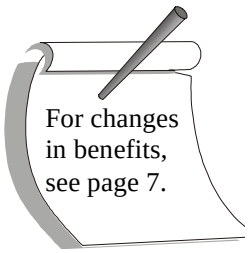
Altius Health Plans 2001

www.altiushealthplans.com

A Health Maintenance Organization



Serving: *Parts of Utah along the Wasatch Front*

Enrollment in this Plan is limited; see page 6 for requirements.

HORIZON BEHAVIORAL SERVICES

Enrollment codes for this Plan:

9K1 Self Only

9K2 Self and Family

Authorized for distribution by the:

OPM
United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-564

Table of Contents

Introduction

Altius Health Plans
10421 South Jordan Gateway, Suite 400
South Jordan, Utah 84095

This brochure describes the benefits of Altius Health Plans under our contract (CS2839) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Altius Health Plans.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

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.

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 only pay the copayments, and coinsurance, as 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. We compensate contracted providers by either discount fee-for-service fee schedules or capitation agreements.

Altius Health Plans is a Mixed Model Plan (MMP). This means the doctors provide care in contracted medical centers or in their own offices. Approximately 950 Primary Care Physicians and 2,050 specialists participate in this Plan.

All members must select a Primary Care Physician, or PCP, from the Plan's Participating Provider Directory. Your PCP should practice one of the following disciplines: General Practice, Family Medicine, Internal Medicine, Obstetrics/Gynecology (OB/GYN), or Pediatrics. Choosing a PCP is very important to Plan members because the PCP provides the coordination of all medical care, including referrals and authorizations for surgery, visits to specialists, hospitalization, durable medical equipment and other services. Each of your family members may choose a different Primary Care Physician. You can find locations and telephone numbers of Plan providers in the Altius Provider Directory, or call our Customer Service Department at 801-323-6200 or 1-800-377-4161. You may also visit our website at www.altiushealthplans.com to see the most current listing of Plan providers.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (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.

- Altius Health Plans is a State of Utah licensed and Federally Qualified Health Maintenance Organization.
- Altius Health Plans (formerly PacifiCare of Utah) has been in existence for over 24 years.
- Altius Health Plans is a private for-profit corporation.

If you want more information about us, call 801-323-6200 or 1-800-377-4161, or write to Altius Health Plans, Attn: Customer Service department, 10421 South Jordan Gateway, Suite 400, South Jordan, UT 84095. You may also contact us by fax at 801-933-3639 or visit our website at www.altiushealthplans.com.

Section 1. Facts about this HMO plan (continued)

Service Area

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

The counties of Box Elder, Davis, Morgan, Salt Lake, Summit, Tooele, Utah, Wasatch, Weber and portions of the following counties as defined by zip codes:

Jaub - 84628, 84639, 84640, 84645, 84648

Sanpete - 84629, 84632

You must get you care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgently needed care. We will not pay for any other health care service.

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 for information.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to coinsurance and copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed different day and visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 1-800-377-4161 or 801-323-6200, **or** checking our website www.altiushealthplans.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 19.5% for Self Only or 16.7% for Self and Family.
- Inpatient Hospital/Room and Board, (including Maternity Care). You pay nothing.
- Inpatient Hospital/Physician, Surgeon and Anesthesia (including Maternity Care). You pay 10%.
- Major Diagnostic Lab/X-ray services provided in an outpatient setting. You pay 10%.
- Inpatient Mental Health and Substance Abuse Care/Room and Board. You pay nothing .
- Inpatient Mental Health and Substance Abuse Care/Physicians, Psychologists, Psychiatrists. You pay 10%.
- Outpatient Mental Health and Substance Abuse Care. You pay a $10 copay each office visit.
- A separate Out-Of-Pocket Maximum for Mental Health and Substance Abuse Care is included in the plan: one family member for $2,000 and $4,000 for two or more family members.
- Prescription Drug Mail Service - 90 Day Supply. You pay a $20 copay for generic/formulary medications, a $30 copay for preferred/name brand medications, and a $60 copay for non-formulary medications.

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 Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-377-4161 or 801-323-6200.

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 website. If you have questions about plan providers, call us at 1-800-377-4161 or 801-323-6200 or visit our website at www.altiushealthplans.com.

