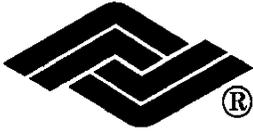


Health Plan of Nevada

www.hpnfederalbenefits.com

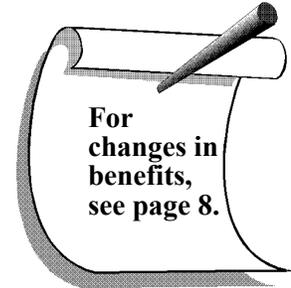


2008

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 2008 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>



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

OPM has determined that the Health Plan of Nevada prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. 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 your plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that 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 many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) 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, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 61. 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 fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits 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) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 702-242-7300 or 800-777-1840 and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

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.
- Contact your doctor or pharmacist if you have any questions.

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.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.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. 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, and our providers. 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 25 years. Health Plan of Nevada has been awarded an accreditation status of "Commendable" from the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to measuring the quality of America's healthcare. Accreditation is for the Commercial HMO, Commercial point-of-service (POS) and Medicare HMO product lines in Nevada effective May 2006.
- We understand the importance of getting your questions answered. Whether you need an answer to a benefit question, 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 702-242-7300 or 800-777-1840.
- At times, services required 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 702-242-7300 or 800-777-1840, or write to Health Plan of Nevada, P.O. Box 15645, Las Vegas, NV 89114-5645. You may also contact us by fax at 702-242-9350 or visit our Web site at www.hpnfederalbenefits.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

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 Wahoe County as defined by the towns listed below:

Sparks, Sun Valley, Wadsworth and Reno

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 2008

Do not rely only 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

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 62.

Changes to High Option Only

- If you are enrolled in Code NM, your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 62.
- If you are enrolled in Code 2L, your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 62.
- We cover abdominal aortic aneurysm screening for men between the ages 65-75 years, who have a history of smoking. A \$10 copayment applies (see page 15).
- We no longer cover immunizations provided at immunization clinics at no charge (see page 16 and page 17).
- The copayment for maternity care decreases from \$15 per office visit to \$10 per office visit (see page 17).
- Physical and occupational therapy is now limited to 60 days/visits per member per calendar year (see page 19).
- Speech therapy is now limited to 60 days/visits per member per calendar year (see page 20).
- You now pay a \$5 orientation fee plus \$30 - \$55 for a three-month smoking cessation program that includes an individual counseling session and at least six group counseling sessions (see page 23).
- Inpatient respite services are now limited to \$1,500 per member per calendar year (see page 31).
- Outpatient respite services are now limited to \$1,000 per member per calendar year (see page 31).
- We cover prior authorized non-emergency transport (ground or air) at no charge (see page 32 and page 34).
- You pay a \$25 copayment for physician services in addition to the hospital emergency room facility copayment for emergency care within the service area. Only the facility copayment is waived if admitted (see page 34).
- You pay a \$50 copayment for physician services in addition to the hospital emergency room facility copayment for emergency care outside of the service area. Only the facility copayment is waived if admitted (see page 34).
- The copayment for a therapeutic supply of preferred brand-name prescriptions increases from \$30 to \$35 (see page 38).
- The copayment for a therapeutic supply of non-formulary generic and brand-name prescriptions increases from \$50 to \$55 (see page 38).
- The copayment for prescription compounds increases from \$50 to \$55 (see page 38).
- The catastrophic protection out-of-pocket maximum increases from \$2,000 per person/\$5,000 per family to \$3,000 per person/\$6,000 per family (see page 12 and page 61).

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 702-242-7300 or 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 www.hpnfederalbenefits.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 physician 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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 702-242-7300 or 800-777-1840. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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 cases, 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

All covered services not provided by your primary care provider must be coordinated through your primary care provider and authorized by the Plan. Before making a decision, we consider eligibility, if the service is covered, medically necessary and/or appropriate, the required duration of treatment or admission, the appropriateness of the proposed setting, 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
- Specialists visits or consultations
- Many diagnostic procedures
- Courses of treatment, including allergy testing or treatment, angioplasty, physiotherapy or manual manipulation
- Physical, occupational and speech therapy
- Inpatient and outpatient mental health and substance abuse treatment
- Home health
- Prosthetic devices, orthotic 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
- Non-emergency (ground or air) transport

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 702-242-7300 or 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 certain 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 \$50 per admission.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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 the treatment of temporomandibular joint pain dysfunction syndrome.

