p>\$10 per test or procedure</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>
<ul style="list-style-type: none"> • Genetic disease testing when medically necessary and prior authorized by the Plan 	<p>50% of EME</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>
<ul style="list-style-type: none"> • Positron Emission Tomography (PET) scan 	<p>\$750</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>

Preventive care, adult	You pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Double contrast barium enema – once every five years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Screening for Chlamydial infection • Routine mammogram – covered for women age 35 and older as follows: <ul style="list-style-type: none"> – From age 35 through 39, one during this five year period – Age 40 and older, one every calendar year • Osteoporosis screening • Routine Pap test <p>Note: The office visit is covered if the Pap test is received on the same day; see <i>Diagnostic and treatment services</i>, above.</p>	<p>\$5 per test plus office visit copayment</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>
<ul style="list-style-type: none"> • Sigmoidoscopy – one every five years starting at age 50; or • Colonoscopy – one every 10 years starting at age 50 	<p>\$50 per procedure</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>
<ul style="list-style-type: none"> • Routine immunizations limited to: <ul style="list-style-type: none"> – Tetanus-diphtheria (Td) booster, once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) – Influenza vaccine, annually – Pneumococcal vaccine, age 65 and older 	<p>\$10 per office visit</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p> <p>No charge at immunization clinics</p>

Preventive care, adult - continued on next page

High Option

Preventive care, adult <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment, licensing, insurance, attending schools or camp, travel, sports, or adoption purposes</i> • <i>Exams or treatment ordered by a court, or in connection with legal proceedings</i> • <i>Immunizations related to foreign travel</i> 	<p><i>All charges.</i></p>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) 	<p>\$10 per office visit</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment, licensing, insurance, attending schools or camp, travel, sports, or adoption purposes</i> • <i>Exams or treatment ordered by a court, or in connection with legal proceedings</i> • <i>Immunizations related to foreign travel</i> 	<p><i>All charges.</i></p>

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to have your normal delivery prior authorized. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Circumcision is covered under the Surgical benefits (<i>Section 5(b)</i>). 	<p>\$15 per office visit</p> <p>Applicable facility and surgery copayments apply. See Hospital benefits <i>Section 5(c)</i> and Surgical benefits <i>Section 5(b)</i>.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Routine sonograms to determine fetal age, size or sex</i> • <i>Amniocentesis, except when medically necessary under the guidelines of the American College of Obstetrics and Gynecology</i> • <i>Services and supplies rendered in connection with member acting as or utilizing the services of a surrogate mother</i> 	<p><i>All charges.</i></p>

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Family planning	You pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (see Surgical procedures <i>Section 5 (b)</i>) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit. See <i>Section 5(f)</i>.</p>	<p>\$10 per office</p> <p>Applicable facility and surgery copayments apply. See Hospital benefits <i>Section 5(c)</i> and Surgical benefits <i>Section 5(b)</i>.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Voluntary abortions</i> 	<p><i>All charges.</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Diagnostic and therapeutic infertility services determined to be medically necessary and prior authorized by the Plan. <ul style="list-style-type: none"> – Laboratory studies – Diagnostic procedures – Artificial insemination services, up to six cycles per member per lifetime 	<p>\$10 per office visit</p> <p>Applicable facility and surgery copayments apply. See Hospital benefits <i>Section 5(c)</i> and Surgical benefits <i>Section 5(b)</i>.</p>

Infertility services - continued on next page

Infertility services <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> – <i>in vitro</i> fertilization – embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) • Services and supplies related to excluded ART procedures • Cost of donor sperm • Cost of donor egg • Injectable and oral fertility drugs • Low tubal transfers 	<p><i>All charges.</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$10 per office visit</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>
<ul style="list-style-type: none"> • Allergy serum 	<p>Nothing</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Provocative food testing • Sublingual allergy desensitization 	<p><i>All charges.</i></p>

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Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 34.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit (<i>Section 5(f)</i>). We will only cover GHT when we prior authorize the treatment. Call 1-702-242-7300 or 1-800-777-1840 for prior authorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and prior authorization is given. If you do not request prior authorization or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> on page 12.</p>	<p>\$10 per office visit</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Sports medicine treatment intended to primarily improve athletic ability 	<p><i>All charges.</i></p>
Physical and occupational therapies	
<ul style="list-style-type: none"> • Two consecutive months per condition for the services of each of the following: <ul style="list-style-type: none"> – Qualified physical therapists and – Occupational therapists <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"> • Cardiac rehabilitation is provided for up to 30 days following a heart transplant, bypass surgery or a myocardial infarction. <p>Note: Cardiac rehabilitation services must be provided on a monitored basis.</p>	<p>\$5 per office visit</p> <p>Applicable facility copayment may apply. See <i>Section 5(c)</i>.</p>

