

<DATE: no later than December 1, 2003>

<CASE NAME>

<ADDRESS>

<CITY> <STATE> <ZIP>

AGENDA VII (DUARTE)**Nevada Medicaid Open Enrollment**

Welcome to the Nevada Medicaid Managed Care Program. During this open enrollment period you have the right to choose a health maintenance organization (HMO) for you and your family. The HMO you choose will help you get the care you need when you are sick or if you have a special medical problem.

What is an HMO?

An HMO is an organization responsible for providing health care to its enrolled members. An HMO offers health care coverage through a group of doctors, specialists, hospitals, and pharmacies that work together to provide health care to its enrolled members. You have a choice of HMOs. We have included a comparison chart with this letter which will provide you with basic information as you start to consider which HMO is best for you and your family.

IF YOU ARE CURRENTLY ENROLLED IN AN HMO AND DO NOT WISH TO CHANGE YOUR HEALTH PLAN, DISREGARD THIS NOTICE. IF YOU ARE NOT ENROLLED IN AN HMO OR IF YOU WANT TO CHANGE YOUR CURRENT HEALTH PLAN, YOUR CHOICES OF HMOs ARE:

Health Plan of Nevada-Northern Choice Participant Services: 1-800-962-8074	Nevada Health Solutions – NevadaCare, Inc. Participant Services: 1-800-447-9834
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Next Steps:

Within the next few days you should receive information packets from both of the health plans noted above. These packets will provide you with detailed information about each of the health plan's benefits. Please review these packets carefully so that you are able to make the best choice for you and your family. If you do not receive these packets, please call the health plans and request the information be sent to you.

When you have made your choice of health plans, you must complete the information below and return the bottom portion of this letter in the enclosed self addressed, stamped envelope **NO LATER THAN JANUARY 23, 2004**. If you do not return your choice decision by January 23, 2004, you will be automatically assigned to one of the two health plans noted above. If you are currently enrolled in an HMO and do not make a choice decision, you will remain enrolled with your current health plan. **Your HMO choice will become effective FEBRUARY 1, 2004.**

Please complete and return the bottom portion of this letter. Keep the top portion for your records. If you have any questions, please call the HMO Participant Services Departments at the telephone numbers provided above.

**Nevada Medicaid Managed Care Program**

After you have received the detailed information from the health plans and have reviewed the information, you will need to make a choice about which health plan is best for you and your family. Please indicate the health plan you have chosen by checking the appropriate box below.

☐ **Health Plan of Nevada Northern Choice**
☐ **Nevada Health Solutions – NevadaCare, Inc.**

Print full name (Case Name)

Authorized Signature

Social Security Number

Medicaid Billing Number

Date

EXHIBIT K Committee Name **HealthCare** Document consists of **1 Page**
☒ Entire document provided.

☐ Due to size limitations, pages _____ provided. A copy of the complete document is available through the Research Library (775/684-6827) or e-mail library@lcb.state.nv.us. Meeting Date: **1-21-04**