Eligible Medical Expense

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 \$3,000 per person or \$6,000 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.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

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 702-242-7300 or 800-777-1840 or at our website at www.hpnfederalbenefits.com.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals.....15

- Diagnostic and treatment services.....15
- Lab, X-ray and other diagnostic tests.....15
- Preventive care, adult.....16
- Preventive care, children.....17
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**Section 5(a). Medical services and supplies
provided by physicians and other health care professionals**

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.
- 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	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Speciality services and consultations 	\$10 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center 	\$20 per office visit within the service area \$40 per office visit outside the service area
Professional services of physicians <ul style="list-style-type: none"> • House calls by physician 	\$20 per 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> .
Lab, X-ray and other diagnostic tests	High Option
<ul style="list-style-type: none"> • Laboratory Services Routine tests, such as: <ul style="list-style-type: none"> • EKG • X-rays 	\$5 plus office visit copayment
<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 • Abdominal aortic aneurysm screening, one screening for men between the ages of 65 and 75 with a history of smoking 	\$10 per test or procedure Applicable facility copayment may apply. See <i>Section 5(c)</i> .

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	High Option
<ul style="list-style-type: none"> Genetic disease testing when medically necessary and prior authorized by the Plan 	25% of EME
<ul style="list-style-type: none"> Positron Emission Tomography (PET) scan 	\$750
Preventive care, adult	High Option
<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 - 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>, on the previous page.</p>	\$5 per test plus office visit copayment
<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 	\$50 per procedure Applicable facility copayment may apply. See <i>Section 5(c)</i> .
<ul style="list-style-type: none"> Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	\$10 per office visit Applicable facility copayment may apply. See <i>Section 5(c)</i> .
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Physical exams and immunizations 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> 	<i>All charges</i>

Benefit Description	You pay
Preventive care, children	High Option
<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) 	\$10 per office visit
<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> 	<i>All charges</i>
Maternity care	High Option
<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>\$10 per office visit</p> <p>Applicable facility and surgery copayments apply. See Hospital benefit <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> 	<i>All charges</i>

Benefit Description	You pay
Family planning	
<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) • 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 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>
<ul style="list-style-type: none"> • Injectable contraceptive drugs (such as Depo provera) 	<p>Three times preferred brand-name prescription copayment plus office visit copayment</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>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Injectable and oral fertility drugs</i> • <i>Low tubal transfers</i> 	<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><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
<p>Treatment therapies</p> <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 28.</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 702-242-7300 or 800-777-1840 for prior authorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT services 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 11.</p>	<p>High Option</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"> • <i>Sports medicine treatment intended to primarily improve athletic ability</i> 	<p><i>All charges</i></p>
<p>Physical and occupational therapies</p> <ul style="list-style-type: none"> • 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> <p>Note: Maximum benefit of 60 days/visits per member per calendar year.</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>High Option</p> <p>Outpatient: \$5 per office visit</p> <p>Inpatient: \$50 per admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Milieu therapy, biofeedback, behavior modification, sensitivity training, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolfing, residential treatment, vocational rehabilitation and wilderness programs</i> • <i>Treatment for mental retardation</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Speech therapy	
Services of a speech therapist Note: Maximum benefit of 60 days/visits per member per calendar year.	High Option Outpatient: \$5 per office visit Inpatient: \$50 per admission
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Testing when medically necessary or necessitated by an accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Annual eye refraction Note: See <i>Preventive care, children</i> for eye exams for children.	\$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
<i>Not covered:</i> <ul style="list-style-type: none"> • Eye examination required as a condition of employment or by a government body • Low vision aids • Orthoptics or vision training and exercises • Medical or surgical treatment of the eyes • Any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses 	<i>All charges</i>
Foot care	
<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 Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above • Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All charges</i>