- **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 website. If you have questions about plan providers, call us at 1-800-377-4161 or 801-323-6200 or visit our website at www.altiushealthplans.com.

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. If you have been seeing a primary care physician or you need to choose a primary care physician, make sure he/she is listed in the provider directory. If you need help choosing a primary care physician, call us at 1-800-377-4161 or 801-323-6200.

- **Primary care**

Your primary care physician can be a Family Practitioner, Internist, Pediatrician or an OB/GYN. Some OB/GYN's do not provide primary care, so you need to ask that provider if he/she is willing to provide primary care services. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one. When you change your primary care physician, the change will be effective the first of the month following the date of the change.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, female members may self-refer to an Altius contract OB/GYN Physician for one outpatient examination per year.

Here are 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 physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician 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 physician. Your primary care physician 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 physician, 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 or 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 Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us at 1-800-377-4161 or 801-323-6200 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 physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-377-4161 or 801-323-6200.

If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

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

We call this review and approval process Prior Authorization. Your primary care physician must obtain prior authorization for the following services:

- Abortion Services
- All Out-of-Network Services (applicable to all Altius HMO plans)
- Behavioral Health Services (inpatient and outpatient) – including neuro-psychological testing and treatment, alcohol and substance abuse treatments
- Cardiac-Pulmonary Rehabilitation (outpatient)
- Durable Medical Equipment
- Genetic Counseling – evaluation and treatment
- Health Education Services
- Home Health Care
- Infertility evaluations and treatment
- Injectable Medications (excluding Imitrex, insulin, glucagon kits and bee sting kits)
- Inpatient Facility Admissions (including maternity)
- Inpatient Rehabilitation Admissions
- Osteopathic Manipulative Treatment
- Outpatient Surgeries
- Outpatient Therapy – occupational, physical and speech therapy services
- Pain Management Services – evaluation and treatment
- PET and SPECT Scans
- Photodynamic Therapy of the Retina
- Plastic Surgery and related procedures (cosmetic procedures are not covered)
- Radiation Oncology Services
- Skilled Nursing Facility Admissions
- Transportation (non-urgent)

If you are under the care of a specialist for treatment that requires prior authorization and you change your primary care physician, your new primary care physician must approve the care and treatment of the specialist.

Your primary care or specialty care physician must request prior authorization for you by calling or faxing us directly. We will authorize or deny services as soon as possible, but within 24 hours for emergent services and within two to five business days for routine

services. If we deny the request for prior authorization, we will notify your provider by telephone. We will also send a letter to you and to your provider with an explanation of the denial.

Emergent hospital admissions do not require prior authorization, but we must be notified as soon as reasonably possible. If you, a friend, or family member does not let us know, it could result in no coverage for all services received after your condition is stabilized.

Section 4. Your costs for covered services

You must share the cost of some services.

You are responsible for:

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **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 our allowance for infertility services and durable medical equipment.

Your out-of-pocket maximum

After your copayments and/or coinsurance total $2,000 per person or $4,000 per family enrollment in any calendar year, you do not have to pay any more for covered services for the remainder of the calendar year. However, copayments and/or coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Durable Medical Equipment (DME)
- Prescription Drugs
- Dental Services
- Non-Covered Services

Under you plan you have a separate out-of-pocket maximum for Mental Health and Substance Abuse Services. After your copayments and/or coinsurance reach $2,000 per person or $4,000 per family during a calendar year, you do not have to pay any more for covered mental health services.

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 55 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-801-323-6200 or 1-800-377-4161 or at our website at www.altiushealthplans.com

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In a primary care physician's office • In a specialist's office • Second surgical opinion • In an urgent care center	$10 per office visit
Lab, X-ray and other diagnostic tests	
Minor diagnostic tests, such as: • Blood tests • Urinalysis • Non-routine and Routine pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EEG	$10 per office visit (waived if performed in conjunction with an office visit)
Major diagnostic labs and x-rays, such as, • Cat Scans and MRI's • PET and SPECT Scans • Angiography	10% of Plan Allowance