Physical and occupational therapies - continued on next page

Physical and occupational therapies <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Milieu therapy, biofeedback, behavior modification, sensitivity training, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolfing, residential treatment, vocational rehabilitation and wilderness programs • Treatment for mental retardation 	All charges.
Speech therapy	
<ul style="list-style-type: none"> • Two consecutive months per condition for the services of a speech therapist 	\$5 per office visit Applicable facility copayment may apply. See Section 5(c).
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$10 per office visit Applicable facility copayment may apply. See Section 5(c).
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	All charges.
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Annual eye refraction <p>Note: See <i>Preventive care, children</i> for eye exams for children</p>	\$10 per office visit
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	50% of costs

Vision services - continued on next page

High Option

Vision services (testing, treatment, and supplies) <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eye examination required as a condition of employment or by a government body</i> • <i>Low vision aids</i> • <i>Orthoptics or vision training and exercises</i> • <i>Medical or surgical treatment of the eyes</i> • <i>Any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses</i> 	<p><i>All charges.</i></p>
<p>Foot care</p> <ul style="list-style-type: none"> • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	<p><i>All charges.</i></p>

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants and surgically implanted breast implants following mastectomy • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Terminal devices, such as hand or hook • Artificial limbs and eyes; stump hose • Braces which include only rigid and semi-rigid devices used for supporting a weak or deformed body member or restricting or eliminating motion of a diseased or injured part of the body • Foot orthotics when part of a lower body brace • Lumbosacral supports • Adjustment of an initial Prosthetic or Orthotic device required by wear or by change in the patient's condition when ordered by a Plan provider 	<p>50% of cost, not to exceed \$200 per device</p> <p>Applicable facility and surgery copayments may apply. See Hospital benefits <i>Section 5(c)</i> and Surgical benefits <i>Section 5(b)</i>.</p>
<ul style="list-style-type: none"> • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome 	<p>50% of EME</p> <p>Applicable facility and surgery copayments may apply. See Hospital benefits <i>Section 5(c)</i> and Surgical benefits <i>Section 5(b)</i>.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Arch supports</i> • <i>Special shoe accessories or corrective shoes unless they are an integral part of a lower body brace</i> • <i>Heel pads and heel cups</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements provided less than three years after the last one we covered</i> 	<p><i>All charges.</i></p>

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Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician and prior authorized by the Plan, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Wheelchairs – limited to coverage of single standard manual wheelchair as deemed medically necessary and appropriate • Hospital beds • Traction equipment • Walkers • Crutches • Insulin pumps <p>Note: Call us at 1-702-242-7300 or 1-800-777-1840 as soon as your Plan physician prescribes this equipment.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs</i> • <i>Custom wheelchairs</i> • <i>More than one piece of equipment serving essentially the same function except for replacements as authorized by the Plan. Coverage for alternate or spare equipment is not provided.</i> 	<p><i>All charges.</i></p>
Home health services	
<p>Covered services and supplies provided by a Home Health Care agency include:</p> <ul style="list-style-type: none"> • Professional services of a registered nurse, licensed practical nurse, licensed vocational nurse or a health aide on an intermittent basis. • Physical therapy, speech therapy and occupational therapy by licensed therapists. • Medical and surgical supplies that are customarily furnished by the Home Health Care agency or program for its patients. • Prescribed drugs furnished and charged for by the Home Health Care agency or program. Prescribed drugs under this provision do not include self-injectable prescription drugs. • Health aid services furnished to member only when receiving nursing services or therapy. 	<p>Nothing</p>