Benefit Description	You pay
Orthopedic and prosthetic devices	
<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 • Adjustments of an initial Prosthetic or Orthotic device required by wear or by change in 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 such as dental splints for the 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 (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>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Wheelchairs - limited to coverage of single standard manual wheelchair as deemed medically necessary and appropriate • Hospital beds • Traction equipment • Walkers • Crutches <p>Note: Call us at 702-242-7300 or 800-777-1840 as soon as your Plan physician prescribes this equipment.</p>	<p>Nothing</p>
<ul style="list-style-type: none"> • Insulin pumps 	<p>\$100 per device</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Motorized wheelchairs • Custom wheelchairs • More than one piece of equipment serving essentially the same function except for replacements as authorized by the Plan. Coverage for alternate or spare equipment is not provided. 	All charges
Home health services	High Option
<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 therapy. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative • Housekeeping or meal service 	All charges
Chiropractic	High Option
<ul style="list-style-type: none"> • Chiropractic services for manual manipulation of the spine (except for reductions of fractures or dislocations) 	\$10 per office visit
Alternative treatments	High Option
<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"> • Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry • Services that are specifically excluded from coverage under this Plan regardless of whether such services are provided under the clinical trial or study 	All charges

Alternative treatments - continued on next page
High Option Section 5(a)

Benefit Description	You pay
Alternative treatments (cont.)	High Option
<ul style="list-style-type: none"> • Services that are customarily provided by the sponsors of the clinical trial or study • Expenses related to participation in the clinical trial or study including, but not limited to travel, housing and other expenses • Expenses incurred by a person who accompanies a member during the clinical trial or study • 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 • Any cost for the management of research relating to the clinical trial or study 	All charges
Educational classes and programs	High Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation - Three-month program includes one individual counseling session and at least six group counseling sessions <p>Note: Maximum benefit of \$100 for one smoking cessation program per member per lifetime.</p> <p>Note: See Prescription drug benefits (<i>Section 5(f)</i>) for coverage of smoking cessation medication.</p>	\$5 orientation fee plus \$30 - \$55
<ul style="list-style-type: none"> • Diabetes self-management • Education - Three-part class 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 	\$10 per office visit with diabetes educator plus \$20 material fee
<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 	\$5 per 30-day therapeutic supply
<ul style="list-style-type: none"> • Insulin pump supplies 	\$10 per 30-day therapeutic supply
<ul style="list-style-type: none"> • Diabetes equipment, including: <ul style="list-style-type: none"> - blood glucose monitor - lancet device 	\$20 per unit (maximum one unit per year)

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	High Option
<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

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.
- 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.).
- **YOUR PHYSICIAN 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	High Option
<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>)) • 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>Outpatient: No charge, included in \$50 facility copayment</p> <p>Inpatient: No charge, included in \$50 admission copayment</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 	<p>50% of EME</p>

Surgical procedures - continued on next page
High Option Section 5(b)

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> - Individuals must be age 18 or over and have a psychological/psychiatric evaluation by a licensed practitioner, with a recommendation for gastric restrictive surgery - Covered services rendered in the treatment of complications in connection with gastric restrictive surgery - Contact the Plan at 702-242-7300 or 800-777-1840 for additional eligibility criteria <p>Note: See <i>Services requiring our prior approval</i> on page 11.</p>	50% of EME
<ul style="list-style-type: none"> • Surgical Assistant Services 	Nothing
<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 (see Foot care (Section 5 (a)))</i> 	<i>All charges</i>
Reconstructive surgery	High Option
<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>Outpatient: No charge, included in \$50 facility copayment</p> <p>Inpatient: No charge, included in \$50 admission copayment</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 <i>Section 5(a)</i>) <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>	Outpatient: No charge, included in \$50 admission copayment
<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> 	<i>All charges</i>

Benefit Description	You pay
Oral and maxillofacial surgery	High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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>Outpatient: No charge, included in \$50 facility copayment</p> <p>Inpatient: No charge, included in \$50 admission copayment</p>
<ul style="list-style-type: none"> • Treatment of temporomandibular joint (TMJ) pain dysfunction syndrome 	50% of EME
<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>All charges</i>
Organ/tissue transplants	High Option
<p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single or double lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	Inpatient: No charge, included in \$50 admission copayment
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. (The medical necessity limitation is considered satisfied if the patient meets the staging description.)</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia 	Inpatient: No charge, included in \$50 admission copayment

