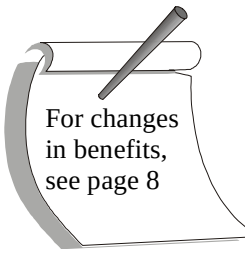
Altius Health Plans

2002

www.altiushealthplans.com

A Health Maintenance Organization



Serving: *Parts of Utah along the Wasatch Front and St. George*

Enrollment in this Plan is limited; see page 7 for requirements.

Enrollment codes for this Plan:

9K1 Self Only

9K2 Self and Family

Authorized for distribution by the:

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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means *Altius Health Plans.*
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

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 or write

THE HEALTH CARE FRAUD HOTLINE
202-418-3300
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 someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

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.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB 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.

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, Cache, Carbon, Davis, Morgan, Salt Lake, Summit, Tooele, Unita, Utah, Wasatch, Washington, Weber and portions of the following counties as defined by zip codes:

Jaub - 84628, 84639, 84640, 84645, 84648

Sanpete - 84629, 84632

Ordinarily, 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 care benefits. We will not pay for any other health care services out of our service area unless the services have received prior plan approval.

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

Section 2. How we change for 2002

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

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- We now cover routine screening for chlamydial infection. (Section 5(a))
- We clarified the brochure to show why we think you should use generic drugs whenever possible. We moved other language around within the Prescription drugs section but didn't change its meaning. (Section 5(f)
- We clarified the Medicare Primary Payer Chart to explain how we coordinated benefits for former spouses. (Section 9)
- We clarified other language about coordinating benefits with Medicare. (Section 9)
- Your share of the non-Postal premium will increase by 7.1% for Self Only or 4.5% for Self and Family.
- We have changed our Prior Authorization List. (Section 3)
- Your copay for after-hours and urgent care visits in a provider's office or urgent care facility has increased to $20 each visit.
- Your cost share for services provided by physicians and other health care professionals in an outpatient hospital or surgical center has increased to 10% of Plan Allowance.
- We now cover chiropractic services, up to 20 visits per member per calendar year. Prior authorization is required after your initial consultation. (Sections 3 and 5(a))
- We no longer cover clomiphene for treatment of infertility. (Section 5(f))
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a))
- We clarified the Family planning and Infertility benefits by providing more examples of covered and not covered benefits. (Section 5(a))
- We clarified Surgical procedures to show that we cover a comprehensive ranges of services, such as operative procedures. (Section 5(b))
- We now cover certain intestinal transplants. (Section 5(b))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))

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 to get covered care

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. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals.

The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, female members may self-refer to an Altius contract OB/GYN Physician for one outpatient examination per year. You may see a contracted optometrist without a referral. Your optometrist will refer you to a contracted ophthalmologist when medically necessary.

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 physician must obtain prior authorization for the following services:

- Abortion Services
- All Services from Non-Plan Providers (except urgent and emergency care)
- Behavioral Health Services (inpatient and outpatient) – including neuro-psychological testing and treatment, alcohol and substance abuse treatments
- Cardiac-Pulmonary Rehabilitation (outpatient)
- Chiropractic Services (after initial consultation)
- Durable Medical Equipment
- Genetic Counseling – evaluation and testing
- 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
- Medical Coverage of Dental Services
- Osteopathic Manipulative Treatment
- Outpatient Surgeries
- Outpatient Therapy – occupational, physical, speech, biofeedback, and hyperbaric oxygen therapy services
- Pain Management Services
- 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)
- We require prior authorization for certain prescription drugs. See section 5(f) for a list of these drugs.

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.

You must verify that your physician has obtained prior authorization from us before you receive the services on our prior authorization list. If you do not verify that we have authorized your service, we may deny your claim and your physician may bill you. To verify prior authorization, you may call your physician and ask for the prior authorization number we provided, or you may call us directly at 801-323-6200 or 1-800-377-4161.

