

# Altius Health Plans

[www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com)

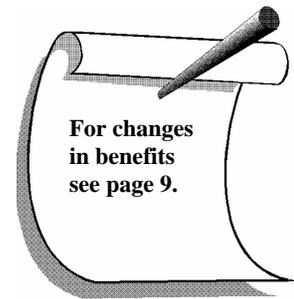


## 2006

### A Health Maintenance Organization (high option) and a high deductible health plan

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

**Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 8 for requirements.**



**Enrollment code for this Plan:**

- 9K1 High Option – Self Only
- 9K2 High Option – Self and Family
- 9K4 HDHP Option – Self Only
- 9K5 HDHP Option – Self and Family



Authorized for distribution by the:



**United States  
Office of Personnel Management**

Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>

**RI 73-564**

## **Notice of the United States Office of Personnel Management's Privacy Practices**

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the Government Accountability Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at [www.opm.gov/insure](http://www.opm.gov/insure) on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints  
United States Office of Personnel Management  
P.O. Box 707  
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

## **Important Notice from Altius Health Plans About Our Prescription Drug Coverage and Medicare**

OPM has determined that Altius Health Plans' prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and Altius Health Plans will coordinate benefits with Medicare.

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

---

### **Please be advised**

---

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

#### **Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

---

## Table of Contents

---

Introduction.....	3
Plain Language.....	3
Stop Health Care Fraud!.....	3
Preventing medical mistakes.....	4
Section 1 Facts about this HMO plan.....	6
General features of our High Option.....	6
How we pay providers.....	6
General features of our High Deductible Health Plan (HDHP).....	6
Your Rights.....	7
Service Area.....	8
Section 2 How we change for 2006.....	9
Section 3 How you get care.....	11
Identification cards.....	11
Where you get covered care.....	11
• Plan providers.....	11
• Plan facilities.....	11
What you must do to get covered care.....	11
• Primary care.....	11
• Specialty care.....	11
• Hospital care.....	12
Circumstances beyond our control.....	12
Services requiring our prior approval.....	13
Section 4 Your cost for covered services.....	15
Copayments.....	15
Deductible.....	15
Coinsurance.....	15
Your catastrophic protection out-of-pocket maximum.....	15
Carryover.....	16
Section 5 Benefits.....	
High Option Benefits.....	17
High Deductible Health Plan Benefits.....	52
Non-FEHB benefits available to Plan members.....	97
Section 6 General exclusions – things we don’t cover.....	98
Section 7 Filing a claim for covered services.....	99
Section 8 The disputed claims process.....	101
Section 9 Coordinating benefits with other coverage.....	103
When you have other health coverage.....	103
What is Medicare?.....	103
• Should I enroll in Medicare?.....	104
• The Original Medicare Plan (Part A or Part B).....	104
• Medicare Advantage (Part C).....	105
• Medicare prescription drug coverage (Part D).....	105
TRICARE and CHAMPVA.....	107
Workers’ Compensation.....	107
Medicaid.....	107
When other Government agencies are responsible for your care.....	107
When others are responsible for injuries.....	107

Section 10 Definitions of terms we use in this brochure .....	108
Section 11 FEHB Facts .....	110
Coverage information.....	110
• No pre-existing condition limitation.....	110
• Where you can get information about enrolling in the FEHB Program.....	110
• Types of coverage available for you and your family .....	110
• Children’s Equity Act.....	110
• When benefits and premiums start .....	111
• When you retire .....	111
When you lose benefits .....	111
• When FEHB coverage ends.....	111
• Spouse equity coverage .....	111
• Temporary Continuation of Coverage (TCC).....	112
• Converting to individual coverage.....	112
• Getting a Certificate of Group Health Plan Coverage .....	112
Section 12 Two Federal Programs complement FEHB benefit.....	113
The Federal Flexible Spending Account Program – <i>FSAFEDS</i> .....	113
The Federal Long Term Care Insurance Program.....	116
Index.....	118
Summary of benefits for the High Option of Altius Health Plans - 2006.....	120
Summary of benefits for the HDHP of Altius Health Plans - 2006.....	121
2006 Rate Information for Altius Health Plans.....	122

---

## Introduction

---

This brochure describes the benefits of *Altius Health Plans* under our contract (CS 2839) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for *Altius Health Plans* administrative offices is:

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

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 9. Rates are shown at the end of this brochure.

---

## Plain Language

---

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

---

## Stop Health Care Fraud!

---

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

**Protect Yourself From Fraud** – Here are some things that you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-800-377-4161 or 801-323-6200 and explain the situation.
  - If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE  
202-418-3300**

**OR WRITE TO:**  
**United States Office of Personnel Management  
 Office of the Inspector General Fraud Hotline  
 1900 E Street NW Room 6400  
 Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

## **Preventing medical mistakes**

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That’s about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

**1. Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

**2. Keep and bring a list of all the medicines you take.**

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

### **3. Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

### **4. Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

### **5. Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery?
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- ▶ [www.ahrq.gov/consumer/pathqpack.htm](http://www.ahrq.gov/consumer/pathqpack.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- ▶ [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- ▶ [www.talkaboutrx.org/index.jsp](http://www.talkaboutrx.org/index.jsp). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- ▶ [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- ▶ [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- ▶ [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

---

## Section 1 Facts about this HMO plan

---

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option or a High Deductible Health Plan (HDHP).

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles 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.**

### **General features of our High Option**

- Our High Option Plan has no deductible.
- Inpatient services billed by a hospital or other facility are covered at 100%.
- Most services provided by physicians and other health care professionals, including physician services that are provided while you are in a hospital, are subject to a copayment or coinsurance.
- Comprehensive dental coverage is included.

### **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, coinsurance, and/or deductibles. We compensate contracted providers by either discount fee-for-service fee schedules or capitation agreements. **It is your responsibility to verify that the provider you use is a Plan provider. Except for emergency and out-of-area urgent care, we will not pay for care or services from non-Plan providers or facilities unless it has been authorized by us. If you use a non-Plan provider or facility without authorization from us, you may be responsible for all charges.**

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 1,250 Primary Care Physicians and 2,150 specialists participate in this Plan.

You do not have to select a Primary Care Physician (PCP). You may self refer to Plan specialists. However, we recommend that you select a PCP to coordinate all of your medical care. A PCP should practice one of the following disciplines: General Practice, Family Medicine, Internal Medicine, Obstetrics/Gynecology (OB/GYN) or Pediatrics. **You are responsible for making sure that a provider is a Plan provider.** Should you have any questions, please contact our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com).

### **General features of our High Deductible Health Plan (HDHP)**

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. Our HDHP does not include dental coverage, except for dental services that are necessary as a result of an accidental injury to sound, natural teeth.

### **Preventive care services**

Services listed in the HDHP *Preventive care* section are paid as first-dollar coverage (you do not pay a deductible). We pay 100% for those services.

### **Annual deductible**

The annual deductible must be met before Plan benefits are paid for covered services other than those listed in the *Preventive care* section.

## **Health Savings Account (HSA)**

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

## **Health Reimbursement Arrangement (HRA)**

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

## **Catastrophic protection**

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles, coinsurance, and copayments, cannot exceed \$5,000 for Self Only enrollment, or \$10,000 family coverage.

## **Health education resources and accounts management tools**

We make available a wide variety of self-service tools and resources to help you take personal control of your health. Below is a list of some of these tools and resources, many of which are available through our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com):

- Health education resources – preventive guidelines, patient safety tips, wellness and disease information, prescription drug interaction and pricing tools, and newsletters
- Account management tools – online claims payment history and HSA or HRA balance information
- Consumer choice information – online provider directory and health services pricing tool
- Care support – case management programs and e-mail reminders for screening tests.

For more information about these and other available tools and resources, please see HDHP Section 5(i).

## **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 Web site ([www.opm.gov/insure](http://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 Health Maintenance Organization.
- Altius Health Plans (formerly PacifiCare of Utah) has been in existence for over 25 years.
- Altius Health Plans is a for-profit, wholly-owned subsidiary of Coventry Health Care, Inc.

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 Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com).

## **Service Area**

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

The counties of Box Elder, Cache, Carbon, Davis, Iron, Morgan, Salt Lake, Sanpete, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Weber, and portions of Juab as defined by the following zip codes:

Juab – 84628, 84639, 84640, 84645, 84648

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

---

## Section 2 How we change for 2006

---

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

### Changes to this Plan

- We are offering a High Deductible Health Plan (HDHP) option for the first time under the Federal Employees Health Benefits Program during the 2005 Open Season. See Section 5 for details. (Please note: We now refer to our existing plan option as “High Option.”)
- Under the High Option, your share of the non-Postal premium will increase by 18.8% for Self Only or 20.2% for Self and Family.
- Most injectable and intravenous (IV) therapy drugs you receive in a physician’s office, in an urgent care center, through a home health provider, or through a pharmacy or a pharmaceutical vendor are now subject to a 10% coinsurance for preferred drugs and 20% for non-preferred drugs. See sections 5(a), 5(d), and 5(f) for details. Injectable and IV drugs administered in conjunction with a surgical procedure performed in a physician’s office or in an urgent care center are now subject to a 10% coinsurance. See Section 5(b). The coinsurance you pay for injectable and IV therapy drugs will count toward your catastrophic protection out-of-pocket maximum. See Section 4.
- We have changed and clarified that certain injectable and intravenous (IV) therapy drugs, including those that are administered by a medical professional, are covered only when they are purchased through designated pharmacy vendors. For details, see *Diagnostic and treatment services*, *Treatment therapies*, and *Home health services* in Section 5(a), and *Direct Source Injectables* in Section 5(f).
- Under the High Option, you now pay \$15 per visit for physical therapy, occupational therapy, speech therapy, and cardiac rehabilitation provided in a rehabilitation center, surgical center, or outpatient hospital. See *Physical and occupational therapies* and *Speech therapy* in Section 5(a).
- If you receive a brand-name drug when a preferred generic equivalent can be substituted, and your physician has not specified “Dispense as Written” for the brand-name drug, you will now pay the generic copayment plus the difference in cost between the brand-name drug and the generic. See the dispensing limitations in Section 5(f) for details.
- We have clarified our list of services requiring prior approval. See Section 3.
- We have clarified our list of major diagnostic lab and radiology tests. See sections 5(a) and 5(c).
- We have clarified that we cover routine immunizations according to the guidelines of the Centers for Disease Control, the American Academy of Pediatrics, and local government public health authorities. See *Preventive services, adult* and *Preventive services, children* in Section 5(a).
- We have clarified that ultrasounds and lab tests related to pregnancy are covered as minor diagnostic services. We have also clarified that complications of pregnancy are covered the same as any other illness. See *Maternity care* in Section 5(a).
- We have clarified that we cover health education classes and programs when closely related to the treatment of an illness or injury. See *Education classes and programs* in Section 5(a).
- Our mental health and substance abuse benefits administrator has changed from Horizon Behavioral Services to Mental Health Network (MHNet). See *Prior authorization* in Section 5(e).
- We have clarified that you may be required to pay an additional prescription drug copayment if we authorize any amount of your prescription that exceeds our quantity level limits. See the dispensing limitations in Section 5(f) for details.
- We have clarified that when one dose or single use of a covered drug or pharmaceutical product lasts longer than 30 days, you may be required to pay one copayment for each month of the anticipated duration of the medication. See the dispensing limitations in Section 5(f) for details.
- We have clarified that if the Plan allowance for a prescription drug is less than the copay, you will pay the Plan allowance. See Section 5(f).
- We have clarified that we cover insulin pens. See Section 5(f).

- We have clarified that medications and nutritional supplements for weight loss are not covered. We have also clarified that medications for the treatment of nail fungus are not covered. See Section 5(f).
- Under the High Option Section 5(h) *Dental benefits*, we have changed and/or clarified the following:
  - We have increased dental copayments.
  - We now cover resin-based composite for posterior teeth.
  - We have changed the procedure description for several dental services to more closely match the descriptions used by the American Dental Association (ADA).
  - We have listed a few more dental services that we cover. We have also clarified that we do not list all covered dental services.
  - We have clarified that limits apply to the following dental services: periodic dental exams and prophylaxis, full series and panoramic x-rays, sealant, and crowns.
  - We have clarified that adult fluoride treatment is not covered.

---

## 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 letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-377-4161 or 801-323-6200. You may also request replacement cards through our Web site: [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com).

### Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance and you will not have to file claims.

#### • Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site. If you have questions about Plan providers, call us at 1-800-377-4161 or 801-323-6200 or visit our Web site at [www.AltiusHealthPlans.com](http://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 Web site. If you have questions about Plan providers, call us at 1-800-377-4161 or 801-323-6200 or visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com).

### What you must do to get covered care

It depends on the type of care you need. First, we encourage you and each family member to choose a primary care physician, although you are not required to do so. However, choosing a primary care physician is beneficial since your primary care physician can provide and help coordinate your health care. Your primary care physician will know your overall medical history, help you to make informed decisions, and focus on preventive care to help you stay healthy. If you have been seeing a primary care physician, or you would like 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 General Practitioner, Family Practitioner, Internist, Pediatrician or an OB/GYN. Some OB/GYNs 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 will recommend that you see or refer you to a specialist.

