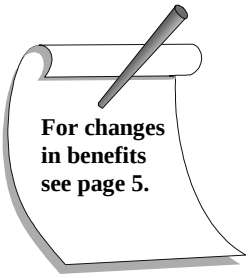
Altius Health Plans 2000

(Formerly PacifiCare® of Utah)

A Health Maintenance Organization



Serving: Parts of Utah along the Wasatch Front

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

Enrollment code:

9K1 Self Only
9K2 Self and Family

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.altiushealthplans.com

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Federal Employees Health Benefits Program

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Introduction

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

This brochure describes the benefits you can receive from Altius Health Plans HMO under its contract (CS2839) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 5. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Altius Health Plans HMO as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB Plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **Health Maintenance Organizations (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.

3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.

4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. **General exclusions – Things we don't cover.** Look here to see benefits that we will not provide.

7. **Limitations – Rules that affect your benefits.** This section describes limits that can affect your benefits.

8. **FEHB facts.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventive care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay the copayments and coinsurance listed in this brochure. When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How To Get Benefits, for more information)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- Your share of the premium will increase by 76.6% for Self Only or 59.4% for Self and Family. Your share of the Non-Postal biweekly premium will increase by $16.54 for Self Only or $30.31 for Self and Family. The Non-postal monthly premium will increase by $35.84 for Self Only or $65.66 for Self and Family. Your share of the Postal "A" biweekly premium will increase by $14.19 for Self Only or $26.62 for Self and Family. The postal "B" biweekly premium will increase by $13.99 for Self Only or $33.34 for Self and Family.

- Under the Hospital/Extended Care Benefits provision, hospital copay of $100 per admission is now required.

- Copayments for prescription drugs increased from $5 copay for generic formulary/$10 copay for name brand formulary/$25 copay for non-formulary, to $10 copay for generic formulary/$15 copay for name brand formulary/$30 for non-formulary.

- Emergency Room services increased from a $40 copay to a $50 copay within the service area and $100 copay outside the service area.

- Plan's out-of-pocket maximum changed from $1,000 for one family member/$2,500 for two or more family members, to $2,000 for one family member/$4,000 for two or more family members.

- Plan name changed from PacifiCare® of Utah to Altius Health Plans.

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, you must live or work in Box Elder, Weber, Morgan, Davis, Salt Lake, Summit, Tooele, Utah, Wasatch, Juab or Sanpete counties. This is where our providers practice. Our service area is identified by the following Zip Codes:

84003-84004, 84006, 84010-84011, 84013-84018, 84020, 84022, 84024-84025, 84029, 84032-84033, 84036-84037, 84040-84044, 84047, 84049-84050, 84054-84062, 84065, 84067-84071, 84074-84075, 84080, 84082, 84084, 84087-84088, 84090-84095, 84097-84098, 84100, 84101-84128, 84131-84145, 84147-84148, 84150-84153, 84157-84158, 84165, 84170-84171, 84180, 84184-84185, 84189, 84190, 84201, 84244, 84301-84302, 84306-84307, 84309, 84317, 84324, 84330-84337, 84400-84409, 84412, 84414, 84601-84606, 84626, 84628-84629, 84632-84633, 84639, 84645, 84648, 84651, 84653-84655, 84660, 84663-84664.

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

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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for when you have reached the Plan's out-of-pocket maximum for the calendar year.

After you pay $2,000 in copayments or coinsurance for one family member or $4,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the calendar year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs, dental services, services that are not covered benefits under the Plan and Durable Medical Equipment (DME) do not count toward these limits and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Section 3. How to get benefits *(continued)*

Who provides my health care?

All members must select a Primary Care Physician, or PCP from the Plans' 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 family member may choose a different Primary Care Physician. Locations and telephone numbers of Plan providers are listed in the Altius Provider Directory or can be obtained by calling the Customer Service Department at 801-323-6200 or 1-800-377-4161.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan Physician. If you need to be hospitalized, your Primary Care Physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our Customer Service Department at 801-323-6200 or 1-800-377-4161. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your Primary Care Physician will arrange your referral to a specialist. In the course of treatment, your Altius contracting Primary Care Physician (PCP) may refer you to a contracted Altius Specialist. You should verify that the Specialist is contracted and that appropriate referrals have been obtained before you receive 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.

What do I do if I am seeing a specialist when I enroll?

Your Primary Care Physician will decide what treatment you need. If they decide 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.

What do I do if my 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.