Prior authorization of a service does not guarantee payment. We will not pay if on the date you receive services:

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

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, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of $10 per office visit and $20 for an after-hours or urgent care 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 catastrophic protection out-of-pocket maximum for coinsurance and copayments

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 your 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 8 for how our benefits changed this year and page 59 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 • Office medical consultations • Second surgical opinion	$10 per office visit; $20 for after-hours or urgent care
Professional services of physicians • In an urgent care center	$20 per visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	10% of Plan Allowance
Lab, X-ray and other diagnostic tests	
Minor diagnostic tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EEG	$10 per office visit; $20 for after-hours or urgent care (waived if performed in conjunction with an office visit) 10% of Plan Allowance in a hospital or other facility
Major diagnostic labs and x-rays, such as, • Cat Scans and MRIs • PET and SPECT Scans • Angiography	10% of Plan Allowance

Preventive care, adult	You pay
Routine screenings, such as: • Total Blood Cholesterol – once every three years • 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; $20 for after-hours visit 10% of Plan Allowance in a hospital or other facility
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, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit; $20 for after-hours visit
Not covered: Immunizations exclusively for travel	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (to age 22) • 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 (toage 22)	$10 per office visit; $20 for after-hours visit 10% of Plan Allowance in a hospital or other facility
Not covered: Immunizations exclusively for travel.	*All charges*

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Obstetrical care in an observation setting	10% of Plan Allowance
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	
A broad range of voluntary family planning services, such as: • Voluntary sterilization (in a physician's office) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) Note: We cover oral contraceptives and diaphragms under the prescription drug benefit; see section 5(f).	$10 per office visit; $20 for after-hours visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Predictive genetic testing and/or counseling*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterine insemination (IUI)	50% of Plan Allowance

Infertility services - continued on next page

Infertility services *(continued)*	**You pay**
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *invitro fertilization* – *embryo transfer, gamete GIFT and zygote zift* – *zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility Medications* • *Infertility services after voluntary sterilization*	*All charges*
Allergy care	
Testing and treatment	$10 per office visit; $20 for after-hours 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 Note: We cover home IV infusion therapy under the under the home health services benefit. • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. We require prior authorization for growth hormone and other injectable medicatons. You must verify that your physician has received prior authorization from us for growth hormone. See *Services requiring our prior approval* in Section 3.	$10 per office visit; $20 for after-hours or urgent care 10% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: Injectables for treatment of infertility	*All charges*

Physical and occupational therapies	You pay
• 60 visits per condition for the services of each of the following: – qualified physical therapists – occupational therapists Note: We only cover these therapies to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. We cover physical and occupational therapy under the home health services benefit when provided by a home health agency as part of an authorized home treatment plan. • 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; $20 for after-hours visit 10% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: • *long-term rehabilitative therapy* • *therapy that we determine will not significantly improve your condition* • *exercise programs*	*All charges*
Speech therapy	
60 visits per condition Note: We cover speech therapy under the home health services benefit when provided by a home health agency as part of an authorized home treatment plan.	$10 per office visit; $20 for after-hours visit
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children and adults in a provider's office	$10 per office visit; $20 for after-hours visit
• Inpatient hearing examination of a newborn child covered under a family enrollment	10% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: • *Hearing aids, including testing, examinations, and fittings 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
• Annual eye refractions Note: See Preventive care, children for eye exams for children	$10 per office visit; $20 for after-hours 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	You pay
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; $20 for after-hours visit
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 Note: 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)	You pay
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
• oxygen concentrators	Nothing
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 • Home rehabilitative therapy, including physical therapy, occupational therapy, and speech therapy when significant improvement can be expected. • Home visits by a medical social worker.	Nothing

Home health services - continued on next page

Home health services *(continued)*	**You pay**
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family* • *services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	
Coverage is limited to 20 visits per calendar year. Services include: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$10 per office visit; $20 for after-hours visit
Alternative treatments	
No Benefit	*All charges*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management • Asthma Management	$10 per office visit

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	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Removal of tumors and cysts • Normal pre-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Voluntary sterilization • 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; $20 for after-hours or urgent care 10% of Plan Allowance in a surgical center, 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; $20 for after-hours or urgent care 10% of Plan Allowance in a surgical center, 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; • Other surgical procedures that do not involve the teeth or their supporting structures;	$10 per office visit; $20 for after-hours or urgent care 10% of Plan Allowance in a surgeical center, 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 • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • 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.	10% of Plan Allowance in a surgical center, 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	10% of Plan Allowance
Professional services provided in – • Office	$10 per office visit; $20 for after-hours or urgent care

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 Sections 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 • Minor 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
Major diagnostic labs and x-rays, such as, • Cat Scans and MRIs • PET and SPECT Scans • Angiography	10% of Plan Allowance
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	You pay
• 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	You pay nothing
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 covered services*, 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	$20 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	$20 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

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 visit
• Diagnostic tests • Intensive outpatient treatment	$10 per 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 obtain a treatment plan and follow 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.