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplant for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>Inpatient: No charge, included in \$50 admission copayment</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency disease (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Kostmann's syndrome - Myeloproliferative disorders 	<p>Inpatient: No charge, included in \$50 admission copayment</p>
<ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Amyloidosis (limited to primary Amyloidosis) - Multiple myeloma - Breast cancer - Epithelial ovarian cancer <p>Limited Benefits - Treatment for multiple myeloma, breast cancer, and epithelial ovarian cancer covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Inpatient: No charge, included in \$50 admission copayment</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>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
Anesthesia	High Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Physician office 	<p>Nothing</p>

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

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.
- 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 FOR ELECTIVE HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	High Option
<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> <p>Other hospital services and supplies, such as:</p> <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 and its administration • Blood or blood plasma, if not donated or replaced • Intravenous injections and solutions • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	\$50 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>

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	High Option
<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	High Option
<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>	\$50 per admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<i>All charges</i>
Hospice care	High Option
<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 <p>Note: Inpatient respite services benefit is limited to \$1,500 per member per calendar year.</p>	\$50 per admission
<ul style="list-style-type: none"> • Outpatient hospice 	Nothing
<ul style="list-style-type: none"> • Outpatient respite services <p>Note: Outpatient respite services benefit is limited to \$1,000 per member per calendar year.</p>	\$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. Treatment must be completed within six months of the date of death.</p>	\$20 per visit

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing</i> • <i>Homemaker services</i> 	<i>All charges</i>
Ambulance	High Option
<ul style="list-style-type: none"> • Covered services include ground ambulance transportation to the nearest appropriate facility 	\$50 per trip
<ul style="list-style-type: none"> • Emergency air ambulance 	50% of EME
<ul style="list-style-type: none"> • Non-emergency (ground or air) transport <p>Note: Non-emergency transport requires prior authorization.</p>	Nothing
<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 re not medically necessary.</p> <p>Note: Non-emergency medically necessary benefits are payable only upon prior authorization from the Plan.</p>	

Section 5(d). Emergency services/accidents

	<p>Important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> • 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. • Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. 	
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What is a medical emergency?

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

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.

Benefit Description	You pay
Emergency within our service area	High Option
<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 	\$25 physician services copayment plus \$50 facility copayment plus amount exceeding EME The facility copayment is waived if admitted
Emergency outside our service area	High Option
<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 	\$50 physician services copayment plus \$75 facility copayment plus amount exceeding EME The facility copayment is waived if admitted
<i>Not covered:</i> <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	High Option
<ul style="list-style-type: none"> Covered services include ambulance services to the nearest appropriate hospital Note: See <i>Section 5(c)</i> for non-emergency ambulance services.	\$50 per trip
<ul style="list-style-type: none"> Emergency air ambulance 	50% of EME
<ul style="list-style-type: none"> Non-emergency (ground or air) transport Note: Non-emergency transport requires prior authorization.	Nothing
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(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.

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.
- 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 FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	High Option
<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 • Facility-based intensive outpatient treatment 	<p>\$50 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> • <i>Treatment in a half-way house, residential treatment or full-day hospitalization</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>

Prior authorization	To be eligible to receive these benefits you must obtain a treatment plan and follow the network authorization process. Mental Health and Substance Abuse services are provided by Behavioral Healthcare Options through the Harmony Health Network. Services can be accessed directly by calling Harmony Healthcare at (702) 251-8000 or (800) 363-4874.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 38.
- 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.
- 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 702-242-7300 or 800-777-1840, or visit our web site at www.hpnfederalbenefits.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.

- **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 242-7300 or 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, 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.

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>High Option</p> <p>\$5 per therapeutic supply for preferred generic prescriptions</p> <p>\$35 per therapeutic supply for preferred brand-name prescriptions</p> <p>\$55 per therapeutic supply for non-formulary generic and brand-name prescriptions</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>\$55</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> 	<p><i>All charges</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	High Option
<ul style="list-style-type: none"> • <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> 	<i>All charges</i>

Section 5(g). Dental benefits

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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- 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.

Benefit Description	You Pay
Accidental injury benefit	High Option
<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(h). Special features

Feature	Description
Feature	High Option
<p>Flexible benefits option</p>	<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 claim process.
<p>Telephone Advice Nurse Service</p>	<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 702-242-7330 or 800-288-2264.</p>
<p>Services for deaf and hearing impaired</p>	<p>We have a TTY/TDD number for use by hearing-impaired members. The TTY/TDD number is 702-242-9214 or 800-349-3538.</p>
<p>Preventive Health Disease Management</p>	<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. For information and registration, call 702-877-5356 or 800-720-7253.</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>
<p>HPN@YourService</p>	<p>Our 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

Feature - continued on next page

Feature	Description
Feature (cont.)	High Option
	Simply visit us at www.hpnfederalbenefits.com . First time visitors will need to register for a user ID and password.