Home health services - continued on next page

Home health services <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Housekeeping or meal service</i> 	<p><i>All charges.</i></p>
<p>Chiropractic</p> <ul style="list-style-type: none"> • Chiropractic services for manual manipulation of the spine (except for reductions of fractures or dislocations) <p>Note: Limited to 60 consecutive calendar days per condition.</p>	<p>\$10 per office visit</p>
<p>Alternative treatments</p> <ul style="list-style-type: none"> • Medical treatment in a Phase I, II, III or IV clinical trial or study for the treatment of cancer conducted in the state of Nevada • Medical treatment in a Phase II, III or IV clinical trial or study for the treatment of chronic fatigue syndrome conducted in the state of Nevada <p>Note: See Prescription drug benefits (<i>Section 5(f)</i>) for coverage of drugs and medicines.</p>	<p>\$10 per office visit</p> <p>Applicable facility copayment may apply. See Hospital benefits <i>Section 5(c)</i>.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry</i> • <i>Services that are specifically excluded from coverage under this Plan regardless of whether such services are provided under the clinical trial or study</i> • <i>Services that are customarily provided by the sponsors of the clinical trial or study free of charge in the clinical trial or study</i> • <i>Expenses related to participation in the clinical trial or study including, but not limited to, travel, housing and other expenses</i> • <i>Expenses incurred by a person who accompanies a member during the clinical trial or study</i> • <i>Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the member</i> • <i>Any cost for the management of research relating to the clinical trial or study</i> 	<p><i>All charges.</i></p>

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Educational classes and programs	You pay
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime <p>Note: See Prescription drug benefits (<i>Section 5(f)</i>) for coverage of smoking cessation medication.</p> <ul style="list-style-type: none"> • Diabetes self-management • Education – Includes coverage for education for treatment of diabetes. Covered services include medically necessary training and education for: <ul style="list-style-type: none"> – the care and management of diabetes, after initial diagnosis of diabetes, to include counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes – a subsequent diagnosis that indicates a significant change in the symptoms or condition which requires modification of the self-management program – the development of new techniques and treatment for diabetes 	<p>\$10 per office visit</p> <p>\$5 per educational site visit</p>
<ul style="list-style-type: none"> • Diabetes supplies, including: <ul style="list-style-type: none"> – syringes – needles – blood glucose measuring strips – urine checking reagents • Disposable needles and syringes for the administration of covered medications 	<p>\$5 per 30-day therapeutic supply</p>
<ul style="list-style-type: none"> • Diabetes equipment, including: <ul style="list-style-type: none"> – blood glucose monitor – lancet device <p>Note: See Durable medical equipment (<i>Section 5(a)</i>) for coverage of insulin pumps. See Prescription drug benefits (<i>Section 5(f)</i>) for coverage of diabetes medication.</p>	<p>\$20 per unit (maximum one unit per year)</p>

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

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

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

Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus (see Reconstructive surgery (<i>Section 5(b)</i>)) • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery (<i>Section 5(b)</i>)) 	<p>\$5 plus office visit copayment in a physician's office</p> <p>Nothing in an outpatient facility</p> <p>Nothing for inpatient admissions</p>

Surgical procedures - continued on next page

High Option

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See Orthopedic and prosthetic devices (<i>Section 5(a)</i>) for device coverage information. • Treatment of burns • Surgically implanted contraceptives • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.</p>	<p>\$5 plus office visit copayment in a physician's office</p> <p>Nothing in an outpatient facility</p> <p>Nothing for inpatient admissions</p>
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery) <ul style="list-style-type: none"> – Individuals must have a body mass index (BMI) of greater than 40 kg/m², or greater than 35kg/m² with significant co-morbidities such as cardiac disease; diabetes; hypertension; or diseases of the endocrine system, e.g. Cushing's syndrome, hypothyroidism, or disorders of the pituitary or adrenal glands – Individuals must show documentation that medically supervised weight loss therapy for at least 3 months within the last 24 months have been ineffective – Individuals must be age 18 or over and have a psychological/psychiatric evaluation by a licensed practitioner, with a recommendation for gastric restrictive surgery – The copayment for any covered services rendered in the treatment of complications in connection with gastric restrictive surgery is 50% of EME – Contact the Plan at 1-702-242-7300 or 1-800-777-1840 for additional eligibility criteria <p>Note: See <i>Services requiring our prior approval</i> on page 12.</p>	<p>50% of EME</p>
<ul style="list-style-type: none"> • Surgical Assistant Services 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot</i> (see Foot care (<i>Section 5(a)</i>)) 	<p><i>All charges.</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a function defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – The condition produced a major effect on the member’s appearance and – The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: cleft lip, cleft palate, birthmarks, webbed fingers, and webbed toes. 	<p>\$5 plus office visit copayment in a physician’s office</p> <p>Nothing in an outpatient facility</p> <p>Nothing for inpatient admissions</p>
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – Surgery to produce a symmetrical appearance on the other breast; – Treatment of any physical complications, such as lymphedemas; – Breast prostheses and surgical bras and replacements (see Prosthetic devices Section 5(a)) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>Nothing for inpatient admissions</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>