Preventive care, adult	You pay
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test ••Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above. • Routine mammogram –covered for women age 35 and older, as follows: •• From age 35 through 39, one during this five year period •• From age 40 through 64, one every calendar year •• At age 65 and older, one every two consecutive calendar years	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Not covered: Immunizations exclusively for travel	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: ◦ 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 (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit
Not covered: Immunizations exclusively for travel.	*All charges*

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Hospital care requires prior authorization • Prenatal care, postnatal care and delivery (physician, surgeon and anesthesia)	10% of Plan Allowance
• Delivery (room and board)	Nothing
• Obstetrical care in an observation setting	$10 per office visit
Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	
Not covered: • *Routine sonograms to determine fetal age, size or sex.* • *Home delivery*	*All charges*
Family planning	
• Voluntary sterilization (in a physician's office) • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Predictive genetic testing and/or counseling* • *Elective abortions, except when the life of the mother would be endangered if the fetus were carried to term, in cases where the pregnancy is the result of rape or incest, or to prevent the birth of a child that would be born with grave defects.*	*All charges*

Infertility services	You pay

Diagnosis and treatment of infertility, such as:
• Artificial insemination:
  • Intravaginal insemination (IVI)
  • Intracervical insemination (ICI)
  • Intrauterine insemination (IUI)
	50% of Plan Allowance

Not covered:
• *Assisted reproductive technology (ART) procedures, such as:*
  •• *invitro fertilization*
  •• *embryo transfer and GIFT*
• *Services and supplies related to excluded ART procedures*
• *Cost of donor sperm*
• *Fertility Medications, other than Clomiphene*
	All charges

Allergy care	
Testing and treatment	$10 per office visit
Allergy serum Allergy Injections	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy Injectable Medications such as Growth hormone therapy (GHT) when obtained in a physician's office.	$10 per office visit
Not covered: Injectables for treatment of infertility	*All charges*

Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy – • 60 visits per condition for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. • Outpatient Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility for up to 12 weeks for Phase II and Phase III combined.	$10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children and adults	$10 per office visit
Not covered: • *hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• 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 Plan Allowance
• Eye exam to determine the need for vision correction • Annual eye refractions	$10 per office visit
Not covered: • *Eyeglasses or contact lenses for refractive purposes* • *Eye exercises and orthoptics* • *Routine eye exams performed by an Ophthalmologist* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit

Foot care continued on next page

Foot care *(Continued)*	**You pay**
Not covered: • *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)* • *Foot orthotics*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	50% of Plan Allowance
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. See Sections 5(b) and 5(c) for coverage of the surgery to insert the device.	Nothing
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices unless medically necessary* • *Replacement of prosthetic devices and corrective appliances unless it is needed because of a change in the member's condition,* • *Replacement due to malicious damage, neglect or wrongful disposition*	*All charges*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds • wheelchairs • crutches • walkers • blood glucose monitors • insulin pumps	50% of Plan Allowance

Durable medical equipment (DME) continued on next page

Durable medical equipment (DME) *(Continued)*	**You pay**
• Medically necessary accessories and supplies such as hoses, tubes, oxygen and ostomy supplies. Note: Call us at 1-800-377-4161 or 801-323-6200 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing
Not covered: • *Durable medical equipment, corrective appliances, prostheses and artificial aids, including supplies and accessories, are excluded when primarily used for convenience, comfort, or in the absence of an illness or injury. Routine periodic servicing, such as cleaning and regulating is not covered.* • *Replacement of prosthetic devices and corrective appliances unless it is needed because of a change in the member's condition,* • *Replacement due to malicious damage, neglect or wrongful disposition*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications • Home visits made by a physician	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*	*All charges*
Alternative treatments	
No Benefit	
Educational classes and programs	
Coverage is limited to: • Diabetes self-management • Asthma Management	$10 per office visit
Not covered: Health education services that are not related to the care and treatment of an illness or injury.	*All charges*

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Removal of tumors and cysts • Normal pre-operative care by the surgeon • Endoscopy procedure • Biopsy procedure • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) • Correction of congenital anomalies (see reconstructive surgery) • Treatment of burns • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic braces and prosthetic devices for device coverage information • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. 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.	$10 per office visit Nothing in an outpatient hospital or surgical center 10% of Plan Allowance in an inpatient hospital or other facility

Surgical procedures continued on next page

Surgical procedures *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*
Reconstructive surgery	