Section 3. How to get benefits *(continued)*

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

The Plan accepts the determination of Altius's Medical Management Committee as to whether treatments, procedures and drugs are accepted as no longer experimental or investigational. The determinations are based on the safety and efficacy of new medical procedures, technologies, devices and drugs.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at 801-323-6200 or 1-800-377-4161 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division II at 202-606-3818 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

Section 4. What to do if we deny your claim or request for service *(continued)*

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. BENEFITS

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 office visit copay and no additional copay for laboratory tests and X-rays performed during the same office visit. Within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; **you pay** nothing for a doctor's house call or for visits by nurses and health aides.

The following services are included, and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well-baby care and periodic checkups
- Mammograms are covered as follows, and not subject to a copay: for women age 35 through age 39, one mammogram during this five-year period; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan Provider. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary family planning services
- Implanted contraceptive devices, such as Norplant
- IUD's
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials such as allergy serum
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints, are not subject to a copay
- Cornea, heart, heart-lung, kidney, liver, lung (single or double), and pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for 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. Treatment for breast cancer, multiple myeloma and epithelial ovarian cancer may be provided in a non-randomized clinical trial when treatment is 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. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan, (not subject to a copay for inpatient hospital care)

Section 5. BENEFITS *(continued)*

What is covered ***(continued)***

- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. The hospital stay is not subject to a copay
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you
- Blood and blood products are not subject to a copay

Limited benefits

Oral and maxillofacial surgery is provided for non-dental and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months; **you pay** a $10 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved function in other activities of daily living.

Diagnosis and treatment of infertility is covered; **you pay** 50% of charges. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); you pay 50% of charges; cost of donor sperm is not covered. Fertility drugs (other than Clomiphene) are not covered. Clomiphene is covered under the Prescription Drug Benefit. Other assisted reproductive technology (ART) procedures, such as in-vitro fertilization and embryo transfer are not covered.

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 when specific clinical indications are met. **You pay** a $10 copay per visit.

Durable Medical Equipment Medically necessary DME such as contact lenses post-cataract removal, corrective appliances, orthopedic braces, artificial aids, and prosthetic devices, including breast prostheses and surgical bras and replacements. **You pay** 50% of charges.

Section 5. BENEFITS *(continued)*

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntarily induced sterility
- Transplants not listed as covered
- Surgery primarily for cosmetic purposes
- Hearing aids
- Chiropractic services
- Homemaker services
- Orthopedic devices, such as foot orthotics
- Long-term rehabilitative therapy

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** a $100 copay per admission. All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits for up to 30 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is in lieu of hospitalization. **You pay** nothing. All necessary services are covered, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged for by a skilled nursing facility when prescribed by a Plan doctor
- Blood and blood products

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance care

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay** a $50 copay.

Section 5. BENEFITS *(continued)*

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care

Section 5. BENEFITS *(continued)*

Emergency Benefits

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 the Plan may determine are medical emergencies; what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your Primary Care Physician. In extreme emergencies, if you are unable to contact your Primary Care Physician, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. It is your responsibility to pay for any non-emergency services you receive in the emergency room or non-urgent care you receive in the urgent care center.

If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

Plan pays

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay

A $50 copay per hospital emergency room visit or $10 copay per urgent care visit at a contracted Plan provider, facility or office visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency copay is waived.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Section 5. BENEFITS *(continued)*

Emergencies outside the service area ***(continued)***

Plan pays	Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.
You pay	A $100 copay per hospital emergency room visit or $10 copay per urgent care visit at a contracted Plan provider, facility or office visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency copay is waived.
What is covered	• Emergency care at a doctor's office or an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services • Ambulance service approved by the Plan
What is 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
Filing claims for non-Plan providers	With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 9.

Section 5. BENEFITS *(continued)*

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, this Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 30 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** a $10 copay for each covered visit – you pay all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing for the first 30 days – you pay all charges thereafter.

What is not covered

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance abuse

What is covered

This Plan provides medical and hospital services, such as acute detoxification services, for the medical, nonpsychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Unlimited outpatient visits per calendar year to Plan providers for treatment; **you pay** a $10 copay for each covered visit.

Inpatient care

Up to 30-days per calendar year for substance abuse rehabilitation (intermediate care) programs in an alcohol detoxification or rehabilitation center approved by the Plan; **you pay** nothing during the benefit period – all charges thereafter. No yearly limit for detoxification.

What is not covered

Treatment that is not authorized by a Plan Provider.