High Option

Oral and maxillofacial surgery	You pay
<ul style="list-style-type: none"> • Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Treatment of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth • Removal of teeth necessary in order to perform radiation therapy • Removal of stones from salivary ducts • Other surgical procedures that do not involve the teeth or their supporting structures 	<p>\$10 in a physician's office</p> <p>Nothing in an outpatient facility</p> <p>Nothing for inpatient admissions</p>
<ul style="list-style-type: none"> • Non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome 	<p>50% of EME</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Shortening of the mandible or maxillae for cosmetic purposes</i> • <i>Charges for dental services in connection with TMJ</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Lung • Kidney • Liver • Pancreas • Allogenic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing for inpatient admissions</p>
<ul style="list-style-type: none"> • Transportation, lodging and meals <p>Note: Prior authorization is required.</p>	<p>All costs exceeding \$200 per day and \$10,000 per transplant period</p>
<ul style="list-style-type: none"> • Organ procurement 	<p>All costs exceeding \$15,000 of EME</p>
<ul style="list-style-type: none"> • Retransplantation services 	<p>All costs exceeding 50% of EME</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges.</i></p>

High Option

Anesthesia	You pay
Professional services provided in – <ul style="list-style-type: none">• Hospital (inpatient)• Hospital outpatient department• Skilled nursing facility• Ambulatory surgical center• Physician office	Nothing

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

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

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

Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: If you want a private room or special duty nursing when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <ul style="list-style-type: none"> • Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Clinical pathology and laboratory services and supplies and x-rays • Dressing, splints, casts, and sterile tray services 	<p>\$100 per admission</p>

Inpatient hospital - continued on next page

High Option

Inpatient hospital <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Medical supplies including oxygen and its administration • Blood or blood plasma, if not donated or replaced • Intravenous injections and solutions • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	\$100 per admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care, except when medically necessary</i> 	<i>All charges.</i>
Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Clinical pathology and laboratory services and supplies and x-rays • Dressing, splints, casts, and sterile tray services • Medical supplies including oxygen • Blood or blood plasma, if not donated or replaced • Pre-surgical testing • Intravenous injections and solutions <p>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.</p>	\$50 per visit

Extended care benefits/Skilled nursing care facility benefits	You pay
<p>Skilled nursing facility (SNF):</p> <ul style="list-style-type: none"> • Bed, board, and general nursing care • Prescribed drugs and medicines • Clinical pathology and laboratory services and supplies and x-rays • Dressing, splints, casts, and sterile tray services • Oxygen and its administration • Blood or blood plasma, if not donated or replaced • Intravenous injections and solutions <p>Note: Maximum benefit of 100 days per member per calendar year.</p>	\$100 per admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<i>All charges.</i>
Hospice care	
<p>Supportive and palliative care for terminally ill members is covered in the home or in a hospice facility. Covered services include:</p> <ul style="list-style-type: none"> • Inpatient hospice services • Inpatient respite services 	\$100 per admission
<ul style="list-style-type: none"> • Outpatient respite services 	\$5 per visit
<ul style="list-style-type: none"> • Bereavement services <p>Note: Limited to five (5) group therapy sessions or a maximum of \$500, whichever is less, per event.</p>	\$20 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing</i> • <i>Homemaker services</i> 	<i>All charges.</i>

High Option

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

Section 5(d) Emergency services/accidents

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

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

What is a medical emergency?

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

What to do in case of emergency:

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

You may also receive care at the Plan's Urgent Care Centers (see Provider Directory). Benefits are available from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

We pay up to the eligible medical expense (EME) for emergency services to the extent the services would have been covered if received from Plan providers.

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

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

We pay up to the eligible medical expense (EME) for emergency services to the extent the services would have been covered if received from Plan providers.

High Option

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> Emergency care at a physician's office 	\$25 per visit plus amount exceeding EME
<ul style="list-style-type: none"> Emergency care at an urgent care facility 	\$20 per visit plus amount exceeding EME
<ul style="list-style-type: none"> Emergency care in a hospital emergency room 	\$50 per visit plus amount exceeding EME Waived if admitted
Emergency outside our service area	
<ul style="list-style-type: none"> Emergency care at a physician's office 	\$50 per visit plus amount exceeding EME
<ul style="list-style-type: none"> Emergency care at a non-plan urgent care facility 	\$40 per visit plus amount exceeding EME
<ul style="list-style-type: none"> Emergency care in a hospital emergency room 	\$75 per visit plus amount exceeding EME Waived if admitted
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>
Ambulance	
<ul style="list-style-type: none"> Covered services include ambulance services to the nearest appropriate hospital <p>Note: See <i>Section 5(c)</i> for non-emergency ambulance services.</p>	\$50 per trip
<ul style="list-style-type: none"> Emergency air ambulance 	50% of EME
<p>Note: Ambulance services will be reviewed on a retrospective basis to determine medical necessity. The member will be fully liable for the cost of ambulance services that are not medically necessary.</p> <p>Note: Non-emergency medically necessary benefits are payable only upon prior authorization from the Plan.</p>	