• Surgery to correct a functional defect
• Surgery to correct a condition caused by injury or illness if:
  • 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: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.
• All stages of breast reconstruction surgery following a mastectomy, such as:
  • Surgery to produce a symmetrical appearance on the other breast;
  • Treatment of any physical complications;
  • breast prostheses, lymphedema pumps, surgical bras and replacements (See Prosthetic devices)
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.
	$10 per office visit in a physician's office
	Nothing in an outpatient hospital or surgical center
	10% of Plan Allowance in an inpatient hospital or other facility

Not covered: • *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* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing in an outpatient hospital or surgical center 10% of Plan Allowance in an inpatient hospital or other facility
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogenic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • National Transplant Program (NTP) - We provide over 48 contracted Centers of Excellence throughout the United States, when determined medically necessary and prior authorized by the plan. Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing in an outpatient hospital or surgical center 10% of Plan Allowance in an inpatient hospital or other facility
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Travel expenses, lodging, and meals*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	10% of Plan Allowance
Professional services provided in – • Hospital outpatient department • Ambulatory surgical center • Skilled Nursing Facility	Nothing
Professional services provided in – • Office	$10 per office visit

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

IMPORTANT

Here are some important things to remember about these benefits:

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

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations • general nursing care • meals and special diets NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing

Inpatient hospital continued on next page

Inpatient hospital *(Continued)*	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, long-term care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesiologist services 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.	Nothing
Not covered: • *Blood and blood derivatives not replaced by the member* • *Personal comfort items*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF)/Extended care benefits: 30 days per member per calendar year • Professional services – physicians and general nursing care • Medical supplies and medications • Medical equipment ordinarily provided by a skilled nursing facility • Room and board	Nothing
Not covered: custodial care, personal, comfort or convenience items	*All charges*
Hospice care	
• Services for pain and symptom management • Short-term inpatient care and procedures necessary for pain control • Respite care may be provided only on an occasional basis and may not be provided longer than five days • Home visits made by a physician, nurse, home health aide, social worker or therapist with no limit on number of visits • General medical equipment and supplies related to the terminal illness	Nothing

Hospice care continued on next page

Hospice care *(Continued)*	**You pay**
Not covered: • *Independent nursing* • *Homemaker services* • *Specialized, customized equipment*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	$50 copayment per incident
Not covered: Medical transportation for the convenience of the member or family	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible
- Be sure to read Section 4, Your Costs, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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 have a life-threatening or serious condition, immediately call 911 or other emergency services, or go to the nearest medical facility. It is important to call your Primary Care Provider (PCP) in an emergency so that he or she can be involved in your care. Please contact your PCP as soon as reasonably possible. We will cover emergency care provided by non-plan providers as long as the condition continues to be an emergency. Once your condition is stable, your PCP will work together with us to transfer you to a plan facility.

  If your life is not in danger and you have a condition that is not serious but still requires prompt medical attention, contact your PCP and follow his or her instructions. If you are not able to contact your PCP, you may go to any Plan urgent care facility. Please refer to your Altius Participating Provider Listing. After you receive urgent care, contact your PCP as soon as you can. Your PCP will coordinate any follow-up care you need.

- **Emergencies outside our service area:**

  If you have an emergency while outside of the service, please seek the appropriate medical treatment. You may be asked to pay the bill at the time of service. Keep your receipts so we can reimburse you for those costs. We will cover emergency care provided by non-plan providers as long as the condition continues to be an emergency. Once your condition is stable, your PCP will work with us to transfer you to a plan facility. Please contact us as soon as reasonably possible at 1-800-377-4161 or 801-323-6200.