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.
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR CERTAIN DRUGS.**
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** 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 35 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**. The Altius formulary is a list of "preferred" prescription drugs that are identified by our team of physicians and pharmacists (Pharmacy and Therapeutics Committee) to be the best overall value based on quality, safety, effectiveness, and cost. Our formulary includes all covered generic drugs, and specific brand-name drugs selected by the Committee. We list the most commonly requested formulary drugs on our Preferred Drug List. To order a Preferred Drug List, call our Customer Service Department at 1-800-377-4161 or 801-323-6200. The Preferred Drug List is subject to review and modification on a quarterly basis.

  We also cover non-preferred drugs prescribed by your Plan doctor. However, we encourage you to use preferred drugs, especially generics, whenever possible because they will cost you less. Refer to your Preferred Drug List, and check with your doctor or pharmacist to find out if a generic is available, or if a lower-cost alternative might work for you.
- **These are the dispensing limitations.**
  - Your pharmacist will fill up to 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 size. You will pay one copayment for each prescription filled, even if your prescription provides less than a 30-day supply.
  - 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, medications for blood pressure, asthma, antidepressants, diabetes, hormone replacement and birth control. With the exception of insulin (in vials only), injectable medications are not available through mail order. Non-maintenance medications are not available through mail order. 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.

- You must use at least 75% of your current prescription before you can get a refill, either at a pharmacy or, when applicable, through the mail.
- You may ask your pharmacist for a generic equivalent if it is available, unless your physician specifically requires a name brand and indicates "Dispense as Written" on your prescription. If a generic equivalent is not available, or if your physician specifically requires a name brand, you will pay the name brand copayment.

- **Why use generic drugs?** Generic drugs are therapeutically equivalent to brand-name drugs, but they cost less. They have the same active ingredients, and are required by the U.S. Food and Drug Administration to meet the same quality standards for safety, strength, and effectiveness. You pay your lowest copay when you use generic drugs.
- **When you have to file a claim**. If you are outside of the service area 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 purchase, except those listed as *Not Covered* • Contraceptive drugs • 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 • 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
• Aerochamber, limited to one per calendar year	$15 copayment
• Diaphragms, limited to one every three months	$15 copayment

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 specific medications: • Accutane • Aggrenox • Celebrex • Clarinex • Clozaril • DDAVP • Differin • Diflucan • Lamisil • Nexium • Prilosec • Prozac • Regranex • Relenza • Retin-A • Sarafem • Sporanox • Tamiflu Your plan provider must also get prior authorization for the following categories of medications: • Drugs to treat sexual dysfunction when medically necessary • Injectable medications Note: For authorization, physicians must fax the request form to us. Each request will be answered by a return fax.	
Not covered: • *Nonprescription medications* • *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* • *Disposable needles and syringes not required for injecting covered prescribed medication* • *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
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
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; $20 for after-hours or urgent care 10% of Plan Allowance in a surgical center, hospital or other facility
Not covered • *Implants*	*All charges*

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
The following services are limited: • Replacement of prosthetic appliances less than five years old is covered only when good dental care dictates and such replacement is prescribed by a Plan dentist • Single unit gold restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials	
Not Covered • ***Implants*** • ***surgical grafting procedures*** • ***treatment for developmental malformations such as enamel hypoplasia and fluorosis (brown and white stains on teeth)*** • ***maxillary and mandibular malformations and anodontia*** • ***general anesthetic*** • ***composite resin on posterior teeth*** • ***cosmetic or orthodontic treatment*** • ***full mouth rehabilitation, periodontal splints, restoration of tooth structure lost from attrition and restoration for misalignment of the teeth*** • ***dental treatment for temporomandibular (jaw) joint disorders and related dieases*** • ***replacement of lost or stolen denture, bridges or other dental appliances*** • ***services not specified as covered***	*All Charges*

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:

Our "AltiusExtra" web site is continually updated with the latest providers, pricing and special offers for Altius members. There is no cost to this program but you can bank on the savings! Just visit www.altiushealthplans.com and click on "AltiusExtra", then select the programs you are interested in.

No Computer? No Problem!

Just complete and mail the brochure that you will receive with your Altius I.D. card, or contact customer service and we will send you a copy of all the information from our website. The computer is the quickest way to view the most updated information, but isn't required to participate in the AltiusExtra program.