Section 5(e) Mental health and substance abuse benefits

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$10 per visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$5 per procedure plus office visit copayment</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$100 per admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> • <i>Marital or family counseling</i> <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>	<p><i>All charges.</i></p>

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits *(continued)*

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

Contacting Behavioral Healthcare Options (BHO) to make arrangements to authorize medically necessary care. BHO may be contacted at 1-800-873-2246. You may obtain more information on BHO by visiting their website at <http://behavioralhealthcareoptions.com>.

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

Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 46.
- 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.

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

- **Who can write your prescription.** Except for emergencies, a Plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail order for certain maintenance medications. Medications available through mail order are limited to those determined by the Plan to be maintenance medications. The list of maintenance medications is maintained by the Plan at its sole discretion.
- **We use a formulary.** We use a formulary (also referred to as “Preferred Drug List”) to serve as a guide for providers in the selection of cost-effective drug therapy and to help maximize the value of our members’ prescription drug coverage. Our formulary is a list of FDA approved generic and brand-name medications developed and maintained by the Plan. The formulary is reviewed by physicians and pharmacists on a regular basis and may change throughout the year at the Plan’s sole discretion. Patient needs, scientific data, drug effectiveness, availability of drug alternatives currently on the formulary, and cost are considerations in selecting medications for inclusion on the formulary. If your physician believes a brand-name product is necessary or there is no generic available, your physician may prescribe a brand-name drug from the formulary. Inclusion of drugs on the formulary does not guarantee that your provider will prescribe that medication.

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

To obtain a copy of our Preferred Drug List, contact Member Services at 1-702-242-7300 or 1-800-777-1840, or visit our web site at <http://fehbp.healthplanofnevada.com>.

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

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

“Compound” means to form or create a medically necessary customized composite drug product by combining two or more different ingredients according to a physician’s specifications to meet an individual patient’s needs.

Prescription drugs (*continued*)

- **These are the dispensing limitations.** A dispensing limitation is the quantity of a medication for which benefits are available for a single applicable copayment, or in the case of maintenance drugs, two copayments for a 90-day therapeutic supply of maintenance medication obtained through our mail order program. Dispensing limitations may include, but are not limited to:
 - a period of time that a specific medication is recommended by the manufacturer and/or the FDA to be an appropriate course of treatment when prescribed for a particular condition, or
 - a predetermined period of time established by the Plan, or
 - the FDA-approved dosage of a medication when prescribed for a particular condition.

Dispensing limitations may be less than but shall not exceed a 30-day supply for drugs obtained at a Plan pharmacy. Maintenance drugs are available for up to a 90-day supply, provided the medication is on the Plan maintenance drug list. Prescriptions that exceed the dispensing limitation established by the Plan will not be covered.

Plan members called to active military duty or in time of national emergency who need to obtain prescription medication should contact Member Services at 1-702-242-7300 or 1-800-777-1840.

- **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 brand-name drug and the generic in addition to the generic drug copayment.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **When you do have to file a claim.** You normally won't have to submit claims to us. If you do need to file a claim, please send us all of the documents for your claim (including itemized billings and receipts) as soon as possible. You must submit claims by December 31 of the year after you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time. Send completed claims to Health Plan of Nevada, Attn: Correspondence/CRR, P.O. Box 15645, Las Vegas, NV 89114-5645