Emergency service/accidents benefits – Continued on next page

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 copayment per office visit
• Emergency care as an outpatient at a hospital, including doctors' services (copayment is waived if you are admitted to the hospital)	$50 copayment per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 copayment per office visit
• Emergency care as an outpatient at a hospital, including doctors' services (copayment is waived if you are admitted to the hospital)	$100 copayment per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ground ambulance, air ambulance, and/or paramedic services when medically appropriate. See 5(c) for non-emergency service.	$50 copayment per incident
Not covered: • *Medical transportation for the convenience of you or your family* • *Death-related transportation*	*All charges*

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
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. 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.	Your cost sharing responsibilities are no greater than for any other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers on an outpatient basis. • Medication management	$10 per office visit
• Diagnostic tests • Intensive outpatient treatment	$10 per office visit
• Services provided by a hospital or other facility on an inpatient basis (room and board), including partial hospitalization.	Nothing
• Professional services by providers such as psychiatrists, psychologists, or clinical social workers provided on an inpatient basis	10% of Plan Allowance

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You Pay**
Not covered: Services we have not approved. *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.*	*All charges*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

You must contact Horizon Behavioral Services at 1-800-701-8663 for prior authorization of all inpatient and outpatient mental health/substance abuse services, information about contracted mental health providers and/or immediate access to care. You may call 24 hours a day, seven days a week.

Mental Health and Substance Abuse Out-Of-Pocket Maximums

After your copayments and/or coinsurance total $2,000 per person or $4,000 per family in any calendar year, you do not have to pay any more for covered mental health services for the remainder of the calendar year.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply. For information regarding this benefit contact Horizon Behavioral Services at 1-800-701-8663.

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** 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 for a maintenance medication.

  •• At a pharmacy: To get your prescription filled, present your Altius membership card to any Plan pharmacy. You will pay the prescription drug copayment listed on your Altius membership card or on page 32 of this booklet. If you need prescription medications while outside of the service area, contact Express Scripts, Inc (ESI) for the nearest Plan pharmacy, or you may pay for your prescription and ESI will reimburse you according to your benefits. To find out about Plan pharmacies, or get reimbursement for a covered drug, contact: Express Scripts, Inc, Customer Service Department at 1-800-698-0149.

  ••By mail: 1) Get a prescription for your maintenance medication with the maximum refills allowed from your Plan provider (see "Prescription Mail Services" below for a definition of a maintenance medication). 2) Contact ESI's Customer Service Department at 1-800-698-0149 to get an order form. 3) Mail your prescription with the completed order form to Express Scripts, Inc. Prescriptions are mailed within fourteen days, directly to your house or office in a labeled envelope to ensure privacy and safety. ESI has a pharmacist available to you 24 hours a day to answer your questions.

- **We use a formulary**. A team of physicians, health care professionals and pharmacists have developed the preferred prescription drug list. It allows you to receive the most effective medications, while ensuring positive health outcomes at an affordable cost. The preferred prescription drug list is subject to review and modification on a quarterly basis.
- **These are the dispensing limitations.**

  ••Your pharmacist will fill a maximum 30-day supply of medications prescribed by a plan provider, unless otherwise stated by us, State law, Federal law, or as determined by the manufacturer's package.

  ••Prescription Mail Services**:** You can get a 90-day supply of maintenance medications through the mail service. A maintenance medication is a prescription that is recommended by the Food & Drug Administration (FDA) or us to be taken on a daily basis. Examples include, but are not limited to, medication for blood pressure, asthma, antidepressants, diabetes, hormone replacement and birth control. Examples of non-maintenance medications include, but are not limited to: antihistamines, antibiotics, pain management, muscle relaxants, anti-migraine, medications for sleep or anxiety, acne preparations, creams and ointments.

- **When you have to file a claim**. If you are outside of the service care and need a prescription, contact Express Scripts for Plan pharmacies outside of the service area. If one is not available, then Express Scripts will reimburse you. Keep your receipts and mail them along with a reimbursement form. Call Express Scripts at 1-800-698-0149 for the reimbursement form and instructions.

Benefit Description	You Pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purpose, except as excluded below. • Contraceptive drugs and devices • Insulin, insulin syringes, needles, glucose test strips and lancets • Injectable medications obtained through a plan pharmacy need prior authorization. For authorization, physicians must fax the request to us. Each request will be answered by a return fax. • Clomiphene for infertility • Disposable needles and syringes needed for injecting covered prescribed medication	**Generic:** $10 copayment $20 for mail order **Preferred name brand** $15 copayment $30 for mail order **Non-formulary** $30 copayment $60 for mail order Note: If there is no generic equivalent available, you will still have to pay the name brand copay.
Drugs to treat sexual dysfunction, limited to 6 pills per month (see Prior Authorization below).	50% of Plan Allowance
Here are some things to keep in mind about our prescription drug program: • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a Preferred Drug List, call our Customer Service Department at 1-800-377-4161 or 801-323-6200.	