Section 5. BENEFITS *(continued)*

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Creams, liquids, inhalers and suppositories are dispensed in quantities reflected by standard package size or quantity. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. A formulary is a list of drugs covered by the Plan and this list is updated on a regular basis. The Plan's formulary is determined by reviewing pertinent medical literature, provider feedback, and changes/improvements in medical technology. A copy of this Plan's current drug formulary is available by contacting the Plan.

You pay a $10 copayment for generic formulary drugs, or a $15 copayment for name brand formulary drugs, per prescription unit or refill.

Non-formulary drugs will be covered when prescribed by a Plan doctor. **You pay** a $30 copayment per prescription unit or refill.

Mail order service

Up to a 90-day supply of maintenance medications may be obtained through mail order for the cost of one copayment. For information on the mail order drug benefit, contact Express Scripts/Value Rx at 1-800-698-0149. Maintenance Medications are any prescription that is recommended by the Food & Drug Administration (FDA) to be taken on a daily basis. Examples include, but are not limited to, medications for blood pressure, asthma, antidepressants, cholesterol anticoagulants, diabetes, hormone replacement and birth control. Examples of non-maintenance medications include antihistamines, antibiotics, pain management, muscle relaxants, anti-migraine medications for sleep or anxiety, acne preparations, topical cream and ointments.

COVERED MEDICATIONS AND ACCESSORIES INCLUDE;

- Drugs for which a prescription is required by law
- Oral and injectable contraceptives drugs; contraceptive diaphragms and IUD's
- FDA approved prescription drugs and devices for birth control
- Insulin with a copay charge applied to each vial
- Diabetic supplies, including insulin syringes, needles, glucose test strips, (50 strips per prescription unit) and lancets
- Intravenous fluids and medication for home use, implantable drugs and some injectable drugs, such as Depo Provera, are covered under Medical Benefits
- Clomiphene for infertility
- Depo Provera, an injectable, is covered under the Medical and Surgical Benefit, at a $10 office visit copay
- Disposable needles and syringes needed for injecting covered prescribed medication
- Drugs to treat sexual dysfunction when medically necessary, limited to six pills per month. You pay 50% of the cost of the medication per prescription unit or refill

Section 5. BENEFITS *(continued)*

Prescription Drug Benefits *(continued)*

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent
- Drugs obtained at a non-Plan pharmacy, except for out-of-the area emergencies
- Vitamins and nutritional substances which can be purchased without a prescription
- Medical supplies, such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches
- Implanted time-release medications, other than Norplant
- Infertility drugs with the exception of Clomiphene
- Skin patches for motion sickness (Transderm-Scop)
- Anorexiants/antiobesity agents
- Progesterone suppositories and capsules
- Vaccinations for foreign travel

Section 5. BENEFITS *(continued)*

Other Benefits

Dental care

What is covered

The following dental services are covered when provided by participating Primary Care Plan dentists:

Preventive & diagnostic	**You Pay**
Initial examination, including full series x-rays	Nothing
Recall examinations, including bite wing x-rays	Nothing
Single films	Nothing
Prophylaxis and fluoride treatment (child)	Nothing
Prophylaxis (adult)	Nothing
Preventive education	Nothing

Emergency treatment	
Palliative during office hours	$14
After hours or as provided by the Altius dentist on call	$53

Restorative	
Routine fillings - Amalgam or Composite 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

Section 5. BENEFITS *(continued)*

Other Benefits *(continued)*

Dental care

What is covered ***(continued)***

Endodontics……..…….**You Pay**
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
Cast crown…….……..…..$336

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 orthodontics
Space maintainer - unilateral…….$47
Lingual holding arch..... …….$50
Habit-breaking appliance……..$90

Plan Maximum

No annual or lifetime maximum limit.

Plan pays up to $50 for emergency services required when member is over 100 miles from home and a Plan dentist is not available. **You pay** all charges thereafter.

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury; **you pay** nothing.

What is not covered

Other dental services not shown as covered

Section 5. BENEFITS *(continued)*

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescription) may be obtained from Plan providers. **You pay** a $10 copay per visit.

What is not covered

- Eye exercises
- Corrective lenses or frames

Section 5. BENEFITS *(continued)*

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Altius is pleased to provide our members with value-added benefits during 2000.

Optical Discounts

Members can receive from 10% to 30% savings on eyewear, including contact lenses, sunglasses and prescription eyeglasses from contracted Altius Optical Providers.

Lasik Vision Eye Surgery

Permanent solutions to vision problems are now available to all Altius members through the Moran Eye Institute at the University of Utah. The Moran Eye Institute is an expert in Lasik surgery and ophthamological services. The Moran Eye Institute may be able to provide the vision solutions you're looking for at a 10% discounted price. For more information on services call the University of Utah physician referral line at 1-800-662-0052.