Prescription drug benefits begin on the next page

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • 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>. • Insulin (See Educational classes and programs (<i>Section 5(a)</i>) for coverage of diabetes supplies) • Drugs for sexual dysfunction. Sexual dysfunction drugs have specific dispensing limitations and require prior authorization by the Plan. Contact the Plan for details. • Oral contraceptive drugs • Smoking cessation drugs (e.g., nicotine patches) • Growth hormone • Orphan drugs • Self-injectable drugs • Pediatric and prenatal vitamins <p>Note: A “self-injectable” is to be administered subcutaneously or intramuscularly and does not require administration by a licensed practitioner.</p>	<p>\$7 per generic prescription</p> <p>\$30 per brand-name prescription</p> <p>\$50 per non-formulary prescription</p> <p>Note: You pay two applicable copayments for a 90-day therapeutic supply of maintenance medication obtained through our mail order program.</p>
<ul style="list-style-type: none"> • Compounds, when medically necessary and prior authorized by the Plan 	<p>\$40</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Nonprescription medicines (except insulin)</i> • <i>Anorexic agents</i> • <i>Injectable and oral drugs to treat fertility</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies</i> • <i>Drugs and medicines approved by the FDA for experimental or investigational use except when prescribed for the treatment of cancer or chronic fatigue syndrome</i> 	<p><i>All charges.</i></p>

Section 5(g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Telephone Advice Nurse Service	<p>It doesn't matter if it's day or night, a holiday or weekend, our free Telephone Advice Nurse Service is open to provide helpful advice on simple medical concerns. Depending on your situation, our Telephone Advice Nurse may help you decide whether to seek urgent care or wait until the next day to see your primary care provider. When you have health questions or concerns, call our Telephone Advice Nurse Service at 1-702-242-7330 or 1-800-288-2264</p>
Services for deaf and hearing impaired	<p>We have a TTY/TDD number for use by hearing-impaired members. The TTY/TDD number is 1-702-242-9214 or 1-800-349-3538.</p>
Preventive Health Disease Management	<p>We offer numerous preventive health management programs to assist members with early detection and prevention of serious illnesses. These programs may include member notifications for childhood immunizations, annual reminders for breast and cervical cancer screenings, educational classes or consults for heart health, smoking cessation, and weight management for adults and children.</p> <p>We also provide programs to assist those members with chronic conditions to better manage their health. We offer disease management programs for asthma, congestive heart failure, diabetes, and chronic obstructive pulmonary disease.</p>

Special features – continued on next page

Special features *(continued)*

Feature	Description
<u>HPN@YourService</u>	<p>Online Member Center is available 24 hours a day</p> <p>Day, night and even on holidays, you may access information about your benefits through the Health Plan of Nevada online member center. Take advantage of these convenient service features:</p> <ul style="list-style-type: none"> • Change your address • Request new ID cards • Verify your coverage for pharmacy services • Check your copayment amounts for medical services • Review the status of a claim • Find out who is on record as your primary care provider (PCP) • Check status of a prior authorization request <p>Simply visit us at http://fehbp.healthplanofnevada.com. First time visitors will need to register for a user ID and password.</p>

Section 5(h) Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a 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.
- 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.

Accidental injury benefit	You pay
<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.</p> <ul style="list-style-type: none"> • Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an injury (not to include chewing) when the treatment starts within the first 10 days after the injury and ends within 60 days, such as: <ul style="list-style-type: none"> – Root canal therapy, post and build up – Temporary crowns – Temporary partial bridges – Temporary and permanent fillings – Pulpotomy – Extractions of broken teeth – Incision and drainage – Tooth stabilization through splinting 	<p>\$10 per office visit</p> <p>\$50 per outpatient facility</p>
<ul style="list-style-type: none"> • Dental anesthesia for enrolled dependent children when determined to be medically necessary by a Plan provider and prior authorized by the Plan 	<p>Nothing</p>

Dental benefits

We have no other dental benefits.

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

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

- Health Plan of Nevada's Supplemental dental program provides discounted dental care services from dentists who have agreed to participate in the program to FEHB members enrolled in Health Plan of Nevada. The non-refundable annual premium is due at the beginning of each plan year, and you are required to re-enroll into the dental plan every year during the open enrollment period. You may obtain information regarding the discount dental program by contacting us at 1-702-242-7300 or 1-800-777-1840, or by obtaining an enrollment packet during Open Season.
- If you are enrolled in this Plan through FEHB, have Medicare Part A coverage *and* have purchased Part B coverage, you may also enroll in a Medicare Advantage program. For 2006, there are a variety of Medicare Advantage plan types available to you. Health Plan of Nevada (HPN), a subsidiary of Sierra Health Services, Inc. (SHS), offers a Health Maintenance Organization (HMO) plan called Senior Dimensions. This plan provides all Medicare covered Part A and Part B benefits, as well as benefits not covered by Original Medicare, in a managed care environment. Like your FEHB Plan, you generally must obtain your routine services from Senior Dimensions' doctors and providers, except for emergencies, out-of-area urgent care and renal dialysis. Sierra Health and Life Insurance Company, Inc. (SHL), an affiliate of HPN and a subsidiary of SHS, offers two Preferred Provider Organization (PPO) products, Sierra Spectrum and Sierra Nevada Spectrum. Enrollment into Sierra Spectrum versus Sierra Nevada Spectrum depends largely upon where you live. PPO Medicare Advantage plans offer all Medicare covered services as well as some benefits not covered by Medicare. They also offer the freedom of choice to see providers that are in *and* out of the plan's provider network. Cost sharing is generally a bit higher than the HMO plan, but it is substantially less than Original Medicare. Senior Dimensions, Sierra Spectrum and Sierra Nevada Spectrum all offer Medicare Part D prescription drug coverage as a part of their comprehensive health care plan.