Covered medications and supplies continued on next page

Covered medications and supplies *(Continued)*	**You pay**
Prior Authorization Requirements Your plan provider must get prior authorization for the following medications: • Accutane • Celebrex • Clozaril • DDAVP • Differin • Diflucan • Helidac • Lamisil • Prepac • Prevacid • Prozac • Regranex • Retin-A • Sporanox • Tritec • Ultram • Wellbutrin SR • Vioxx • Drugs to treat sexual dysfunction when medically necessary. Note: For authorization, physicians must fax the request form to us. Each request will be answered by a return fax.	
Not covered: • *Drugs available without a prescription or for which there is no nonprescription equivalent* • *Drugs obtained at a non-Plan pharmacy, except for out-of-the-area emergencies* • *Medical supplies, such as dressing and antiseptics* • *Experimental medications* • *Fertility medications, other than Clomiphene* • *Hypodermic needles* • *Natural progesterone (including suppositories and creams)* • *Smoking cessation products and medications prescribed for smoking cessation* • *Skin patches for motion sickness* • *Medications or nutritional supplements for weight loss or weight gain for non-medical indications* • *Immunizations and medications required exclusively for foreign travel* • *Hair growth products* • *Medications for cosmetic indications* • *Insulin pens* • *Medications to enhance athletic performance*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Services for deaf, hard of hearing, and non-English speaking members	If you need interpreter services for an appointment with a Customer Service Representative, you must arrange for these services by calling 801-323-6200 or 1-800-377-4161. When interpreter services are needed in the provider's office, contact the provider's office directly.
High risk pregnancies	If you or your Plan provider feel that your pregnancy may be a difficult one, or that you may be at risk for complications, you or your PCP may ask us to assign you an ABC prenatal case manager. A prenatal care manager is a Registered Nurse with special training in maternity care. Your case manager will ask you questions about your medical history and then tell you what you can do to keep yourself and your baby healthy. Your case manager will also work with your provider to plan a course of treatment for you and will check with you from time to time to see how you are doing.
Centers of excellence for transplants/heart surgery/etc.	We provide over 48 contracted Centers of Excellence throughout the United States, when determined medically necessary and prior authorized by the plan.
Travel benefit/ services overseas	Services outside of our service area are limited to emergency and urgent care only. See Section 5(d) for Emergency services/accidents.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- 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; 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.

IMPORTANT

Accidental injury benefit	You pay
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.	$10 per office visit in a physician's office Nothing in an outpatient hospital or surgical center 10% of Plan Allowance in an inpatient hospital or other facility

Dental benefits

Service	You Pay
Preventive & diagnostic	Nothing
Initial examination, including full series x-rays	
Recall examinations, including bite wing x-rays	
Single films	
Prophylaxis and fluoride treatment (child)	
Prophylaxis (adult)	
Preventive education	
Emergency treatment	
Palliative during office hours	$14
After hours or as provided by the Altius dentist on call	$53
Emergency services required when a member is over 100 miles from home and a Plan dentist is not available.	All charges in excess of $50

Dental benefits continued on next page

Dental benefits *(Continued)*	**You Pay**
Restorative	
Routine fillings – Amalgam posterior or Composite anterior for permanent or primary teeth.	
For each filling:	
1 surface Amalgam	$13
Anterior composite	$19
2 surfaces Amalgam	$19
2 Anterior composite	$33
3 surfaces Amalgam	$25
Anterior composite	$51
4 surfaces Amalgam	$39
Stainless steel crown	$58
Periodontics	
Deep scaling, root planing and curettage per quadrant	$77
Periodontal consultation	$41
Gingevectomy per quadrant	$120
Muco-osseous surgery per quadrant	$270
Gingivectomy per tooth (to three teeth)	$20
Oral surgery	
Extractions (routine) 1st tooth	$32
Each additional tooth	$26
Impacted teeth – soft tissue	$59
Impacted teeth – partial bony	$88
Impacted teeth – full bony	$122
Endodontics	
Pulp cap	$18
Vital pulpotomy	$27
Root Canal, Single canal	$108
Two canals	$131
Three canals	$161
Crowns & Bridges	
Crown build up with pins	$30
Preformed post and build up	$51
Porcelain fused to metal crown per unit	$266
Porcelain fused to precious metal per unit	$336