Overview of the "AltiusExtra" Services:

- **Optical Discounts:** 10-30% discounts on prescription and non-prescription eyewear and other products from participating Altius Optical providers.
- **Lasik Vision Eye Surgery:** AltiusExtra has contracted with multiple LASIK centers to provide more choice and greater convenience at competitive prices.
- **Vitamins, Minerals and Nutritional Supplements:** A complete line of quality vitamins and minerals at significantly discounted prices delivered right to your door!
- **Hearing Aids:** 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:** 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".
- **Cosmetic Dentistry:** Advances in teeth whitening technology along with the cost savings available with AltiusExtra, a brighter smile is more attainable and affordable than ever before.
- **Cosmetic Surgery:** There is virtually no part of the body that can't be enhanced and improved by cosmetic surgery. Thanks to new techniques in surgery and anesthesia, many procedures are easier, less painful, and recovery is faster.
- **Massage Therapy:** Therapeutic massage is an enjoyable, non-invasive way to improve health, fitness, and general wellness.
- **Health Club Membership:** The health clubs participating with AltiusExtra offer discounts on individual and family memberships.
- **Cosmetic Dermatology:** Cosmetic Dermatology offers new ways to help skin look better.

- **Regular member specials and drawings for free services are unique to AltiusExtra! This is a popular feature of Altius Extra and is on-track for expansion in 2002!**

We continually expand 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!

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition and we agree, as discussed under *Services requiring our prior approval* on page 11.**

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;
- Alternative treatments such as acupunture, acupressure, naturopathic or homeopathic services, hypnotherapy, and biofeedback;
- 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;
- Telephone consultations;
- Services or supplies given by a health care provider who lives in the same household as the patient;
- Services, drugs, or supplies related to sex transformations; 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 the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

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

(Continued) To receive reimbursement for copayments, coinsurance, and deductibles that you have paid under your primary plan for eligible prescription medications, you need to submit the following:

- Original receipts or a printout from your pharmacy signed by the Pharmacist that filled the prescription; and
- Altius Coordination of Benefits (COB) claim form; and
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN)

To obtain a COB claim form, and for any questions or assistance, call us at 801-323-6200 or 1-800-377-4161.

Submit your claims to:

Altius Health Plans
Coordination of Benefits Department
10421 South Jordan Gateway, Suite 400
South Jordan, UT 84095

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 2, 1900 E Street, Washington, D.C. 20415-3620.

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 include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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 or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or prior authorization, then call us at 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, your primary payer must process your claim first. After the primary plan pays, we will pay the balance of what the primary plan shows that you owe for covered services (such as copayments, coinsurance and deductibles), up to our regular benefit. However, we will not pay more than our allowance. We will waive any copayments, and/or coinsurance 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 (Part A or Part B)

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

When you are enrolled in Original Medicare along with this plan, you still need to follow the rules in this brochure for us to cover your care. Your care must 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		✓
c) Are a former spouse of an annuitant	✓	
d) Are a former spouse of 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 when you have the Original Medicare Plan—You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your 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 the Original Medicare -- When Original 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 another type of Medicare+Choice plan—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 provide all the benefits that the Original Medicare covers. 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, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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's service area.

• If you do not enroll in Medicare Par A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare

Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. 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.

Coinsurance

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

Copayment

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

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, 2002. If you joined this Plan during open season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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 or 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.

•Temporary continuation of coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent and turn 22 or marry, etc.

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

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

•Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think their health plan and/or Medicare covers long-term care. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need? Consider buying long term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for care in a nursing home, in an assisted living facility, in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but you should have a plan just in case. *LTC insurance may be vital to your financial and retirement planning.*

Is long term care expensive?

- Yes. A year in a nursing home can exceed $50,000 and only three 8- hour shifts a week can exceed $20,000 a year, that's before inflation!
- LTC can easily exhaust your savings but LTC insurance can protect it.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look under "*Not covered*" in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

- Employees will get more information from their agencies during the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

Index

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

Summary of benefits for Altius Health Plans – 2002

- **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
Services provided by physicians:		
• Diagnostic and treatment services provided in the office ...	Office visit copay: $10 primary care; $10 specialist; $20 for after-hours or urgent care	15
• In a hospital, surgical center, or other facility	10%	15, 23-24
Services provided by a hospital:		
• Inpatient	Nothing	27-28
• Outpatient	Nothing	
Emergency benefits:		
• In-area	$50	31
• Out-of-area	$100	31
Mental health and substance abuse treatment	Regular cost sharing	32-33
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	34-36
Dental Care	See schedule of Dental Benefits	38-40
Vision Care	Members can receive discounts on prescription and non-prescription eyewear and other products from participating Altius optical providers	16, 19, 40
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		37
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	13

2002 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 (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 and St. George:							
Self Only	9K1	$97.86	$48.81	$212.03	$105.76	$115.52	$31.15
Self and Family	9K2	$223.41	$99.27	$484.06	$215.08	$263.75	$58.93