If you are enrolled in this Plan through FEHB, have Medicare Part A coverage *and/or* have purchased Part B coverage, and are covered under the Original Medicare, you may want to enroll in a Medicare Prescription Drug Plan (PDP) or a Medicare Supplement plan. Effective January 1, 2006, provisions of the Medicare Modernization Act of 2003 will be implemented that require Medicare beneficiaries to sign up for a Medicare Part D PDP or incur a premium penalty (unless they have evidence that they have coverage that is at least as good as Medicare's standard drug plan). People who have Original Medicare can purchase their Medicare Part D coverage from SHL through SierraRX, a Medicare Part D PDP. The SierraRX plan has a generous formulary from which both generic and brand name medications can be obtained for minimal cost sharing. The pharmacy network is extensive and members may also conveniently purchase drugs by mail (from a plan mail order vendor). Sierra Health and Life also offers Medicare Supplement plans, to offset some of the out-of-pocket medical service costs of the Original Medicare plan.

Medicare offers a tremendous amount of choice for coverage in 2006. Since so much choice can be confusing, we suggest you contact 1-702-821-2300 or 1-800-274-6648 (TTY/TDD 1-702-880-0816) for assistance in determining what plan(s) might be best for your needs. Representatives will be happy to discuss the plans' differences and advantages relative to your needs and/or send you materials with details about the plans so that you can make informed decisions at your convenience.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services requiring our prior approval* on page 12.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies. See *Emergency services/accidents*;
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices except clinical trials for studies for the treatment of cancer or chronic fatigue syndrome conducted in the state of Nevada.
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the participation in the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-702-242-7300 or 1-800-777-1840.

When you must file a claim – such as for services you receive outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to:

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

Prescription drugs

To submit claims for drugs, contact the plan at 1-702-242-7300 or 1-800-777-1840. We will assist you in completing a Direct Member Reimbursement form and help you process your claim.

Deadline for filing your claim

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

When we need more information

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

Section 8 The disputed claims process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: P.O. Box 15645, Las Vegas, NV 89114-5645; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	<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>
4	<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">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</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 or prior approval. This is the only deadline that may not be extended.

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

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

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

- a) We haven't responded yet to your initial request for care or prior authorization, then call us at 1-702-242-7300 or 1-800-777-1840 and we will expedite our review; or
- b) We denied your initial request for care or prior authorization, 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 3 at 1-202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age 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 four 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• 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 more 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 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.

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

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

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-702-242-7300 or 1-800-777-1840. You may also contact us by fax at 1-702-242-9350 or see our Web site at <http://fehbp.healthplanofnevada.com>.

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

- **Medicare Advantage (Part C)**

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 and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. If you are a FEHB annuitant and enrolled in our Medicare Advantage plan, we waive the copayments for your FEHB coverage. If you are an active FEHB employee and enrolled in our Medicare Advantage plan, we do not waive cost sharing for your FEHB coverage.

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 or coinsurance. 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.

- **Medicare prescription drug (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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.