Dental benefits continued on next page

Dental benefits *(Continued)*	**You Pay**
Removable dentures	
Complete denture (upper or lower)	$375
Partial denture – cast frame	$419
Teeth & clasp, extra per unit	$36
Stayplates	$150
Repairs, full or partial dentures, simple or involved teeth (each)	$34
Relines, per denture	$126
Preventive appliances	
Space maintainer – unilateral	$47
Lingual holding arch	$50
Habit-breaking appliance	$90

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 out-of-pocket maximums.

Value-Added Benefits:

Optical Discounts

Members can receive discounts from 10-30% on prescription and non-prescription eyewear and other products from participating Altius Optical providers. Participating providers can be found in the Altius Participating Provider Listing.

Lasik Vision Eye Surgery

Permanent solutions to vision problems are now available at a 10% discount to all Altius members through the Moran Eye Institute at the University of Utah. For more information, call the University of Utah physician referral line at 1-800-662-0052.

Vitamins, Minerals and Nutritional Supplements

Thanks to an exclusive agreement with Earth's Pharmacy, Altius members can now get quality vitamins and minerals at significantly discounted prices. The Earth's Pharmacy Physician Formula product line includes formulations for stress management, antioxidants, insomnia, energy, immunity and many others. For a complete catalogue and price list call 1-888-562-9891, or you can order from the web site at http://www.epphysicansformula.com. Orders are shipped on or before the following business day by priority mail.

Hearing Aids

If you're ready to hear what you've been missing, consider a high-quality hearing aid from Beltone. These state-of-the-art hearing aids are smaller and less noticeable than ever before and available at significant discounts for Altius members. For more information call Beltone at 1-800-BEL-TONE.

Smoking Cessation

The decision to quit smoking is one of the best – and also the toughest – decisions many people make. Yet thanks to recent advances in technology and programs, more people than ever are successfully breaking this deadly habit. Altius members have two ways to quit. Express Scripts/Value Rx offers an 18% discount on CQ Nicoderm patches. You can also participate in a personalized stop smoking program called "Committed Quitters". To receive an order form for patches and information on the personalized program, call the Altius Customer Service Department at 1-800-377-4161 or 801-323-6200.

Altius continually expands our value-added benefit program throughout the year. Visit our website at www.altiushealthplans.com**,** for details on the most up-to-date value-added programs.

Other Value-Added Discounts to look forward to in 2001:

- **Expanded list of providers who will offer discounts for Lasik Corrective Vision Eye Surgery**
- **Discounts on Cosmetic dental services- such as teeth whitening and veneers**
- **Discounts for Health Club Memberships**
- **Massage clinic discounts**
- **Discounts for Cosmetic Dermatology and Plastic Surgery services**
- **Monthly Web-based member specials**

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- 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;
- Procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest, or to prevent the birth of a child that would be born with grave defects;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

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 and/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. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 801-323-6200 or 1-800-377-4161.

When you must file a claim -- such as for out-of-area care -- 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 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:

Altius Health Plans
Claims Department
P.O. Box 95950
South Jordan, UT 84095-0950

Prescription drugs

Call Express Scripts, Inc. (ESI) Customer Service Department at 1-800-698-0149 to get forms and instructions for reimbursement.

Submit your claims to:

Express Scripts, Inc.
Attn: Claims
P.O. Box 52123
Phoenix, AZ 85072-2123

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within six months from the date of our decision; and (b) Send your request to us at: Altius Health Plans Appeals Department, 10421 South Jordan Gateway, Suite 400, South Jordan, UT 84095; 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: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436.

The Disputed Claims process *(Continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, 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 provide 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.

5 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.

6 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. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or prior authorization, then call us at 1-800-377-4161 or 801-323-6200 and we will expedite our review; or

(b) We denied your initial request for care or prior authorization/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 can call OPM's Health Benefits Contracts Division II at 202-606-3818 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 are covered or a family member is covered under another group health plan or have automobile insurance that pays care expenses without regard to fault. This is called "double coverage."

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. We will waive any copayments, coinsurance, and deductibles you have under this Plan.