#### • Specialty care

Your primary care physician will refer you to a specialist for needed care, or you may self-refer to a specialist. Either way, we suggest that you return to the primary care physician after the consultation, unless your primary care physician recommended a certain number of visits to the specialist.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician can work with your specialist to develop a treatment plan that recommends you to see the specialist for a certain number of visits. Your Plan provider will use our criteria when creating your

treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician can help decide what treatment you need. If he or she decides to refer you to or recommends that you see a specialist, let him or her know that you would like to 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 and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - reduce our service area and you enroll in another FEHB Plan;you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us 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. **Please note:** It is your responsibility to verify that your physician has arranged for your care in a Plan facility. We will not pay for services provided by a non-Plan facility without our prior authorization. See *Services requiring our prior approval* in this section.

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 92<sup>nd</sup> day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

## Circumstances beyond our control

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

## Services requiring our prior approval

For certain services, 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:

- All Services from non-Plan Providers, including hospitals, surgical centers, and other facilities (except emergency care and out-of-area urgent care)
- Capsule Endoscopy
- Chiropractic Services (after initial consultation)
- Durable Medical Equipment
- Educational Classes and Programs
- Eyeglasses and Contact Lenses (covered only to correct an impairment directly caused by accidental ocular injury or intraocular surgery, such as for cataracts)
- Genetic Counseling – evaluation and testing
- Home Health Care
- Infertility evaluations and treatment
- Injectable Medications, including certain intravenous (IV) therapy and chemotherapy drugs. See Sections 5(a) (*Treatment therapies*) and 5(f) for details.
- Inpatient Facility Admissions
- Inpatient Rehabilitation Admissions
- Medical Coverage of Dental Services
- Medical Nutrition Therapy and/or Diet Counseling
- Mental Health and Substance Abuse Services
- Neuropsychological Testing
- Orthopedic and Prosthetic Devices
- Outpatient Surgeries
- Outpatient Therapy – occupational, physical, speech, biofeedback, and hyperbaric oxygen therapy services
- Pain Management Services
- Positron-Emission Tomography (PET) Scans
- Plastic Surgery and related procedures (cosmetic procedures are not covered)
- Skilled Nursing Facility Admissions
- Transportation (non-urgent)
- We require prior authorization for certain prescription drugs. To obtain a list of these drugs, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com).

Your primary care or specialty care physician must request prior authorization for you by calling or faxing us directly. Once we have received all required information, we will authorize or deny services as soon as possible, but within 24 hours for urgent 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.

Emergency care does not require prior authorization, but we must be notified as soon as reasonably possible if you are admitted to the hospital. Please see Section 5(d) for details.

We do not require prior authorization for inpatient maternity admissions in a Plan facility. However, we do require prior authorization if your provider plans to provide other medical or surgical care while you are in the hospital. We should be notified as soon as reasonably possible if either you or your baby needs to stay longer than 48 hours after a regular delivery or 96 hours after a cesarean delivery. We will review all extended hospital stays for medical necessity.

You must verify that your physician has obtained prior authorization from us before you receive the services on our prior authorization list. For services that are to be provided in a hospital, surgical center, or other facility, you must also verify that your physician has arranged for your care in a Plan facility. If you do not verify that we have authorized your service and, if necessary, that you will be using a Plan facility, we may deny your claim and your physician and/or the facility may bill you. To verify prior authorization for medical services, you may call us directly at 801-323-6200 or 1-800-377-4161. For mental health and substance abuse services, please see *Prior authorization* in Section 5(e).

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 cost for covered services

---

This is what you will pay out-of-pocket for covered care.

### Copayments

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

**High Option** Example: When you see a primary care physician, you pay a copayment of \$10 per office visit; and when you see a specialist, you pay a copayment of \$15 per office visit.

**High Deductible Health Plan** Example: When you see a primary care physician, you pay a copayment of \$20 per office visit (after your deductible has been met). When you see a specialist, you pay a copayment of \$30 per office visit (after your deductible has been met).

### Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- **High Option:** We do not have a deductible.
- **High Deductible Health Plan:** The calendar year deductible is \$1,100 for individual coverage (Self Only enrollment). Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for all family members reach \$2,200. The entire family deductible must be satisfied before benefits are payable for any individual family member.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

### Coinsurance

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

Example: You pay 50% of our allowance for infertility services and durable medical equipment. (With the High Deductible Health Plan, this coinsurance applies after your deductible has been met.)

### Your catastrophic protection out-of-pocket maximum

#### High Option

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 services for the remainder of the calendar year. However, copayments and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Durable Medical Equipment (DME)
- Prescription Drugs (except those injectable and intravenous (IV) therapy drugs for which you pay a coinsurance instead of a copayment)
- Dental Services

Under your High Option plan, you have a separate catastrophic protection 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 and substance abuse services.

Be sure to keep accurate records of your copayments and/or coinsurance. If you have a

question about when the out-of-pocket maximum is reached, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161.

### **High Deductible Health Plan**

After your deductibles, copayments, and/or coinsurance total \$5,000 for individual coverage (Self Only enrollment) or \$10,000 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. Under family enrollment, the entire family out-of-pocket maximum must be met before any individual family member is no longer required to pay copayments or coinsurance.

Be sure to keep accurate records of your copayments, coinsurance, and deductibles. If you have a question about when the out-of-pocket maximum is reached, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161.

### **Carryover**

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

**High Option Benefits**

See page 9 for how our benefits changed this year and page 120 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 claim 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 Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com).

Section 5(a) Medical services and supplies provided by physicians and other health care professionals .....19

- Diagnostic and treatment services .....19
- Lab, X-ray and other diagnostic tests .....20
- Preventive care, adult .....20
- Preventive care, children .....21
- Maternity care .....22
- Family planning .....22
- Infertility services .....23
- Allergy care .....23
- Treatment therapies .....24
- Physical and occupational therapies .....24
- Speech therapy .....25
- Hearing services (testing, treatment, and supplies) .....25
- Vision services (testing, treatment, and supplies) .....25
- Foot care .....26
- Orthopedic and prosthetic devices .....26
- Durable medical equipment (DME) .....27
- Home health services .....27
- Chiropractic .....28
- Alternative treatments .....28
- Educational classes and programs .....29

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals .....30

- Surgical procedures .....30
- Reconstructive surgery .....31
- Oral and maxillofacial surgery .....32
- Organ/tissue transplants .....32
- Anesthesia .....33

Section 5(c) Services provided by a hospital or other facility, and ambulance services .....34

- Inpatient hospital .....34
- Outpatient hospital or ambulatory surgical center .....35
- Extended care benefits/Skilled nursing care facility benefits .....36
- Hospice care .....36
- Ambulance .....36

Section 5(d) Emergency services/accidents .....37

- Emergency within our service area .....37
- Emergency outside our service area .....38
- Ambulance .....38

Section 5(e) Mental health and substance abuse benefits .....39

- Mental health and substance abuse benefits .....39

Section 5(f) Prescription drug benefits .....41

- Covered medications and supplies .....44

Section 5(g) Special features .....46

- Flexible benefits option .....46

Services for deaf, hard of hearing, and non-English speaking members .....46  
High risk pregnancies.....46  
Travel benefit/services overseas.....46  
Section 5(h) Dental benefits .....47  
    Accidental injury benefit.....47  
    Dental benefits.....47  
Summary of benefits for the High Option of Altius Health Plans - 2006.....120

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- 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 PRIOR AUTHORIZATION FOR SOME SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>● In a physician’s office</li> <li>● Office medical consultations</li> <li>● Second surgical opinion</li> </ul>	\$10 per office visit to a primary care physician \$15 per office visit to a specialist \$20 for an after-hours or urgent care visit to a primary care physician or specialist
Professional services of physicians <ul style="list-style-type: none"> <li>● In an urgent care center</li> </ul>	\$20 per visit
Injectable and intravenous (IV) therapy drugs provided in a physician’s office or in an urgent care center	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
Note: Certain injectable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see <i>Direct Source Injectables</i> in Section 5(f).  Note: We cover routine immunizations under the preventive care benefits for adults and children. We cover allergy serum under the <i>Allergy care</i> benefit.	
Professional services of physicians <ul style="list-style-type: none"> <li>● During a hospital stay</li> <li>● In a skilled nursing facility</li> </ul>	10% of Plan Allowance

Lab, X-ray and other diagnostic tests	You pay
<p>Minor diagnostic tests, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	<p>Nothing in a physician’s office or at an independent lab if performed in conjunction with an office visit</p> <p>10% of Plan Allowance in a hospital or other facility</p>
<p>Major diagnostic labs and radiology tests, such as:</p> <ul style="list-style-type: none"> <li>• CAT scans, MRIs, MRAs, and electron beam scans</li> <li>• PET and SPECT scans</li> <li>• Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance</li> <li>• Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures)</li> <li>• Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes</li> <li>• Cytogenetic studies</li> </ul>	<p>10% of Plan Allowance</p>
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Total Blood Cholesterol</li> <li>• Fasting lipid profile (total cholesterol, LDL, HDL, triglycerides)</li> <li>• Colorectal Cancer Screening, including <ul style="list-style-type: none"> <li>– Fecal occult blood test</li> <li>– Sigmoidoscopy screening – every five years starting at age 50</li> <li>– Colonoscopy screening – every 10 years starting at age 50</li> <li>– Double contrast barium enema – every five years starting at age 50</li> </ul> </li> <li>• Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</li> <li>• Routine Pap test</li> </ul>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a hospital or other facility</p>
<p>Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> above.</p>	

*Preventive care, adult – continued on next page*

<b>Preventive care, adult</b> <i>(continued)</i>	<b>You pay</b>
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>● Routine mammogram – covered for women age 35 and older, as follows:               <ul style="list-style-type: none"> <li>– From age 35 through 39, one during this five year period</li> <li>– From age 40 through 64, one every calendar year</li> <li>– At age 65 and older, one every two consecutive calendar years</li> </ul> </li> <li>● Osteoporosis screening               <ul style="list-style-type: none"> <li>– for women age 65 and older</li> <li>– for women age 60 though 64 who are at increased risk for osteoporosis</li> </ul> </li> </ul>	<p>\$10 per office visit to a primary care physician            \$15 per office visit to a specialist            \$20 for an after-hours visit to a primary care physician or specialist            10% of Plan Allowance in a hospital or other facility</p>
<p>Routine immunizations recommended by the Centers for Disease Control and local government public health authorities, such as:</p> <ul style="list-style-type: none"> <li>● Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>● Influenza vaccine, annually</li> <li>● Pneumococcal vaccine, age 65 and older</li> </ul>	<p>\$10 per office visit to a primary care physician            \$15 per office visit to a specialist            \$20 for an after-hours visit to a primary care physician or specialist</p>
<ul style="list-style-type: none"> <li>● Routine physicals – one exam every 12 months</li> <li>● Routine exams limited to:               <ul style="list-style-type: none"> <li>– One routine eye exam every 12 months</li> <li>– One routine OB/GYN exam every 12 months including 1 Pap smear and related services</li> <li>– One routine hearing exam every 24 months</li> </ul> </li> </ul>	<p>\$10 per office visit to a primary care physician            \$15 per office visit to a specialist            \$20 for an after-hours visit to a primary care physician or specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel</li> <li>● Immunizations exclusively for travel</li> </ul>	<p><i>All charges</i></p>
<b>Preventive care, children</b>	
<ul style="list-style-type: none"> <li>● Childhood immunizations recommended by the American Academy of Pediatrics, the Centers for Disease Control, and local government public health authorities</li> <li>● Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> <li>● Examinations, such as:               <ul style="list-style-type: none"> <li>– Eye exams through age 17 to determine the need for vision correction</li> <li>– Hearing exams through age 17 to determine the need for hearing correction</li> </ul> </li> </ul>	<p>\$10 per office visit to a primary care physician            \$15 per office visit to a specialist            \$20 for an after-hours visit to a primary care physician or specialist            10% of Plan Allowance in a hospital or other facility</p>

*Preventive care, children – continued on next page*

Preventive care, children <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel</li> <li>• Immunizations exclusively for travel</li> </ul>	<p><i>All charges</i></p>
<b>Maternity care</b>	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> <li>• Obstetrical care in an observation setting</li> </ul>	<p>10% of Plan Allowance</p>
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need prior authorization for normal delivery; see page 14 for other circumstances, such as extended stays for your baby.</li> <li>• 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.</li> <li>• We cover <u>routine</u> 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. Note: For newborn circumcision, see surgery benefits in Section 5(b).</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See hospital benefits in Section 5(c) and surgery benefits in Section 5(b).</li> <li>• We cover ultrasounds and lab tests under the minor diagnostic services benefit. See <i>Lab, x-ray and other diagnostic tests</i> in this section.</li> <li>• We cover services related to complications of pregnancy the same as for any other illness.</li> </ul>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Routine sonograms to determine fetal age, size or sex</i></li> <li>• <i>Home delivery</i></li> </ul>	<p><i>All charges</i></p>
<b>Family planning</b>	
<p>A range of voluntary family planning services, such as:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See <i>Surgical procedures</i> in Section 5(b))</li> <li>• Surgically implanted contraceptives</li> <li>• Intrauterine devices (IUDs)</li> </ul>	<p>\$10 per office visit to a primary care physician            \$15 per office visit to a specialist            \$20 for an after-hours visit to a primary care physician or specialist</p>