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. These programs and materials are the responsibility of the Plan and all appeals must follow their guidelines. For additional information contact the Plan at 702-242-7300 or 800-777-1840 or visit their website at www.healthplanofnevada.com.

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 702-242-7300 or 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 2008, 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, and private fee-for-service products. 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 less than Original Medicare. Senior Dimensions, Sierra Spectrum and Sierra Nevada Spectrum all offer Medicare Part D prescription drug coverage as part of their comprehensive health care 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). SHL 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 2008. Since so much choice can be confusing, we suggest you contact 702-821-2300 or 800-274-6648 (TTY/TDD 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. There may be other exclusions and limitations listed in Section 5 of this brochure. **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 11** (except for transplants, specifics regarding transplants are on pages 27-29).

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 (see specifics on pages 22-23);
- 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 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 702-242-7300 or 800-777-1840.

When you must file a claim – such as for services you received 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 702-242-7300 or 800-777-1840. We will assist you in completing a Direct Member Reimbursement form and help you process your claim.

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for 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 required by Section 3.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: P.O. Box 15645, Las Vegas, NV 89114-5645; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

 - 90 days after the date of our letter upholding our initial decision; or
 - 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
 - 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

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 precertification 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 702-242-7300 or 800-777-1840 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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; and
- 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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 private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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 will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 702-242-7300 or 800-777-1840. You may also contact us by fax at 702-242-9350 or see our Web site at www.hpnfederalbenefits.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... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• 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 • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• 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 • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• 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 TRICARE or CHAMPVA.

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 a 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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
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 service	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 information 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 Benefits*, 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 family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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 2008 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 2007 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.

Any person covered under the 31 day extension of coverage who is confined to a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce** 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. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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 Benefits 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. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account 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.

Third, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). 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.

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. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** - Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** - Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** - Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependants unable to care for themselves that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements and preferred provider listings.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dental/vision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

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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 High Option of the Health Plan of Nevada - 2008

- **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.

High Option Benefits	You pay	You pay
Medical services provided by physicians:		
<ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	Office visit copay: \$10 primary care; \$10 specialist	15
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient 	\$50 per admission	30
<ul style="list-style-type: none"> • Outpatient 	\$50 per visit	31
Emergency benefits:		
<ul style="list-style-type: none"> • In-area 	\$20 plus amount exceeding EME in an urgent care facility \$25/physician services plus \$50/facility plus amount exceeding EME in a hospital emergency room	34
<ul style="list-style-type: none"> • Out-of-area 	\$40 plus amount exceeding EME in an urgent care facility \$50/physician services plus \$75/facility plus amount exceeding EME in a hospital emergency room	34
Mental health and substance abuse treatment:		
	Regular cost sharing	35
Prescription drugs:		
	\$5 generic preferred \$35 brand preferred \$55 non-preferred	38
Dental care:		
	No benefit	40
Vision care:		
	\$10 per visit for one refraction annually and 50% of costs associated with vision supplies	20
Special features: Flexible benefits option, Telephone Advice Nurse Service, Services for the deaf and hearing impaired, Preventive Health/Disease Management, HPN@YourService		
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Protection against catastrophic costs (out-of-pocket maximum):		
	Nothing after \$3,000/Self Only or \$6,000/Family enrollment per year Some costs do not count toward this protection	12

2008 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 *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees, RI 70-2*, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, Option 5

TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, potential retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share

Las Vegas metropolitan area and surrounding communities

High Option Self Only	NM1	\$84.02	\$28.00	\$182.03	\$60.68	\$14.00	\$12.60
High Option Self and Family	NM2	\$215.13	\$71.71	\$466.12	\$155.37	\$35.85	\$32.27

Reno/Sparks metropolitan area

High Option Self Only	2L1	\$119.25	\$39.75	\$258.38	\$86.12	\$19.87	\$17.89
High Option Self and Family	2L2	\$305.30	\$101.77	\$661.49	\$220.50	\$50.88	\$45.80