Optional Enhanced Dental Coverage

Altius offers you a dental option to enhance your basic Federal dental coverage. By paying an annual premium, which can be billed to you by the Plan, your basic dental coverage would be expanded for the following dental services: Restorative, Periodontics, Oral surgery, Endodontics, Crown & Bridges and Dentures.

The monthly cost to you would be: Self only-$10.13; Family-$26.10 Additional copay may be necessary if services of a Dental Specialist are necessary.

To enroll in this dental option: check your Altius informational packet for detailed benefit information on the enhanced dental package, or call the Customer Service Department at 1-800-377-4161.

Note: Enrollment in the Enhanced Dental is limited to open season. This dental package is optional. You are not required to enroll in the Enhanced Dental to join the regular Altius FEHB.

Vitamins, Minerals and Nutritional Supplements

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

Hearing Aids

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

Smoking Cessation

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

BENEFITS ON THIS PAGE ARE NOT PART OF THE FEHB CONTRACT

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 or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan doctors or hospitals, except for authorized referrals or emergencies (see Emergency Benefits);
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not covered by this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare
.

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice Plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice Plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice Plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice Plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800-638-6833.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

Section 7. Limitations – Rules that affect your benefits *(continued)*

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

If you have a malpractice claim

If you have a malpractice claim because of services you did or did not receive from a plan provider, it must go to binding arbitration. Contact us about how to begin our binding arbitration process.

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

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

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

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

What happens when I 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, which is described later in this section.

Section 8. FEHB FACTS *(continued)*

What types of coverage are available for me and my 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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

If you or one of your family members is enrolled in one FEHB Plan, that person may not be enrolled in another FEHB Plan.

Are my medical and claims records 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,
- 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old Plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

We will not refuse to cover the treatment of a condition that you or a family member had before you enrolled in this Plan solely because you had the condition before you enrolled.

Section 8. FEHB FACTS *(continued)*

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

Section 8. FEHB FACTS *(continued)*

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB Plans, you may request a certificate from them, as well.

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 801-323-6200 or 1-800-377-4161 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202-418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

NOTES

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Summary of Benefits for Altius 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services with no dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room intensive care and complete maternity care. **You pay** $100 copy per admission, plan pays 100% thereafter……...13	
	Extended care	All necessary services, up to 30 consecutive days per calendar year. **You pay** nothing……. ……13	
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing …….……....……..17	
	Substance Abuse	Each member is entitled to a 30-day per calendar year substance abuse program. **You pay** nothing; no limit for detoxification…….…..……17	
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** $10 copy per office visit…….……11	
	Home Health care	All necessary visits by nurses and home health aides. **You pay** nothing…….…….12	
	Mental conditions	Up to 30 outpatient visits per year. **You pay** $10 copy per visit……..17	
	Substance Abuse	Unlimited outpatient visits per year. **You pay** $10 copy per visit……..….17	
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $50 copy to the hospital for each emergency room visit in-area, a $100 copy to the hospital for each emergency room visit out-of-area, and a $10 copy for Urgent Care Centers and any charges for services that are not covered benefits of this Plan…….…….15-16	
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $10 copy for generic formulary drugs, a $15 copy for formulary name brand drugs, or a $30 copy for non-formulary drugs per prescription unit or refill…….……18-19	
Dental care		Accidental injury benefit; **you pay** nothing. Preventive dental care, and diagnostic services; **you pay** nothing. Restorative services, periodontics, oral surgery, crowns and bridges, dentures, preventive orthodontics and emergencies are covered; **you pay** a fixed copy per procedure (see copy schedule)……..…….……20-21	
Vision care		One refraction annually. **You pay** a $10 copy per visit……..…..……22	
Out-of-pocket		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $2,000 per Self Only or $4,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs, dental services, eyeglasses, or durable medical equipment……..…..…...6	

2000 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 an FEBH Guide or contact the agency that maintains your health benefits enrollment.

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	**Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**USPS Share**	**Your Share**	**USPS Share**	**Your Share**
Wasatch Front									
Self Only	**9K1**	**$78.83**	**$38.14**	**$170.80**	**$82.64**	**$93.06**	**$23.91**	**$93.26**	**$23.71**
Self and Family	**9K2**	**$175.97**	**$81.36**	**$381.27**	**$176.28**	**$207.74**	**$49.59**	**$201.02**	**$56.31**