*Family planning – continued on next page*

<b>Family Planning</b> <i>(continued)</i>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Injectable contraceptive drugs (such as Depo-Provera)</li> </ul>	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
Note: We cover oral contraceptives and diaphragms under the prescription drug benefit; see Section 5(f).	
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Reversal of voluntary surgical sterilization</li> <li>• Predictive genetic testing and/or counseling</li> </ul>	<i>All charges</i>
<b>Infertility services</b>	
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> <li>• Artificial insemination:               <ul style="list-style-type: none"> <li>– intravaginal insemination (IVI)</li> <li>– intracervical insemination (ICI)</li> <li>– intrauterine insemination (IUI)</li> </ul> </li> </ul>	50% of Plan Allowance
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Assisted reproductive technology (ART) procedures, such as:               <ul style="list-style-type: none"> <li>– in vitro fertilization</li> <li>– embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</li> </ul> </li> <li>• Services and supplies related to ART procedures</li> <li>• Cost of donor sperm</li> <li>• Cost of donor egg</li> <li>• Fertility Medications</li> <li>• Infertility services after voluntary sterilization</li> </ul>	<i>All charges</i>
<b>Allergy care</b>	
<ul style="list-style-type: none"> <li>• Testing and treatment</li> </ul>	\$10 per office visit to a primary care physician \$15 per office visit to a specialist \$20 for an after-hours visit to a primary care physician or specialist
<ul style="list-style-type: none"> <li>• Allergy serum</li> <li>• Allergy injections</li> </ul>	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Provocative food testing</li> <li>• Sublingual allergy desensitization</li> </ul>	<i>All charges</i>

Treatment therapies	You pay
<ul style="list-style-type: none"> <li>● Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 32.</p> <ul style="list-style-type: none"> <li>● Respiratory and inhalation therapy</li> <li>● Dialysis – hemodialysis and peritoneal dialysis</li> <li>● Growth hormone therapy (GHT)</li> <li>● Intravenous (IV)/Infusion Therapy and IV antibiotic therapy</li> </ul>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours or urgent care visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p>Note: When provided in a physician’s office or in an urgent care center, the services listed above do not include the cost of injectable and IV drugs; see below for the cost of the drugs.</p> <p>Note: We cover home IV infusion and antibiotic therapy administered by a home health agency under the <i>Home health services</i> benefit.</p>	
<ul style="list-style-type: none"> <li>● Injectable and IV therapy drugs provided in a physician’s office or in an urgent care center</li> </ul>	<p>10% of Plan Allowance for preferred drugs</p> <p>20% of Plan Allowance for non-preferred drugs</p>
<p>Note: We require prior authorization for certain injectable and IV therapy drugs, including some chemotherapy drugs and growth hormone. To obtain a list of injectable and IV drugs that require prior authorization, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a>.</p> <p>Note: Certain injectable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see <i>Direct Source Injectables</i> in Section 5(f).</p>	
Physical and occupational therapies	
<ul style="list-style-type: none"> <li>● 60 visits per condition per year for the services of each of the following:             <ul style="list-style-type: none"> <li>– qualified physical therapists</li> <li>– occupational therapists</li> </ul> </li> </ul>	<p>\$15 per office visit</p> <p>\$15 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility</p>
<p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. We cover physical and occupational therapy under the <i>Home health services</i> benefit when provided by a home health agency as part of an authorized home treatment plan.</p>	
<ul style="list-style-type: none"> <li>● 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</li> </ul>	<p>\$15 per office visit</p> <p>\$15 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● Long-term rehabilitative therapy</li> <li>● Therapy that we determine will not significantly improve your condition</li> <li>● Exercise programs</li> </ul>	<p><i>All charges</i></p>

Speech therapy	You pay
60 visits per condition per year	\$15 per office visit \$15 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility
Note: We cover speech therapy under the <i>Home health services</i> benefit when provided by a home health agency as part of an authorized home treatment plan.	
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> <li>Hearing testing for children and adults in a provider’s office</li> </ul>	\$10 per office visit to a primary care physician \$15 per office visit to a specialist \$20 for an after-hours visit to a primary care physician or specialist
<ul style="list-style-type: none"> <li>Inpatient hearing examination for a newborn child covered under a family enrollment</li> </ul>	10% of Plan Allowance
<i>Not covered: Hearing aids, including testing, examinations, and fittings for them</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> <li>One pair of eyeglasses or contact lenses (including professional services for such fitting) to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul>	50% of Plan Allowance
<ul style="list-style-type: none"> <li>Annual eye refractions and exams performed by an optometrist</li> </ul>	\$10 per office visit; \$20 for after-hours visit
Note: See <i>Preventive care, children</i> for eye exams for children	
<ul style="list-style-type: none"> <li>Eye exams performed by an ophthalmologist</li> </ul>	\$15 per office visit; \$20 for after-hours or urgent care visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Extra charges for designer or deluxe frames</i></li> <li><i>Extra charges for progressive lenses</i></li> <li><i>Scratch resistant lens coating</i></li> <li><i>Oversize lenses, tinting, antireflective coating, and U-V lenses, unless prescribed by an ophthalmologist for eyeglasses that are necessary to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts)</i></li> <li><i>Eyeglasses or contact lenses for refractive purposes</i></li> <li><i>Eye exercises and orthoptics</i></li> <li><i>Radial keratotomy, LASIK, and other refractive surgery</i></li> </ul>	<i>All charges</i>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p>	<p>\$10 per office visit to a primary care physician                      \$15 per office visit to a specialist                      \$20 for an after-hours visit to a primary care physician or specialist</p>
<p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> <li>• <i>Foot orthotics</i></li> </ul>	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</li> </ul>	<p>50% of Plan Allowance</p>
<ul style="list-style-type: none"> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy</li> </ul>	<p>Nothing</p>
<p>Note: See Sections 5(b) and 5(c) for coverage of the surgery to insert the device.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices, unless medically necessary</i></li> <li>• <i>Replacement of prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's physical condition</i></li> </ul>	<p><i>All charges</i></p>

<b>Durable medical equipment (DME)</b>	<b>You pay</b>
<p>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:</p> <ul style="list-style-type: none"> <li>● Hospital beds</li> <li>● Wheelchairs</li> <li>● Crutches</li> <li>● Walkers</li> <li>● Blood glucose monitors</li> <li>● Insulin pumps</li> </ul>	50% of Plan Allowance
<ul style="list-style-type: none"> <li>● Oxygen concentrators</li> <li>● Medically necessary accessories and supplies such as hoses, tubes, oxygen and ostomy supplies</li> </ul>	Nothing
<p>Note: Call us at 1-800-377-4161 or 801-323-6200 as soon as your Plan physician prescribes durable medical 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.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>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.</i></li> <li>● <i>Replacement of durable medical equipment, prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's condition</i></li> </ul>	<i>All charges</i>
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>● 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</li> <li>● Services include oxygen therapy, oral medications, and injectable and intravenous (IV) therapy (this does not include the cost of injectable and IV drugs; see next page for the cost of the injectable and IV drugs)</li> <li>● Home visits made by a physician</li> <li>● Home rehabilitative therapy, including physical therapy and occupational therapy when significant improvement can be expected</li> <li>● Home speech therapy</li> <li>● Home visits by a medical social worker</li> </ul>	Nothing

*Home health services – continued on next page*

Home health services <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>● Injectable and IV therapy drugs</li> </ul>	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
<p>Note: Certain injectable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see <i>Direct Source Injectables</i> in Section 5(f).</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i></li> <li>● <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i></li> <li>● <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i></li> </ul>	<p><i>All charges</i></p>
Chiropractic	
<p>Coverage is limited to 20 visits per calendar year. Services include:</p> <ul style="list-style-type: none"> <li>● Manipulation of the spine and extremities</li> <li>● Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul>	\$10 per office visit to a primary care physician \$15 per office visit to a specialist \$20 for an after-hours visit to a primary care physician or specialist
Alternative treatments	
<p>Biofeedback therapy that we have pre-authorized for the treatment of certain conditions</p>	\$10 per office visit to a primary care physician \$15 per office visit to a specialist \$20 for an after-hours visit to a primary care physician or specialist 10% of Plan Allowance in a surgical center, hospital, or other facility
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● Acupuncture</li> <li>● Acupressure</li> <li>● Naturopathic or homeopathic services</li> <li>● Massage therapy</li> <li>● Hypnotherapy</li> <li>● Biofeedback that we have not pre-authorized</li> </ul>	<p><i>All charges</i></p>

Educational classes and programs	You pay
<p>Coverage is limited to classes and programs that we authorize for the care and treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> <li>• Diabetes self-management</li> <li>• Asthma management</li> <li>• Medical nutrition therapy and/or diet counseling:               <ul style="list-style-type: none"> <li>– for a member who, based on our criteria, is a candidate for surgical treatment of morbid obesity</li> <li>– for a member with a disease, illness, or injury that is treated by changing the types of foods or nutrients in the member’s diet, provided that such treatment is not intended primarily for weight loss</li> </ul> </li> </ul>	<p>\$10 per office visit to a primary care physician            \$15 per office visit to a specialist            Nothing in a hospital or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Literature such as books, journals, or subscriptions, unless included in an educational program that we approve</i></li> <li>• <i>Smoking cessation programs</i></li> <li>• <i>Medical nutrition therapy and/or diet counseling intended primarily for weight loss, unless the member meets our criteria for surgical treatment of morbid obesity</i></li> <li>• <i>Health education services that are not closely related to the care and treatment of an illness or injury</i></li> </ul>	<p><i>All charges</i></p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must use a Plan facility. It is your responsibility to verify that your physician has scheduled your surgery in a Plan facility. We will not pay for services provided by a non-Plan provider or facility without our prior authorization.
- 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 FOR SURGICAL PROCEDURES.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>● Operative procedures</li> <li>● Treatment of fractures, including casting</li> <li>● Removal of tumors and cysts</li> <li>● Normal pre- and post-operative care by the surgeon</li> <li>● Endoscopy procedures</li> <li>● Biopsy procedures</li> <li>● Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>● Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>● Treatment of burns</li> <li>● Routine circumcision of a newborn</li> <li>● Insertion of internal prosthetic devices. See Section 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information</li> </ul>	<p>\$10 per office visit to a primary care physician                      \$15 per office visit to a specialist                      \$20 for an after-hours or urgent care visit to a primary care physician or specialist                      10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	
<ul style="list-style-type: none"> <li>● Injectable and intravenous (IV) drugs administered in conjunction with a surgery in a physician’s office or in an urgent care center</li> </ul>	<p>10% of Plan Allowance</p>

*Surgical procedures – continued on next page*

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>● Surgical treatment of morbid obesity (bariatric surgery), subject to all of the following criteria:               <ul style="list-style-type: none"> <li>– the member is 18 years of age or older and has a body mass index (BMI) greater than 40, or a BMI of 35 or greater if the member has a serious comorbid condition;</li> <li>– the member has at least a three year history of chronic morbid obesity that has not responded to at least six months of a medically supervised weight loss program including diet, exercise, and behavior modification;</li> <li>– the member is a good candidate for surgery and has no medical or psychological condition that may reduce the likelihood of a successful outcome of surgery;</li> <li>– the member has successfully lost at least 5% of body weight within six months prior to surgery to demonstrate his or her ability to comply with the required postoperative diet; and</li> <li>– the member must be willing and able to commit to, and participate in, lifelong medical surveillance and follow up care as well as altered eating habits.</li> </ul> </li> </ul>	<p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● Reversal of voluntary sterilization</li> <li>● <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> <li>● Surgery to correct a functional defect</li> <li>● Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>● 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; and webbed fingers and toes.</li> <li>● All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance of breasts</li> <li>– treatment of any physical complications</li> <li>– breast prostheses, lymphedema pumps, surgical bras and replacements (See <i>Orthopedic and prosthetic devices</i> in Section 5(a))</li> </ul> </li> </ul>	<p>\$10 per office visit to a primary care physician            \$15 per office visit to a specialist            \$20 for an after-hours or urgent care visit to a primary care physician or specialist            10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	
<ul style="list-style-type: none"> <li>● Injectable and intravenous (IV) drugs administered in conjunction with a surgery in a physician’s office or in an urgent care center</li> </ul>	<p>10% of Plan Allowance</p>

*Reconstructive surgery – continued on next page*

Reconstructive surgery ( <i>continued</i> )	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>● <i>Surgeries related to sex transformation</i></li> </ul>	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>● Reduction of fractures of the jaws or facial bones;</li> <li>● Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>● Removal of stones from salivary ducts;</li> <li>● Excision of leukoplakia or malignancies;</li> <li>● Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>● Other surgical procedures that do not involve the teeth or their supporting structures</li> </ul>	<p>\$10 per office visit to a primary care physician            \$15 per office visit to a specialist            \$20 for an after-hours or urgent care visit to a primary care physician or specialist            10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<ul style="list-style-type: none"> <li>● Injectable and intravenous (IV) drugs administered in conjunction with a surgery in a physician’s office or in an urgent care center</li> </ul>	<p>10% of Plan Allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Oral implants and transplants</i></li> <li>● <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> <li>● Cornea</li> <li>● Heart</li> <li>● Heart/lung</li> <li>● Kidney</li> <li>● Kidney/Pancreas</li> <li>● Liver</li> <li>● Lung</li> <li>● Pancreas</li> <li>● Allogeneic (donor) bone marrow transplants</li> </ul>	<p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>

*Organ/tissue transplants – continued on next page*

<b>Organ/tissue transplants (continued)</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>● 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</li> <li>● Autologous tandem transplants for testicular tumors and other germ cell tumors</li> <li>● Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>● Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute- or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</li> </ul> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● Donor screening tests and donor search expenses, except those performed for the actual donor</li> <li>● Implants of artificial organs</li> <li>● Transplants not listed as covered</li> <li>● Travel expenses, lodging, and meals</li> </ul>	<p><i>All charges</i></p>
<b>Anesthesia</b>	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>● Hospital (inpatient)</li> <li>● Hospital outpatient department</li> <li>● Skilled nursing facility</li> <li>● Ambulatory surgical center</li> </ul>	<p>10% of Plan Allowance</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>● Office</li> </ul>	<p>\$10 per office visit to a primary care physician            \$15 per office visit to a specialist            \$20 for an after-hours or urgent care visit to a primary care physician or specialist</p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. It is your responsibility to verify that your physician has arranged for your care in a Plan facility. We will not pay for services provided by a non-Plan facility without our prior authorization.
- 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 in Sections 5(a) or (b).
- **YOU MUST GET PRIOR AUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.