Primary Payer Chart

A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
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"> • You have FEHB coverage on your own or through your spouse who is also an active employee 		✓
<ul style="list-style-type: none"> • You have FEHB coverage through your spouse who is an annuitant 	✓	
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. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and... <ul style="list-style-type: none"> • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period) 		✓
<ul style="list-style-type: none"> • It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD 	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... <ul style="list-style-type: none"> • This Plan was the primary payer before eligibility due to ESRD 		✓ for 30-month coordination period
<ul style="list-style-type: none"> • Medicare was the primary payer before eligibility due to ESRD 	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
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	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

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.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care that is designed essentially to assist individuals in meeting activities of daily living. These include personal care services (help in walking and getting in or out of bed; assistance in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision over medication which can usually be self-administered) that do not require the continuing attention of trained medical or paramedical personnel. Custodial care that lasts 90 days or more is sometimes known as Long term care.
Eligible Medical Expense (EME)	Charges up to the Plan reimbursement schedule amount, incurred by you while covered under this Plan for covered services. Plan providers have agreed to accept the Plan's reimbursement schedule amount as payment in full for covered services, plus your payment of any applicable copayment. Non-plan providers have not. If you use the services of non-plan providers, you will receive no benefit payments or reimbursement for charges for the service, except in the case of emergency services, urgently needed services, or other covered services provided by a non-plan provider that are prior authorized by the Plan. In no event will the Plan pay more than the applicable Plan reimbursement schedule amount for such services.
Experimental or investigational services	This plan regularly evaluates for possible coverage new medical technologies and new applications of existing technologies. New technologies may include medical procedures, drugs and devices. The evaluation process includes a review of information on the proposed service from appropriate government regulatory bodies as well as from published scientific evidence.
Medical necessity	Medical necessity (also “Medically Necessary”) means a service is needed to improve a specific health condition or to preserve your health. Medical necessity is present when the Plan determines that the care requested is: consistent with the diagnosis and treatment of your illness or injury; the most appropriate level of service which can be safely provided to you; and, not provided solely for your convenience or that of your provider or hospital. When applied to inpatient services, Medically Necessary further means that your condition requires treatment in a hospital rather than any other setting. Services and accommodations are not automatically considered to be Medically Necessary because a physician prescribes them.
Us/We	Us and We refer to Health Plan of Nevada.
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

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/health for enrollment as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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 2006 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 2005 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.

- **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. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

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

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at 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.

Section 12 Two Federal Programs complement FEHB benefits

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, which 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 \$5,000. *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 \$5,000 each (\$10,000 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 annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual 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.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit www.FSAFEDS.com and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), 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 responsible for 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 an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

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 have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, 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 requires that you 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. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The [FSAFEDS Calculator](http://www.FSAFEDS.com) at 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. These out-of-pocket costs are summarized on page 13 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for 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: pharmacy, office visit and diagnostic test copayments. The most common and significant expenses not covered by the Plan are non-injury related dental services, eyeglasses and contact lenses, and services, drugs or supplies provided by non-plan providers.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. ***Note:* While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** 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 <https://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:

Annual Tax Savings Example	With FSA	Without FSA
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
Your tax savings:	\$576	-\$0-

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 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 plus 2½ month grace period, 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, 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
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- 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 request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit 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 the Health Plan of Nevada - 2006

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

Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$10 specialist	16
Services provided by a hospital:		
• Inpatient	\$100 per admission	36
• Outpatient	\$50 per visit	37
Emergency benefits		
• In-area	\$25 per visit	41
• Out-of-area	\$50 per visit	41
Mental health and substance abuse treatment	Regular cost sharing	42
Prescription drugs	\$7 generic preferred \$30 brand preferred \$50 non-preferred	44
Dental care	No benefit.	49
Vision care	\$10 per visit for one refraction annually and 50% of costs associated with vision supplies	24
Special features: Flexible benefits option, Telephone Advice Nurse Service, Services for the deaf and hearing impaired, Preventive Health/Disease Management, HPN@YourService		47
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after \$2,000/Self Only or \$5,000/Family enrollment per year Some costs do not count toward this protection	13

2006 Rate Information for Health Plan of Nevada

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.

Type of Enrollment	Code	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Postal Premium</i>	<i>Postal Premium</i>
		<u>Biweekly</u>	<u>Biweekly</u>	<u>Monthly</u>	<u>Monthly</u>	<u>Biweekly</u>	<u>Biweekly</u>
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Las Vegas metropolitan area and surrounding communities							
Self Only	NM1	\$ 72.47	\$ 24.16	\$ 157.03	\$ 52.34	\$ 85.76	\$ 10.87
Self and Family	NM2	\$ 185.57	\$ 61.86	\$ 402.08	\$ 134.02	\$ 219.59	\$ 27.84
Reno/Sparks metropolitan area							
Self-Only	2L1	\$ 126.89	\$ 42.30	\$ 274.94	\$ 91.64	\$ 150.16	\$ 19.03
Self and Family	2L2	\$ 316.08	\$ 117.09	\$ 684.84	\$ 253.70	\$ 373.15	\$ 60.02