•What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan provider, or prior authorized by us as required. When we pay as secondary, we will waive any copayments or coinsurance, you have under this Plan.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original 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 either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a re-employed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) 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,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee		✓

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

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

- 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 claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 801-323-6200 or 1-800-377-4161.

We waive some costs when you have Medicare -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, and we pay as secondary, we will waive any copayments, coinsurance, and deductibles you have under this Plan. However, if Medicare denies coverage for a service or supply, we will not waive your out-of-pocket costs for that service or supply.

•Medicare managed care plan

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

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary. You still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan provider, or prior authorized by us as required. When we pay as secondary, we will waive any copayments, coinsurance, and deductibles you have under this Plan. However, if the Medicare managed care plan denies coverage for a service or supply, we will not waive your out-of-pocket expenses for that service or supply.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan. 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 managed care plan service area.

• Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for members, eligible dependents of military persons, and retirees of the military. TRICARE includes the

CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

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 illnesses caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January1 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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services

Care we provide benefits for, as described in this brochure.

Elective Surgery

Surgery that can be scheduled for two or more days in advance without any anticipated detriment to the health of the patient.

Experimental or investigational services

Treatments, procedures, devices, or drugs that are experimental, investigational, unproven, not generally accepted, or part of research study.

Hospital

A facility that is licensed by the State of Utah as a general hospital or a specialty hospital.

Medical necessity

Services that are (1) appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition and (2) within recognized standards of medical practice and (3) not primarily for the convenience of a Member or his or her family, physician or other Non-Contracted Provider.

Member

Any Subscriber or Eligible Dependent who is enrolled for coverage.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. We determine our allowance as follows: The total dollar amount allowed by the Plan for Covered Services, including the amounts payable by the Plan and payable by the Member.

With respect to Participating Providers and Facilities, this amount is based on the applicable contractual payment schedule (fee schedule) negotiated with the Provider or facility.

Provider

Any person, organization, health facility or institution licensed by the State of Utah to deliver or furnish health care services.

Skilled nursing facility

A qualified, licensed facility designated by us that has the staff and equipment to provide skilled nursing care as well as other related health services.

Urgent medical problems

Those problems resulting from an unforeseen illness or injury that do not place life in jeopardy, but require prompt treatment.

Us/We	Us and we refer to Altius Health Plans.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- 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 health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1, 2001. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1, 2001. Annuitants' premiums begin on January 1, 2001.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

•When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

•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.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, *the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

•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

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-377-4161 or 801-323-6200 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202-418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for a person who is not an eligible family member, or are no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

NOTES:

Summary of benefits for Altius Health Plans - 2001

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	14
• Physician, surgeon, anesthesiologist and anesthesiology for Outpatient Surgery……...	Nothing	25
• Physician, surgeon, anesthesiologist and anesthesiology for Inpatient Hospitalization…….	10%	21-23
Services provided by a hospital:		
• Inpatient (room and board)……	Nothing	24-26
• Outpatient Surgery.....	Nothing	
Emergency benefits:		
• In-area.....	$50	28
• Out-of-area	$100	28
Mental health and substance abuse treatment.....	Regular cost sharing	29-30
Prescription drugs	**Prescription Drugs/30-day supply** - $10 copay generic/formulary, $15 copay brand/formulary, $30 copay non-formulary **Prescription Mail Order/90-day supply - $**20 copay generic, $30 copay brand name, $60 copay non-formulary	31-33
Dental Care	See schedule of Dental Benefits	35-37
Vision Care	Members can receive discounts on prescription and non-prescription eyewear and other products from participating Altius optical providers	15, 18, 38
Special Features: Services for deaf, hard of hearing, and non-English speaking, High risk Pregnancies, Centers of excellence for transplants/heart surgery/etc,Travel benefit/services overseas		34
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $2,000/Self Only or $4,000/Family enrollment per year Some costs do not count toward this protection	12

2001 Rate Information for
ALTIUS HEALTH PLANS

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Wasatch Front employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Wasatch Front							
Self Only	9K1	$86.59	$45.58	$187.61	$98.76	$102.22	$29.95
Self and Family	9K2	$195.82	$94.96	$424.28	$205.74	$231.17	$59.61