Benefit Description	You pay
<b>Inpatient hospital</b>	
Room and board, such as: <ul style="list-style-type: none"> <li>● Ward, semiprivate, or intensive care accommodations</li> <li>● General nursing care</li> <li>● Meals and special diets</li> </ul>	Nothing
Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	
Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>● Operating, recovery, maternity, and other treatment rooms</li> <li>● Prescribed drugs and medicines</li> <li>● Diagnostic laboratory tests and X-rays</li> <li>● Administration of blood and blood products</li> <li>● Blood or blood plasma</li> <li>● Dressings, splints, casts, and sterile tray services</li> <li>● Medical supplies and equipment, including oxygen</li> <li>● Anesthetics</li> <li>● Take-home items</li> <li>● Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul>	Nothing

*Inpatient hospital – continued on next page*

Inpatient hospital (continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, long-term care facilities schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> </ul>	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Minor diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics</li> </ul>	<p>Nothing</p>
<p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	
<p>Major diagnostic labs and radiology tests, such as:</p> <ul style="list-style-type: none"> <li>• CAT scans, MRIs, MRAs, and electron beam scans</li> <li>• PET and SPECT scans</li> <li>• Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance</li> <li>• Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures)</li> <li>• Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes</li> <li>• Cytogenetic studies</li> </ul>	<p>10% of Plan Allowance</p>
<p><i>Not covered: Personal comfort items</i></p>	<p><i>All charges</i></p>

Extended care benefits/Skilled nursing care facility benefits	You pay
<p>Skilled nursing facility (SNF) /Extended care benefits: 30 days per member per calendar year</p> <ul style="list-style-type: none"> <li>• Professional services – physicians and general nursing care</li> <li>• Medical supplies and medications</li> <li>• Medical equipment ordinarily provided by a skilled nursing facility</li> <li>• Room and board</li> </ul>	Nothing
<i>Not covered: Custodial care, personal, comfort or convenience items</i>	<i>All charges</i>
Hospice care	
<ul style="list-style-type: none"> <li>• Services for pain and symptom management</li> <li>• Short-term inpatient care and procedures necessary for pain control</li> <li>• Respite care may be provided only on an occasional basis and may not be provided longer than five days</li> <li>• Home visits made by a physician, nurse, home health aide, social worker or therapist with no limit on number of visits</li> <li>• General medical equipment and supplies related to the terminal illness</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Independent nursing</i></li> <li>• <i>Homemaker services</i></li> <li>• <i>Specialized, customized equipment</i></li> </ul>	<i>All charges</i>
Ambulance	
Local professional ambulance service when medically appropriate	\$50 copayment per incident
<i>Not covered: Medical transportation for the convenience of you or your family</i>	<i>All charges</i>

**Section 5(d) Emergency services/accidents**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.

**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 Plan provider in an emergency so that he or she can be involved in your care. Please contact your Plan provider 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 Plan provider will work together with us to transfer you to a Plan facility.

An urgent medical problem is one in which your life is not in danger, but you require prompt medical attention. If you need urgent care, contact a Plan provider (your primary care provider if you have one) and follow his or her instructions. If you are not able to contact a Plan provider, you may go to any Plan urgent care facility. Please refer to your Altius Participating Provider Listing. After you receive urgent care, contact a Plan provider as soon as you can. A Plan provider will coordinate any follow-up care you need. If you have any questions about emergency or urgent care, or about Plan providers, please call us at 801-323-6200 or 1-800-377-4161. For a current list of Plan providers and Plan urgent care facilities, you may also visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com).

**● Emergencies outside our service area:**

If you have an emergency or you need urgent care while outside of our service area, 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 Plan provider 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.

Benefit Description	You pay
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>● Emergency care at a doctor’s office</li> <li>● Emergency care at an urgent care center</li> </ul>	\$20 copayment per office visit
<ul style="list-style-type: none"> <li>● Injectable and intravenous (IV) therapy drugs provided in a physician’s office or in an urgent care center</li> </ul>	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs

*Emergency within our service area – continued on next page*

Emergency within our service area <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>Emergency care as an outpatient at a hospital, including doctors' services</li> </ul>	\$50 copayment per visit
<p>Note: We waive the ER copay if you are admitted to the hospital.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care in a hospital emergency room</i></li> <li><i>Follow-up care in a hospital emergency room, unless we have given prior authorization</i></li> </ul>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> <li>Emergency care at an urgent care center</li> </ul>	\$20 copayment per office visit
<ul style="list-style-type: none"> <li>Injectable and intravenous (IV) therapy drugs provided in a physician's office or in an urgent care center</li> </ul>	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
<ul style="list-style-type: none"> <li>Emergency care as an outpatient at a hospital, including doctors' services</li> </ul>	\$100 copayment per visit
<p>Note: We waive the ER copay if you are admitted to the hospital.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>
Ambulance	
<p>Professional ground ambulance, air ambulance, and/or paramedic services when medically appropriate.</p>	\$50 copayment per incident
<p>Note: See 5(c) for non-emergency service.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Medical transportation for the convenience of you or your family</i></li> <li><i>Death-related transportation</i></li> </ul>	<i>All charges</i>

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

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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 PRIOR AUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> <li>● Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers on an outpatient basis</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>● Intensive outpatient treatment</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>● Diagnostic tests</li> <li>● Medication management</li> </ul>	\$10 per office visit to a primary care physician \$15 per office visit to a specialist
<ul style="list-style-type: none"> <li>● Services provided by a hospital or other facility on an inpatient basis (room and board), including partial hospitalization</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>● Professional services by providers such as psychiatrists, psychologists, or clinical social workers provided on an inpatient basis</li> </ul>	10% of Plan Allowance
<i>Not covered: Services we have not approved</i>	<i>All charges</i>
<p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	

*Mental health and substance abuse benefits – continued on next page*

**Mental health and substance abuse benefits (continued)**

<b>Prior authorization</b>	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:  You must contact Mental Health Network (MHNet) 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.
<b>Mental Health and Substance Abuse Catastrophic Protection Out-Of-Pocket Maximum</b>	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 and/or substance abuse services for the remainder of the calendar year.
<b>Limitation</b>	We may limit your benefits if you do not obtain a treatment plan.

## Section 5(f) Prescription drug benefits

### Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 44.
- 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.
- 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.
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR CERTAIN DRUGS.**

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

- **Who can write your prescription.** A licensed practitioner who has the legal authority to prescribe medications.
- **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 page 44 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.
  - Through a Direct Source vendor: Certain injectable and intravenous (IV) therapy drugs, including those that are administered by a medical professional, that are covered only when they are purchased through designated pharmacy vendors. See *Direct Source Injectables* on page 43.
- **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 nearly 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, or visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com). The Preferred Drug List is subject to review and modification on a quarterly basis.
- We also cover non-preferred (non-formulary) drugs prescribed by your Plan physician. However, we encourage you to use preferred drugs, especially preferred generics, whenever possible because they will cost you less. Refer to your Preferred Drug List, and check with your physician or pharmacist to find out if a preferred generic is available, or if a lower-cost alternative might work for you.
- **Prior Authorization.** We require prior authorization for certain drugs. We also require prior authorization for injectable medications, including certain drugs used for intravenous (IV) therapy and chemotherapy. To obtain a list of drugs that require prior authorization, or to obtain a list of injectable medications that require prior authorization, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com). The prior authorization drug list is reviewed by our Pharmacy and Therapeutics Committee and may change from time to time due to new drugs, new generics, new therapies, new guidelines from the Food and Drug Administration (FDA), or other factors.

To request prior authorization, you or your physician may contact our Prior Authorization Department at 801-323-6440 or 1-800-879-0234. We will work with your physician to obtain the information we need to process the request. We will communicate our approval or denial to your physician. You may also contact our Customer Service Department for a status of

---

your request.

- **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.
- Some medications have specific limits on how much of the medication you can get with each prescription or refill. This is to ensure that you receive the recommended and proper dose and length of drug therapy for your condition. Quantity level limits are reviewed by the Pharmacy and Therapeutics Committee and are based on maximum dosage levels indicated by the drug manufacturer and the FDA. **Your physician must get authorization for any amount of your prescription that exceeds the quantity level limit.** If we authorize the extra amount, you may be required to pay an additional copayment.
- Certain covered medications and pharmaceutical products are manufactured, packaged, or used in such a way that one dose provides greater than a 30-day supply of medication. These may require one copayment for each month of the anticipated duration of the medication. For example, if one dose or single use of the medication or product is expected to last for two months, you will pay two copayments.
- Prescription Mail Services: You can get a 90-day supply of maintenance medications through the Express Scripts (ESI) mail order service. A maintenance medication is a prescription that is recommended by the FDA or us to be taken on a regular basis. Examples include, but are not limited to, medications for blood pressure, asthma, antidepressants, diabetes, hormone replacement and birth control. Insulin (in vials only) and Symlin are the only injectable medications available through the ESI mail order service. Non-maintenance medications are not available through the ESI mail order service. 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.
- The amount of medication dispensed to you should last for a specific time period as prescribed by your physician. At least 75% of that time must pass before you can get a refill, either at a pharmacy or, when applicable, through the mail. For example: if your prescription provides a 30-day supply, you can refill your prescription no sooner than 23 days after the prescription was filled (30 days × 75% = 23 days).
- If you receive a brand-name drug when a preferred generic equivalent can be substituted, and your physician has not specified “Dispense as Written” (DAW) for the brand-name drug, you will pay the generic copayment plus the difference in cost between the brand-name drug and the generic. For mail-order drugs, Express Scripts may fill your prescription with a preferred generic equivalent if it is available, unless your physician has indicated “Dispense as Written” (DAW). If a preferred generic equivalent is not available, or if your physician specifically indicates “Dispense as Written” (DAW), you will pay the applicable preferred brand-name or non-preferred (non-formulary) copayment. Note: If your physician writes a prescription for a non-preferred (non-formulary) generic, you may ask your pharmacist for an equivalent preferred brand-name drug.
- If your physician prescribes a medication that needs to be dispensed in two different strengths or dosage forms, you will be responsible for the appropriate copayment for each dispensed prescription.
- When a new generic medication is approved by the FDA, our Pharmacy and Therapeutics Committee may classify it as “non-preferred” (non-formulary). Non-preferred generics are subject to the non-preferred copayment listed in this section. Note: If your physician writes a prescription for a non-preferred generic, you may ask your pharmacist for an equivalent preferred brand-name drug.

- **Why use preferred generic drugs?** Preferred 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 preferred 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.
  - **Preferred Injectables.** Similar to other prescription drugs, injectable and intravenous (IV) therapy drugs are categorized as “preferred” or “non-preferred” by our Pharmacy and Therapeutics Committee. If your injectable or IV medication is not listed on our Preferred Drug List, call our Customer Service Department at 1-800-377-4161 or 801-323-6200 to find out if it is covered
-

---

and whether it is preferred or non-preferred.

- **Direct Source Injectables.** Direct source injectables are certain injectable and intravenous (IV) therapy drugs, including those that are administered by a medical professional, that are covered only when they are purchased through designated pharmacy vendors. We have selected vendors who provide these drugs at the lowest cost, which may help lower your out-of-pocket expenses. To obtain a current list of direct source injectable and IV drugs and designated vendors, please visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com) or call our Customer Service Department. This list may be changed periodically.

If your physician orders a direct source injectable or IV drug for you, the medication can be shipped either to your physician's office or directly to your home. You are responsible to pay your coinsurance to the pharmacy vendor.

In many cases, your physician may write a prescription for your injectable or IV therapy drug rather than order it for you. When you obtain a prescription for an injectable or IV therapy drug, call our Customer Service Department or visit our Web site to see if you must order it through a designated vendor.

Most of the injectable and IV therapy drugs that must be purchased through a designated vendor are available through CuraScript Pharmacy. CuraScript will ship your injectable or IV therapy drug and supplies directly to your home or physician's office within 48 hours of ordering. The supplies for administering your medication will be included without cost to you.

In addition, CuraScript offers toll-free, 24-hour customer service, 365 days a year. Support services for you, your caregivers, and your physicians are offered by a trained staff of nurses and pharmacists who can answer questions about your medications and diseases that they treat.

To find out how to order from CuraScript Pharmacy, please call 1-800-278-0980.

---

*Prescription drug benefits begin on the next page*

Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i></li> <li>• Contraceptive drugs</li> </ul>	<p><b>Preferred generic:</b> \$10 at a Plan pharmacy \$20 for mail order</p> <p><b>Preferred brand name:</b> \$20 at a Plan pharmacy \$40 for mail order</p> <p><b>Non-preferred (non-formulary):</b> \$40 at a Plan pharmacy \$80 for mail order</p> <p>Notes:</p> <ul style="list-style-type: none"> <li>• If there is no preferred generic equivalent available, you will still have to pay the applicable preferred brand-name or non-preferred copay.</li> <li>• If the Plan Allowance for the prescription is less than the copay, you will pay the Plan Allowance.</li> </ul>
<ul style="list-style-type: none"> <li>• Insulin, Symlin, insulin syringes, needles, glucose test strips and lancets</li> </ul>	<p><b>Preferred:</b> \$20 at a Plan pharmacy \$40 for mail order</p> <p><b>Non-preferred (non-formulary):</b> \$40 at a Plan pharmacy \$80 for mail order</p>
<ul style="list-style-type: none"> <li>• Injectable Imitrex, glucagon, insulin pens, Lovenox, and epinephrine kits such as Epi-Pen</li> </ul>	<p>\$20 at a Plan pharmacy (not available through mail order)</p>
<ul style="list-style-type: none"> <li>• Injectable medications (other than Insulin, Imitrex, glucagon, Lovenox, and epinephrine kits) and intravenous (IV) therapy drugs obtained through a Plan pharmacy or a Direct Source pharmacy vendor</li> </ul>	<p><b>Preferred:</b> 10% of Plan Allowance</p> <p><b>Non-preferred (non-formulary):</b> 20% of Plan Allowance</p> <p>(These drugs are not available through the ESI mail order service.)</p>
<ul style="list-style-type: none"> <li>• Disposable needles and syringes needed for injecting covered prescription drugs (other than insulin), when filled as a separate prescription</li> </ul>	<p>\$40 at a Plan pharmacy (not available through mail order)</p>
<ul style="list-style-type: none"> <li>• Drugs to treat sexual dysfunction, limited to 6 pills per month</li> </ul>	<p>50% of Plan Allowance at a Plan pharmacy</p>
<ul style="list-style-type: none"> <li>• Spacers (such as Aerochamber), limited to one per calendar year</li> </ul>	<p><b>Preferred:</b> \$10 at a Plan pharmacy</p> <p><b>Non-preferred (non-formulary):</b> \$40 at a Plan pharmacy</p>

*Covered medications and supplies – continued on next page*

Covered medications and supplies <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>● Diaphragms, limited to one every three months</li> </ul>	<p><b>Preferred:</b> \$20 at a Plan pharmacy</p> <p><b>Non-preferred (non-formulary):</b> \$40 at a Plan pharmacy</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Nonprescription medications, except those specifically listed in the Altius formulary</i></li> <li>● <i>Drugs obtained at a non-Plan pharmacy, except for out-of-the-area emergencies</i></li> <li>● <i>Medical supplies, such as dressing and antiseptics</i></li> <li>● <i>Experimental medications</i></li> <li>● <i>Fertility medications</i></li> <li>● <i>Disposable needles and syringes not required for injecting covered prescribed medication</i></li> <li>● <i>Natural progesterone (including suppositories and creams)</i></li> <li>● <i>Smoking cessation products and medications prescribed for smoking cessation</i></li> <li>● <i>Skin patches for motion sickness</i></li> <li>● <i>Medications or nutritional supplements for weight loss</i></li> <li>● <i>Medications or nutritional supplements for weight gain for non-medical indications</i></li> <li>● <i>Immunizations and medications required exclusively for foreign travel</i></li> <li>● <i>Hair growth products</i></li> <li>● <i>Medications for cosmetic indications</i></li> <li>● <i>Medications to enhance athletic performance</i></li> <li>● <i>Medications for the treatment of nail fungus</i></li> </ul>	<p><i>All charges</i></p>

**Section 5(g) Special features**

Feature	Description
<p><b>Flexible benefits option</b></p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>● We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>● Alternative benefits are subject to our ongoing review.</li> <li>● By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>● The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> <li>● Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<p><b>Services for deaf, hard of hearing, and non-English speaking members</b></p>	<p>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.</p> <p>When interpreter services are needed in the provider’s office, contact the provider’s office directly.</p>
<p><b>High risk pregnancies</b></p>	<p>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 Altius Baby Care prenatal case manager. A prenatal case 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.</p>
<p><b>Travel benefit/services overseas</b></p>	<p>Services outside of our service area are limited to emergency and urgent care only. See Section 5(d) for <i>Emergency services/accidents</i>.</p>

**Section 5(h) Dental benefits**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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 to a primary care physician \$15 per office visit to a specialist \$20 for an after-hours or urgent care visit to a primary care physician or specialist 10% of Plan Allowance in a surgical center, hospital, or other facility
<i>Not covered: Implants</i>	<i>All charges</i>

**Dental benefits**

Dental benefits are administered by Monarch Dental Associates. Refer to your dental provider directory for a list of participating dental providers. The dental provider directory can also be found online at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com). If you have any questions about dental providers, dental benefits, or dental claims (that are not related to accidental injury), please call Monarch Dental Associates at 801-220-0940 or 1-877-221-0940.

**Note: This is not a complete list of covered dental services.** To determine your cost for covered services that are not listed, call Monarch Dental Associates and provide the appropriate dental codes or service descriptions obtained from your dentist’s office.

Oral evaluation	
Periodic oral examination – one per member every six months	\$5
Limited oral evaluation – problem focused	Note: You pay an additional \$5 for prophylaxis (dental cleaning). See <i>Preventive</i> benefits on the next page.
Comprehensive oral evaluation	
Comprehensive periodontal evaluation	\$47

*Dental benefits – continued on next page*

Dental benefits <i>(continued)</i>	You pay
<p><b>Radiographs</b></p> <p>Intraoral full series x-rays – one per member every three years</p> <p>Intraoral periapical and occlusal x-rays</p> <p>Bitewing x-rays</p> <p>Panoramic x-ray – one per member every three years</p>	Nothing
<p><b>Preventive</b></p>	
<p>Prophylaxis and fluoride treatment (child) – one per member every six months</p> <p>Prophylaxis (adult) – one per member every six months</p>	<p>\$5</p> <p>Note: You pay an additional \$5 for the oral examination/evaluation. See <i>Oral evaluation</i> benefits on the previous page.</p>
<p>Sealant – per tooth (through age 14)</p>	\$10
<p><b>Emergency treatment</b></p>	
<p>During office hours</p>	
<p>Palliative treatment of dental pain</p>	\$18
<p>Office visit for observation – no other services performed.</p>	\$26
<p>Specialist consultation</p>	\$26
<p>After hours or as provided by the Monarch dentist on call</p>	\$69
<p>Emergency services required when a member is over 100 miles from home and a Plan dentist is not available.</p>	All charges in excess of \$50
<p><b>Restorative</b></p>	
<p>Routine fillings – Amalgam or Resin-based composite for permanent or primary teeth</p>	
<p>Amalgam</p>	
<p>1 surface</p>	\$17
<p>2 surfaces</p>	\$24
<p>3 surfaces</p>	\$31
<p>4 or more surfaces</p>	\$47

*Dental benefits – continued on next page*

<b>Dental benefits (continued)</b>	<b>You pay</b>
Resin-based composite – anterior	
1 surface	\$24
2 surfaces	\$40
3 surfaces	\$61
4 or more surfaces	\$81
Resin-based composite – posterior	
1 surface	\$63
2 surfaces	\$85
3 surfaces	\$106
4 or more surfaces	\$122
<b>Periodontics</b>	
Comprehensive periodontal evaluation	\$47
Periodontal scaling and root planing – four or more teeth per quadrant	\$89
Periodontal scaling and root planing – one to three teeth per quadrant	\$59
Gingivectomy or gingivoplasty – per quadrant	\$138
Gingivectomy or gingivoplasty – per tooth (to three teeth)	\$23
Osseous surgery – four or more teeth per quadrant	\$311
Osseous surgery – one to three teeth per quadrant	\$205
Localized delivery of antimicrobial agents	100% of Plan Allowance
Periodontal maintenance	\$37
<b>Oral surgery</b>	
Extractions (routine)	\$41
Surgical removal of erupted tooth	\$70
Impacted teeth – soft tissue	\$75
Impacted teeth – partial bony	\$112
Impacted teeth – full bony	\$155

*Dental benefits – continued on next page*

Dental benefits (continued)	You pay
<b>Endodontics</b>	
Pulp cap	\$23
Vital pulpotomy	\$35
Root canal, single canal	\$137
two canals	\$166
three canals	\$204
<b>Crowns</b> – Limited to six crowns per member per year	
Crown build up with pins	\$40
Preformed post and build up	\$68
Stainless steel crown	\$77
Crown – porcelain fused to metal	\$352
Crown – porcelain fused to precious metal	\$444
Replacement crown	\$23
<b>Removable dentures</b>	
Complete denture (upper or lower)	\$488
Partial denture (upper or lower)	\$545
Denture adjustment	\$23
Add tooth to existing partial denture	\$46
Add clasp to existing partial denture	\$46
Interim complete denture (upper or lower)	\$173
Interim partial denture/stayplate (upper or lower)	\$173
Replace missing or broken teeth, full or partial dentures, one involved tooth	\$44
Each additional tooth	\$13
Reline denture (upper or lower) – chairside	\$92
Reline denture (upper or lower) – lab	\$163

Dental benefits – continued on next page

Dental benefits <i>(continued)</i>	You pay
<b>Preventive appliances</b>	
Space maintainer – unilateral	\$60
Space maintainer – bilateral	\$63
Habit-breaking appliance	\$114
<p><b>The following services are limited:</b></p> <ul style="list-style-type: none"> <li>● 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.</li> <li>● Single unit gold restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials.</li> </ul>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Implants</i></li> <li>● <i>Surgical grafting procedures</i></li> <li>● <i>Treatment for developmental malformations such as enamel hypoplasia and fluorosis (brown and white stains on teeth)</i></li> <li>● <i>Maxillary and mandibular malformations and anodontia</i></li> <li>● <i>General anesthetic</i></li> <li>● <i>Cosmetic or orthodontic treatment</i></li> <li>● <i>Full mouth rehabilitation, periodontal splints, restoration of tooth structure lost from attrition and restoration for misalignment of the teeth</i></li> <li>● <i>Dental treatment for temporomandibular (jaw) joint disorders and related diseases</i></li> <li>● <i>Replacement of lost or stolen dentures, bridges or other dental appliances</i></li> <li>● <i>Topical application of fluoride for adults</i></li> </ul>	<i>All charges</i>

**High Deductible Health Plan Benefits**

See page 121 for a benefits summary.

Section 5 High Deductible Health Plan Benefits Overview ..... 54

Section 5 Savings – HSAs and HRAs ..... 57

Section 5 Preventive care ..... 63

    Preventive care, adult ..... 63

    Preventive care, children ..... 64

Section 5 Traditional Medical Coverage subject to the deductible ..... 65

    Deductible before Traditional Medical Coverage begins ..... 65

Section 5(a) Medical services and supplies provided by physicians and other health care professionals ..... 66

    Diagnostic and treatment services ..... 66

    Lab, X-ray and other diagnostic tests ..... 67

    Maternity care ..... 67

    Family planning ..... 68

    Infertility services ..... 69

    Allergy care ..... 69

    Treatment therapies ..... 70

    Physical and occupational therapies ..... 70

    Speech therapy ..... 71

    Hearing services (testing, treatment, and supplies) ..... 71

    Vision services (testing, treatment, and supplies) ..... 71

    Foot care ..... 72

    Orthopedic and prosthetic devices ..... 72

    Durable medical equipment (DME) ..... 73

    Home health services ..... 73

    Chiropractic ..... 74

    Alternative treatments ..... 74

    Educational classes and programs ..... 75

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals ..... 76

    Surgical procedures ..... 76

    Reconstructive surgery ..... 77

    Oral and maxillofacial surgery ..... 78

    Organ/tissue transplants ..... 78

    Anesthesia ..... 79

Section 5(c) Services provided by a hospital or other facility, and ambulance services ..... 80

    Inpatient hospital ..... 80

    Outpatient hospital or ambulatory surgical center ..... 81

    Extended care benefits/Skilled nursing care facility benefits ..... 82

    Hospice care ..... 82

    Ambulance ..... 82

Section 5(d) Emergency services/accidents ..... 83

    Emergency within our service area ..... 84

    Emergency outside our service area ..... 84

    Ambulance ..... 85

Section 5(e) Mental health and substance abuse benefits ..... 86

    Mental health and substance abuse benefits ..... 86

Section 5(f) Prescription drug benefits ..... 88

    Covered medications and supplies ..... 91

Section 5(g) Special features .....	93
Flexible benefits option .....	93
Services for deaf, hard of hearing, and non-English speaking members .....	93
High risk pregnancies .....	93
Travel benefit/services overseas .....	93
Section 5(h) Dental benefits .....	94
Accidental injury benefit .....	94
Dental benefits .....	94
Section 5(i) Health education resources and account management tools .....	95
Health education resources .....	95
Account management tools .....	95
Consumer choice information .....	95
Care support .....	96
Summary of benefits for the HDHP of Altius Health Plans - 2006 .....	121

---

## Section 5 High Deductible Health Plan Benefits Overview

---

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, 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 benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 1-801-323-6200 or 1-800-377-4161 or at our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com).

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or HRA based upon your eligibility.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

### • Preventive care

The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), well-child care, and child and adult immunizations. These services are covered at 100% and are fully described in Section 5 *Preventive care*. *You do not have to meet the deductible before using these services.*

### • Traditional medical coverage

After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. You typically pay \$20 per office visit to a primary care physician, \$30 per office visit to a specialist, and \$30 for an after-hours office visit or urgent care visit. The Plan typically pays 90% for home care and hospital care; you typically pay 10% of the Plan allowance.

Covered services include:

- Medical services and supplies provided by physicians and other health care professionals
- Surgical and anesthesia services provided by physicians and other health care professionals
- Hospital services; other facility or ambulance services
- Emergency services/accidents
- Mental health and substance abuse benefits
- Prescription drug benefits
- Dental benefits for services related to an accidental injury.

### • Savings

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see *Savings – HSAs and HRAs* for more details).

#### Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA

benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2006, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$60 per month for a Self Only enrollment or \$120 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$1,100 for Self Only enrollment, or \$2,200 for Self and Family enrollment. See maximum contribution information on page 58. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

**Federal tax tip:** There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

**HSA features include:**

- Your HSA is administered by Corporate Benefit Services of America (CBSA).
- Your contributions to the HSA are tax deductible.
- Your HSA earns tax-free interest.
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.)
- Your unused HSA funds and interest accumulate from year to year.
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire.
- When you need it, funds up to the actual HSA balance are available.

**Important consideration if you want to participate in a Health Care Flexible Spending Account:** If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Instead, when you inform us of your coverage in an FSA, we will establish an HRA for you.

**Health Reimbursement Arrangements (HRA)**

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2006, we will give you an HRA credit of \$720 per year for a Self Only enrollment and \$1,440 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

**HRA features include:**

- For our HDHP option, the HRA is administered by Corporate Benefit Services of America (CBSA).
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.
- Tax-free credit can be used to pay for qualified medical expenses for you and

any individuals covered by this HDHP.

- Unused credits carryover from year to year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements. See *Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS*.

● **Catastrophic protection for out-of-pocket expenses**

Your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$5,000 per person or \$10,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as non-covered expenses). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum* for more details.

● **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

**Section 5 Savings – HSAs and HRAs**

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA)</b> <b>Provided when you are ineligible for an HSA</b>
<b>Administrator</b>	<p>The Plan will establish an HSA for you with Wells Fargo Bank, this HDHP’s fiduciary (a trustee or custodian as defined by Federal tax code and approved by IRS). Corporate Benefit Services of America (CBSA) is the HSA administrator for this Plan.</p> <p><b>Corporate Benefit Services of America (CBSA)</b>  <b>P.O. Box 270520</b>  <b>Golden Valley, MN 55427</b>  <b>1-800-566-9311</b>  <a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a></p>	<p>CBSA is the HRA administrator for this Plan.</p> <p><b>Corporate Benefit Services of America (CBSA)</b>  <b>P.O. Box 270520</b>  <b>Golden Valley, MN 55427</b>  <b>1-800-566-9311</b>  <a href="https://services.cbsainc.com/eehome.asp">https://services.cbsainc.com/eehome.asp</a></p>
<b>Fees</b>	Set-up fee is paid by the HDHP.	None.
<b>Eligibility</b>	<p>You must:</p> <ul style="list-style-type: none"> <li>• Enroll in this HDHP</li> <li>• Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage)</li> <li>• Not be enrolled in Medicare Part A or Part B</li> <li>• Not be claimed as a dependent on someone else’s tax return</li> <li>• Must not have received VA benefits in the last three months</li> <li>• Complete and return all banking paperwork.</li> </ul> <p>Eligibility for contributions is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.</p>	<p>You must enroll in this HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
<b>Funding</b>	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• <b>Self Only enrollment</b>	For 2006, a monthly premium pass through of \$60 will be made by the HDHP directly into your HSA each month.	For 2006, your HRA annual credit is \$720 (prorated for length of enrollment).

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA)</b>  <b>Provided when you are ineligible for an HSA</b>
<ul style="list-style-type: none"> <li>● <b>Self and Family enrollment</b></li> </ul>	<p>For 2006, a monthly premium pass through of \$120 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2006, your HRA annual credit is \$1,440 (prorated for length of enrollment).</p>
<p><b>Contributions/credits</b></p>	<p>The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the deductible, which is \$1,100 for Self Only enrollment or \$2,200 for Self and Family enrollment. This amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA.</p> <p>For each month you are eligible for HSA contributions, if you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> <li>– The maximum allowable contribution is a combination of employee and employer funds up to the amount of the deductible of \$1,100 for Self Only or \$2,200 for Self and Family. To determine the maximum allowable contribution, take the amount of your deductible divided by 12, times the number of full months enrolled in the HDHP. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute.</li> <li>– You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP).</li> <li>– HSAs earn tax-free interest (does not affect your annual maximum contribution).</li> <li>– Catch-up contribution discussed on page 61.</li> </ul>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.</p>
<ul style="list-style-type: none"> <li>● <b>Self Only enrollment</b></li> </ul>	<p>You may make an annual maximum contribution of \$380.</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> <li>● <b>Self and Family enrollment</b></li> </ul>	<p>You may make an annual maximum contribution of \$760.</p>	<p>You cannot contribute to the HRA.</p>

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA)</b> <b>Provided when you are ineligible for an HSA</b>
<b>Access funds</b>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> <li>• Debit card</li> <li>• Withdrawal form</li> </ul>	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as dental services, a reimbursement form will be sent to you upon your request.</p>
<b>Distributions/withdrawals</b>  <ul style="list-style-type: none"> <li>• <b>Medical</b></li> </ul>	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> <li>• <b>Non-medical</b></li> </ul>	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.</p>

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA)</b> <b>Provided when you are ineligible for an HSA</b>
<b>Availability of funds</b>	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> <li>– Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change).</li> <li>– The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA.</li> <li>– The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.</li> </ul>	<p>The entire amount of your HRA will be available to you upon your enrollment in the HDHP.</p>
<b>Account owner</b>	FEHB enrollee	HDHP
<b>Portable</b>	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
<b>Annual rollover</b>	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

**If you have an HSA**

- **Contributions**

All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was effective after January 1, 2006, you would need to deduct 1/12 of the annual maximum contribution. Contact Corporate Benefit Services of America (CBSA) at 1-800-566-9311 for more details.
- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2006, you may contribute up to \$700 in catch-up contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at [www.ustreas.gov/offices/public-affairs/hsa/](http://www.ustreas.gov/offices/public-affairs/hsa/).
- **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.
- **Qualified expenses**

You can pay for “qualified medical expenses,” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at [www.irs.gov](http://www.irs.gov) and click on “Forms and Publications.” Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.
- **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- **Tracking your HSA balance**

You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.
- **Minimum reimbursements from your HSA**

You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least \$25.

**If you have an HRA****• Why an HRA is established**

If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

**• How an HRA differs**

Please review the chart beginning on page 57 which details the differences between an HRA and an HSA. The major differences are:

- you cannot make contributions to an HRA,
- funds are forfeited if you leave the HDHP,
- an HRA does not earn interest, and
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP.

**Section 5 Preventive care**

**Important things you should keep in mind about these benefits:**

- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- Preventive care services listed in this section are not subject to the deductible. The Plan pays 100% for these preventive care services.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*
- 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.

Benefit Description	You pay
<b>Preventive care, adult</b>	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>● Total Blood Cholesterol</li> <li>● Fasting lipid profile (total cholesterol, LDL, HDL, triglycerides)</li> <li>● Colorectal Cancer Screening, including                             <ul style="list-style-type: none"> <li>– Fecal occult blood test</li> <li>– Sigmoidoscopy screening – every five years starting at age 50</li> <li>– Colonoscopy screening – every 10 years starting at age 50</li> <li>– Double contrast barium enema – every five years starting at age 50</li> </ul> </li> <li>● Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</li> <li>● Routine Pap test</li> <li>● Routine mammogram – covered for women age 35 and older, as follows:                             <ul style="list-style-type: none"> <li>– From age 35 through 39, one during this five year period</li> <li>– From age 40 through 64, one every calendar year</li> <li>– At age 65 and older, one every two consecutive calendar years</li> </ul> </li> <li>● Osteoporosis screening                             <ul style="list-style-type: none"> <li>– for women age 65 and older</li> <li>– for women age 60 though 64 who are at increased risk for osteoporosis</li> </ul> </li> </ul>	Nothing
<p>Routine immunizations recommended by the Centers for Disease Control and local government public health authorities, such as:</p> <ul style="list-style-type: none"> <li>● Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>● Influenza vaccine, annually</li> <li>● Pneumococcal vaccine, age 65 and older</li> </ul>	Nothing

*Preventive care, adult – continued on next page*

<b>Preventive care, adult</b> <i>(continued)</i>	<b>You pay</b>
<ul style="list-style-type: none"> <li>● Routine physicals – one exam every 12 months</li> <li>● Routine exams limited to:               <ul style="list-style-type: none"> <li>– One routine eye exam every 12 months</li> <li>– One routine OB/GYN exam every 12 months including 1 Pap smear and related services</li> <li>– One routine hearing exam every 24 months</li> </ul> </li> </ul>	Nothing
<p><i>Not covered</i></p> <ul style="list-style-type: none"> <li>● Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel</li> <li>● Immunizations exclusively for travel</li> </ul>	<i>All charges</i>
<b>Preventive care, children</b>	
<ul style="list-style-type: none"> <li>● Childhood immunizations recommended by the American Academy of Pediatrics, the Centers for Disease Control, and local government public health authorities</li> <li>● Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> <li>● Examinations, such as:               <ul style="list-style-type: none"> <li>– Eye exams through age 17 to determine the need for vision correction</li> <li>– Hearing exams through age 17 to determine the need for hearing correction</li> </ul> </li> </ul>	Nothing
<p><i>Not covered</i></p> <ul style="list-style-type: none"> <li>● Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel</li> <li>● Immunizations exclusively for travel</li> </ul>	<i>All charges.</i>

**Section 5 Traditional Medical Coverage subject to the deductible**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider. When applicable, you must use Plan facilities. You are responsible for verifying that your provider has arranged for your surgery or hospitalization in a Plan facility. We will not pay for services provided by a non-Plan provider or facility without our prior authorization.
- Preventive care services listed in the previous section are covered at 100% (see page 63) and are not subject to the calendar year deductible.
- The deductible is \$1,100 per person or \$2,200 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total \$5,000 per person or \$10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as non-covered expenses).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION FOR SOME SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay After the calendar year deductible...
<b>Deductible before Traditional Medical Coverage begins</b>	
The deductible applies to all benefits in this section. You are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,100 per person or \$2,200 per family enrollment.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION FOR SOME SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay After the calendar year deductible...
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>● In a physician’s office</li> <li>● Office medical consultations</li> <li>● Second surgical opinion</li> </ul>	\$20 per office visit to a primary care physician \$30 per office visit to a specialist \$30 for an after-hours or urgent care visit to a primary care physician or specialist
Professional services of physicians <ul style="list-style-type: none"> <li>● In an urgent care center</li> </ul>	\$30 per visit
Injectable and intravenous (IV) therapy drugs provided in a physician’s office or in an urgent care center	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
Note: Certain injectable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see <i>Direct Source Injectables</i> in Section 5(f).  Note: We cover routine immunizations under the preventive care benefits for adults and children. We cover allergy serum under the <i>Allergy care</i> benefit.	
Professional services of physicians <ul style="list-style-type: none"> <li>● During a hospital stay</li> <li>● In a skilled nursing facility</li> </ul>	10% of Plan Allowance

<b>Lab, X-ray and other diagnostic tests</b>	<b>You pay</b>
<p>Minor diagnostic tests, such as:</p> <ul style="list-style-type: none"> <li>● Blood tests</li> <li>● Urinalysis</li> <li>● Non-routine Pap tests</li> <li>● Pathology</li> <li>● X-rays</li> <li>● Non-routine mammograms</li> <li>● Ultrasound</li> <li>● Electrocardiogram and EEG</li> </ul>	<p>Nothing in a physician’s office or at an independent lab if performed in conjunction with an office visit</p> <p>10% of Plan Allowance in a hospital or other facility</p>
<p>Major diagnostic labs and radiology tests, such as:</p> <ul style="list-style-type: none"> <li>● CAT scans, MRIs, MRAs, and electron beam scans</li> <li>● PET and SPECT scans</li> <li>● Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance</li> <li>● Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures)</li> <li>● Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes</li> <li>● Cytogenetic studies</li> </ul>	<p>10% of Plan Allowance</p>
<b>Maternity care</b>	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>● Prenatal care</li> <li>● Delivery</li> <li>● Postnatal care</li> <li>● Obstetrical care in an observation setting</li> </ul>	<p>10% of Plan Allowance</p>

*Maternity care – continued on next page*

<b>Maternity care (continued)</b>	<b>You pay</b>
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need prior authorization for normal delivery; see page 14 for other circumstances, such as extended stays for your baby.</li> <li>• 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.</li> <li>• 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. Note: For newborn circumcision, see surgery benefits in Section 5(b).</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See hospital benefits in Section 5(c) and surgery benefits in Section 5(b).</li> <li>• We cover ultrasounds and lab tests under the minor diagnostic services benefit. See <i>Lab, x-ray and other diagnostic tests</i> in this section.</li> <li>• We cover services related to complications of pregnancy the same as for any other illness.</li> </ul>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Routine sonograms to determine fetal age, size or sex</i></li> <li>• <i>Home delivery</i></li> </ul>	<p><i>All charges</i></p>
<b>Family planning</b>	
<p>A range of voluntary family planning services, such as:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See <i>Surgical procedures</i> in Section 5(b))</li> <li>• Surgically implanted contraceptives</li> <li>• Intrauterine devices (IUDs)</li> </ul>	<p>\$20 per office visit to a primary care physician            \$30 per office visit to a specialist            \$30 for an after-hours visit to a primary care physician or specialist</p>
<ul style="list-style-type: none"> <li>• Injectable contraceptive drugs (such as Depo-Provera)</li> </ul>	<p>10% of Plan Allowance for preferred drugs            20% of Plan Allowance for non-preferred drugs</p>
<p>Note: We cover oral contraceptives and diaphragms under the prescription drug benefit; see Section 5(f).</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Predictive genetic testing and/or counseling</i></li> </ul>	<p><i>All charges</i></p>

Infertility services	You Pay
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>● Artificial insemination:               <ul style="list-style-type: none"> <li>– intravaginal insemination (IVI)</li> <li>– intracervical insemination (ICI)</li> <li>– intrauterine insemination (IUI)</li> </ul> </li> </ul>	<p>50% of Plan Allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>– <i>in vitro fertilization</i></li> <li>– <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> </ul> </li> <li>● <i>Services and supplies related to ART procedures</i></li> <li>● <i>Cost of donor sperm</i></li> <li>● <i>Cost of donor egg</i></li> <li>● <i>Fertility Medications</i></li> <li>● <i>Infertility services after voluntary sterilization</i></li> </ul>	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> <li>● Testing and treatment</li> </ul>	<p>\$20 per office visit to a primary care physician            \$30 per office visit to a specialist            \$30 for an after-hours visit to a primary care physician or specialist</p>
<ul style="list-style-type: none"> <li>● Allergy serum</li> <li>● Allergy injections</li> </ul>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Provocative food testing</i></li> <li>● <i>Sublingual allergy desensitization</i></li> </ul>	<p><i>All charges</i></p>

Treatment therapies	You pay
<ul style="list-style-type: none"> <li>● Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 78.</p> <ul style="list-style-type: none"> <li>● Respiratory and inhalation therapy</li> <li>● Dialysis – hemodialysis and peritoneal dialysis</li> <li>● Growth hormone therapy (GHT)</li> <li>● Intravenous (IV)/Infusion Therapy and IV antibiotic therapy</li> </ul>	<p>\$20 per office visit to a primary care physician</p> <p>\$30 per office visit to a specialist</p> <p>\$30 for an after-hours or urgent care visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p>Note: When provided in a physician’s office or in an urgent care center, the services listed above do not include the cost of injectable and IV drugs; see below for the cost of the drugs.</p>	
<p>Note: We cover home IV infusion and antibiotic therapy administered by a home health agency under the <i>Home health services</i> benefit.</p>	
<ul style="list-style-type: none"> <li>● Injectable and IV therapy drugs provided in a physician’s office or in an urgent care center</li> </ul>	<p>10% of Plan Allowance for preferred drugs</p> <p>20% of Plan Allowance for non-preferred drugs</p>
<p>Note: We require prior authorization for certain injectable and IV therapy drugs, including some chemotherapy drugs and growth hormone. To obtain a list of injectable and IV drugs that require prior authorization, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a>.</p> <p>Note: Certain injectable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see <i>Direct Source Injectables</i> in Section 5(f).</p>	
Physical and occupational therapies	
<ul style="list-style-type: none"> <li>● 60 visits per condition per year for the services of each of the following: <ul style="list-style-type: none"> <li>– qualified physical therapists</li> <li>– occupational therapists</li> </ul> </li> </ul>	<p>\$30 per office visit</p> <p>\$30 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility</p>
<p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. We cover physical and occupational therapy under the <i>Home health services</i> benefit when provided by a home health agency as part of an authorized home treatment plan.</p>	
<ul style="list-style-type: none"> <li>● 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</li> </ul>	<p>\$30 per office visit</p> <p>\$30 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● Long-term rehabilitative therapy</li> <li>● Therapy that we determine will not significantly improve your condition</li> <li>● Exercise programs</li> </ul>	<p><i>All charges</i></p>

<b>Speech therapy</b>	<b>You pay</b>
60 visits per condition per year	\$30 per office visit \$30 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility
Note: We cover speech therapy under the <i>Home health services</i> benefit when provided by a home health agency as part of an authorized home treatment plan.	
<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>Hearing testing for children and adults in a provider’s office</li> </ul>	\$20 per office visit to a primary care physician \$30 per office visit to a specialist \$30 for an after-hours visit to a primary care physician or specialist
<ul style="list-style-type: none"> <li>Inpatient hearing examination for a newborn child covered under a family enrollment</li> </ul>	10% of Plan Allowance
<i>Not covered: Hearing aids, including testing, examinations, and fittings for them</i>	<i>All charges</i>
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>One pair of eyeglasses or contact lenses (including professional services for such fitting) to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul>	50% of Plan Allowance
<ul style="list-style-type: none"> <li>Annual eye refractions and exams performed by an optometrist</li> </ul>	\$20 per office visit; \$30 for after-hours visit
Note: See <i>Preventive care, children</i> for eye exams for children	
<ul style="list-style-type: none"> <li>Eye exams performed by an ophthalmologist</li> </ul>	\$30 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li><i>Extra charges for designer or deluxe frames</i></li> <li><i>Extra charges for progressive lenses</i></li> <li><i>Scratch resistant lens coating</i></li> <li><i>Oversize lenses, tinting, antireflective coating, and U-V lenses, unless prescribed by an ophthalmologist for eyeglasses that are necessary to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts)</i></li> <li><i>Eyeglasses or contact lenses for refractive purposes</i></li> <li><i>Eye exercises and orthoptics</i></li> <li><i>Radial keratotomy, LASIK, and other refractive surgery</i></li> </ul>	<i>All charges</i>

<b>Foot care</b>	<b>You pay</b>
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p>	<p>\$20 per office visit to a primary care physician                      \$30 per office visit to a specialist                      \$30 for an after-hours visit to a primary care physician or specialist</p>
<p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>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</i></li> <li>● <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> <li>● <i>Foot orthotics</i></li> </ul>	<p><i>All charges</i></p>
<b>Orthopedic and prosthetic devices</b>	
<ul style="list-style-type: none"> <li>● Artificial limbs and eyes</li> <li>● Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>● Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</li> </ul>	<p>50% of Plan Allowance</p>
<ul style="list-style-type: none"> <li>● Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy</li> </ul>	<p>10% of Plan Allowance</p>
<p>Note: See Sections 5(b) and 5(c) for coverage of the surgery to insert the device.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Orthopedic and corrective shoes</i></li> <li>● <i>Arch supports</i></li> <li>● <i>Foot orthotics</i></li> <li>● <i>Heel pads and heel cups</i></li> <li>● <i>Lumbosacral supports</i></li> <li>● <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices, unless medically necessary</i></li> <li>● <i>Replacement of prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's physical condition</i></li> </ul>	<p><i>All charges</i></p>

<b>Durable medical equipment (DME)</b>	<b>You pay</b>
<p>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:</p> <ul style="list-style-type: none"> <li>● Hospital beds</li> <li>● Wheelchairs</li> <li>● Crutches</li> <li>● Walkers</li> <li>● Blood glucose monitors</li> <li>● Insulin pumps</li> </ul>	<p>50% of Plan Allowance</p>
<ul style="list-style-type: none"> <li>● Oxygen concentrators</li> <li>● Medically necessary accessories and supplies such as hoses, tubes, oxygen and ostomy supplies</li> </ul>	<p>10% of Plan Allowance</p>
<p>Note: Call us at 1-800-377-4161 or 801-323-6200 as soon as your Plan physician prescribes durable medical 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.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>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.</i></li> <li>● <i>Replacement of durable medical equipment, prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's condition</i></li> </ul>	<p><i>All charges</i></p>
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>● 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</li> <li>● Services include oxygen therapy, oral medications, and injectable and intravenous (IV) therapy (this does not include the cost of injectable and IV drugs; see next page for the cost of the injectable and IV drugs)</li> <li>● Home visits made by a physician</li> <li>● Home rehabilitative therapy, including physical therapy and occupational therapy when significant improvement can be expected</li> <li>● Home speech therapy</li> <li>● Home visits by a medical social worker</li> </ul>	<p>10% of Plan Allowance</p>

*Home health services – continued on next page*

Home health services <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Injectable and IV therapy drugs</li> </ul>	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
<p>Note: Certain injectable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see <i>Direct Source Injectables</i> in Section 5(f).</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i></li> <li>• <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i></li> </ul>	<p><i>All charges</i></p>
Chiropractic	
<p>Coverage is limited to 20 visits per calendar year. Services include:</p> <ul style="list-style-type: none"> <li>• Manipulation of the spine and extremities</li> <li>• Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul>	\$20 per office visit to a primary care physician \$30 per office visit to a specialist \$30 for an after-hours visit to a primary care physician or specialist
Alternative treatments	
<p>Biofeedback therapy that we have pre-authorized for the treatment of certain conditions</p>	\$20 per office visit to a primary care physician \$30 per office visit to a specialist \$30 for an after-hours visit to a primary care physician or specialist 10% of Plan Allowance in a surgical center, hospital, or other facility
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Acupuncture</i></li> <li>• <i>Acupressure</i></li> <li>• <i>Naturopathic or homeopathic services</i></li> <li>• <i>Massage therapy</i></li> <li>• <i>Hypnotherapy</i></li> <li>• <i>Biofeedback that we have not pre-authorized</i></li> </ul>	<p><i>All charges</i></p>

Educational classes and programs	You pay
<p>Coverage is limited to classes and programs that we authorize for the care and treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> <li>• Diabetes self-management</li> <li>• Asthma management</li> <li>• Medical nutrition therapy and/or diet counseling:               <ul style="list-style-type: none"> <li>– for a member who, based on our criteria, is a candidate for surgical treatment of morbid obesity</li> <li>– for a member with a disease, illness, or injury that is treated by changing the types of foods or nutrients in the member’s diet, provided that such treatment is not intended primarily for weight loss</li> </ul> </li> </ul>	<p>\$20 per office visit to a primary care physician</p> <p>\$30 per office visit to a specialist</p> <p>10% of Plan Allowance in a hospital or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Literature such as books, journals, or subscriptions, unless included in an educational program that we approve</i></li> <li>• <i>Smoking cessation programs</i></li> <li>• <i>Medical nutrition therapy and/or diet counseling intended primarily for weight loss, unless the member meets our criteria for surgical treatment of morbid obesity</i></li> <li>• <i>Health education services that are not closely related to the care and treatment of an illness or injury</i></li> </ul>	<p><i>All charges</i></p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must use a Plan facility. It is your responsibility to verify that your physician has scheduled your surgery in a Plan facility. We will not pay for services provided by a non-Plan provider or facility without our prior authorization.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses.
- 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 FOR SURGICAL PROCEDURES.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay After the calendar year deductible...
<b>Surgical procedures</b>	
A comprehensive range of services, such as: <ul style="list-style-type: none"> <li>● Operative procedures</li> <li>● Treatment of fractures, including casting</li> <li>● Removal of tumors and cysts</li> <li>● Normal pre- and post-operative care by the surgeon</li> <li>● Endoscopy procedures</li> <li>● Biopsy procedures</li> <li>● Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>● Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>● Treatment of burns</li> <li>● Routine circumcision of a newborn</li> <li>● Insertion of internal prosthetic devices. See Section 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information</li> </ul>	\$20 per office visit to a primary care physician \$30 per office visit to a specialist \$30 for an after-hours or urgent care visit to a primary care physician or specialist 10% of Plan Allowance in a surgical center, hospital, or other facility
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.	

*Surgical procedures – continued on next page*

<b>Surgical procedures (continued)</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Injectable and intravenous (IV) drugs administered in conjunction with a surgery in a physician’s office or in an urgent care center</li> </ul>	10% of Plan Allowance
<ul style="list-style-type: none"> <li>• Surgical treatment of morbid obesity (bariatric surgery), subject to all of the following criteria:               <ul style="list-style-type: none"> <li>– the member is 18 years of age or older and has a body mass index (BMI) greater than 40, or a BMI of 35 or greater if the member has a serious comorbid condition;</li> <li>– the member has at least a three year history of chronic morbid obesity that has not responded to at least six months of a medically supervised weight loss program including diet, exercise, and behavior modification;</li> <li>– the member is a good candidate for surgery and has no medical or psychological condition that may reduce the likelihood of a successful outcome of surgery;</li> <li>– the member has successfully lost at least 5% of body weight within six months prior to surgery to demonstrate his or her ability to comply with the required postoperative diet; and</li> <li>– the member must be willing and able to commit to, and participate in, lifelong medical surveillance and follow up care as well as altered eating habits.</li> </ul> </li> </ul>	10% of Plan Allowance in a surgical center, hospital, or other facility
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<i>All charges</i>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• 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; and webbed fingers and toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance of breasts</li> <li>– treatment of any physical complications</li> <li>– breast prostheses, lymphedema pumps, surgical bras and replacements (See <i>Orthopedic and prosthetic devices</i> in Section 5(a))</li> </ul> </li> </ul>	\$20 per office visit to a primary care physician \$30 per office visit to a specialist \$30 for an after-hours or urgent care visit to a primary care physician or specialist 10% of Plan Allowance in a surgical center, hospital, or other facility
<p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	

*Reconstructive surgery – continued on next page*

<b>Reconstructive surgery (continued)</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Injectable and intravenous (IV) drugs administered in conjunction with a surgery in a physician’s office or in an urgent care center</li> </ul>	10% of Plan Allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All charges</i>
<b>Oral and maxillofacial surgery</b>	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures</li> </ul>	<p>\$20 per office visit to a primary care physician            \$30 per office visit to a specialist            \$30 for an after-hours or urgent care visit to a primary care physician or specialist            10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<ul style="list-style-type: none"> <li>• Injectable and intravenous (IV) drugs administered in conjunction with a surgery in a physician’s office or in an urgent care center</li> </ul>	10% of Plan Allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</li> </ul>	<i>All charges</i>
<b>Organ/tissue transplants</b>	
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow transplants</li> </ul>	10% of Plan Allowance in a surgical center, hospital, or other facility

*Organ/tissue transplants – continued on next page*

<b>Organ/tissue transplants (continued)</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>● 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</li> <li>● Autologous tandem transplants for testicular tumors and other germ cell tumors</li> <li>● Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>● Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute- or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</li> </ul> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● Donor screening tests and donor search expenses, except those performed for the actual donor</li> <li>● Implants of artificial organs</li> <li>● Transplants not listed as covered</li> <li>● Travel expenses, lodging, and meals</li> </ul>	<p><i>All charges</i></p>
<b>Anesthesia</b>	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>● Hospital (inpatient)</li> <li>● Hospital outpatient department</li> <li>● Skilled nursing facility</li> <li>● Ambulatory surgical center</li> </ul>	<p>10% of Plan Allowance</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>● Office</li> </ul>	<p>\$20 per office visit to a primary care physician            \$30 per office visit to a specialist            \$30 for an after-hours or urgent care visit to a primary care physician or specialist</p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. It is your responsibility to verify that your physician has arranged for your care in a Plan facility. We will not pay for services provided by a non-Plan facility without our prior authorization.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRIOR AUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.

Benefit Description	You pay After the calendar year deductible...
<b>Inpatient hospital</b>	
Room and board, such as: <ul style="list-style-type: none"> <li>● Ward, semiprivate, or intensive care accommodations</li> <li>● General nursing care</li> <li>● Meals and special diets</li> </ul>	10% of Plan Allowance
Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	

*Inpatient hospital – continued on next page*

<b>Inpatient hospital (continued)</b>	<b>You pay</b>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul>	<p>10% of Plan Allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Non-covered facilities, such as nursing homes, long-term care facilities schools</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> <li>• <i>Private nursing care</i></li> </ul>	<p><i>All charges</i></p>
<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics</li> </ul>	<p>10% of Plan Allowance</p>
<p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	
<p><i>Not covered: Personal comfort items</i></p>	<p><i>All charges</i></p>

<b>Extended care benefits/Skilled nursing care facility benefits</b>	<b>You pay</b>
<p>Skilled nursing facility (SNF) /Extended care benefits: 30 days per member per calendar year</p> <ul style="list-style-type: none"> <li>• Professional services – physicians and general nursing care</li> <li>• Medical supplies and medications</li> <li>• Medical equipment ordinarily provided by a skilled nursing facility</li> <li>• Room and board</li> </ul>	<p>10% of Plan Allowance</p>
<p><i>Not covered: Custodial care, personal, comfort or convenience items</i></p>	<p><i>All charges</i></p>
<b>Hospice care</b>	
<ul style="list-style-type: none"> <li>• Services for pain and symptom management</li> <li>• Short-term inpatient care and procedures necessary for pain control</li> <li>• Respite care may be provided only on an occasional basis and may not be provided longer than five days</li> <li>• Home visits made by a physician, nurse, home health aide, social worker or therapist with no limit on number of visits</li> <li>• General medical equipment and supplies related to the terminal illness</li> </ul>	<p>10% of Plan Allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Independent nursing</i></li> <li>• <i>Homemaker services</i></li> <li>• <i>Specialized, customized equipment</i></li> </ul>	<p><i>All charges</i></p>
<b>Ambulance</b>	
<p>Local professional ambulance service when medically appropriate</p>	<p>10% of Plan Allowance</p>
<p><i>Not covered: Medical transportation for the convenience of you or your family</i></p>	<p><i>All charges</i></p>

**Section 5(d) Emergency services/accidents**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses.
- 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.

**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 Plan provider in an emergency so that he or she can be involved in your care. Please contact your Plan provider 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 Plan provider will work together with us to transfer you to a Plan facility.

An urgent medical problem is one in which your life is not in danger, but you require prompt medical attention. If you need urgent care, contact a Plan provider (your primary care provider if you have one) and follow his or her instructions. If you are not able to contact a Plan provider, you may go to any Plan urgent care facility. Please refer to your Altius Participating Provider Listing. After you receive urgent care, contact a Plan provider as soon as you can. A Plan provider will coordinate any follow-up care you need. If you have any questions about emergency or urgent care, or about Plan providers, please call us at 801-323-6200 or 1-800-377-4161. For a current list of Plan providers and Plan urgent care facilities, you may also visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com).

● **Emergencies outside our service area:**

If you have an emergency or you need urgent care while outside of our service area, 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 Plan provider 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 services/accidents benefits begin on the next page*

Benefit Description	You pay After the calendar year deductible...
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a doctor’s office</li> <li>• Emergency care at an urgent care center</li> </ul>	\$30 copayment per office visit
<ul style="list-style-type: none"> <li>• Injectable and intravenous (IV) therapy drugs provided in a physician’s office or in an urgent care center</li> </ul>	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
<ul style="list-style-type: none"> <li>• Emergency care as an outpatient at a hospital, including doctors’ services</li> </ul>	\$100 copayment per visit
Note: Inpatient facility benefits apply if you are admitted to the hospital; see <i>Inpatient hospital</i> in Section 5(c).	
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care in a hospital emergency room</i></li> <li>• <i>Follow-up care in a hospital emergency room, unless we have given prior authorization</i></li> </ul>	<i>All charges</i>
<b>Emergency outside our service area</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a doctor’s office</li> <li>• Emergency care at an urgent care center</li> </ul>	\$30 copayment per office visit
<ul style="list-style-type: none"> <li>• Injectable and intravenous (IV) therapy drugs provided in a physician’s office or in an urgent care center</li> </ul>	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
<ul style="list-style-type: none"> <li>• Emergency care as an outpatient at a hospital, including doctors’ services</li> </ul>	\$200 copayment per visit
Note: Inpatient facility benefits apply if you are admitted to the hospital; see <i>Inpatient hospital</i> in Section 5(c).	
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care</i></li> <li>• <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>

<b>Ambulance</b>	
Professional ground ambulance, air ambulance, and/or paramedic services when medically appropriate.	10% of Plan Allowance
Note: See 5(c) for non-emergency service.	
<i>Not covered:</i> <ul style="list-style-type: none"><li>• <i>Medical transportation for the convenience of you or your family</i></li><li>• <i>Death-related transportation</i></li></ul>	<i>All charges</i>

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

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
<b>Mental health and substance abuse benefits</b>	
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: 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 other illnesses or conditions.
● Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers on an outpatient basis	\$30 per visit
● Intensive outpatient treatment	10% of Plan Allowance
● Diagnostic tests ● Medication management	\$20 per office visit to a primary care physician \$30 per office visit to a specialist
● Services provided by a hospital or other facility on an inpatient basis (room and board), including partial hospitalization ● Professional services by providers such as psychiatrists, psychologists, or clinical social workers provided on an inpatient basis	10% of Plan Allowance
<i>Not covered: Services we have not approved</i>	<i>All charges</i>
<i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i>	

*Mental health and substance abuse benefits – continued on next page*

---

**Mental health and substance abuse benefits** *(continued)*

---

**Prior authorization**

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

You must contact Mental Health Network (MHNet) 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.

---

**Limitation**

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

---

## Section 5(f) Prescription drug benefits

### Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 91.
- 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.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts or copayments for eligible prescriptions.
- 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.
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR CERTAIN DRUGS.**

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

- **Who can write your prescription.** A licensed practitioner who has the legal authority to prescribe medications.
- **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 page 91 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.
  - Through a Direct Source vendor: Certain injectable and intravenous (IV) therapy drugs, including those that are administered by a medical professional, that are covered only when they are purchased through designated pharmacy vendors. See *Direct Source Injectables* on page 90.
- **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 nearly 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, or visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com). The Preferred Drug List is subject to review and modification on a quarterly basis.
- We also cover non-preferred (non-formulary) drugs prescribed by your Plan physician. However, we encourage you to use preferred drugs, especially preferred generics, whenever possible because they will cost you less. Refer to your Preferred Drug List, and check with your physician or pharmacist to find out if a preferred generic is available, or if a lower-cost alternative might work for you.
- **Prior Authorization.** We require prior authorization for certain drugs. We also require prior authorization for injectable medications, including certain drugs used for intravenous (IV) therapy and chemotherapy. To obtain a list of drugs that require prior authorization, or to obtain a list of injectable medications that require prior authorization, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com). The prior authorization drug list is reviewed by our Pharmacy and Therapeutics Committee and may change from time to time due to new drugs, new

generics, new therapies, new guidelines from the Food and Drug Administration (FDA), or other factors.

To request prior authorization, you or your physician may contact our Prior Authorization Department at 801-323-6440 or 1-800-879-0234. We will work with your physician to obtain the information we need to process the request. We will communicate our approval or denial to your physician. You may also contact our Customer Service Department for a status of your request.

- **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.
- Some medications have specific limits on how much of the medication you can get with each prescription or refill. This is to ensure that you receive the recommended and proper dose and length of drug therapy for your condition. Quantity level limits are reviewed by the Pharmacy and Therapeutics Committee and are based on maximum dosage levels indicated by the drug manufacturer and the FDA. **Your physician must get authorization for any amount of your prescription that exceeds the quantity level limit.** If we authorize the extra amount, you may be required to pay an additional copayment.
- Certain covered medications and pharmaceutical products are manufactured, packaged, or used in such a way that one dose provides greater than a 30-day supply of medication. These may require one copayment for each month of the anticipated duration of the medication. For example, if one dose or single use of the medication or product is expected to last for two months, you will pay two copayments.
- **Prescription Mail Services:** You can get a 90-day supply of maintenance medications through the Express Scripts (ESI) mail order service. A maintenance medication is a prescription that is recommended by the FDA or us to be taken on a regular basis. Examples include, but are not limited to, medications for blood pressure, asthma, antidepressants, diabetes, hormone replacement and birth control. Insulin (in vials only) and Symlin are the only injectable medications available through the ESI mail order service. Non-maintenance medications are not available through the ESI mail order service. 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.
- The amount of medication dispensed to you should last for a specific time period as prescribed by your physician. At least 75% of that time must pass before you can get a refill, either at a pharmacy or, when applicable, through the mail. For example: if your prescription provides a 30-day supply, you can refill your prescription no sooner than 23 days after the prescription was filled ( $30 \text{ days} \times 75\% = 23 \text{ days}$ ).
- If you receive a brand-name drug when a preferred generic equivalent can be substituted, and your physician has not specified “Dispense as Written” (DAW) for the brand-name drug, you will pay the generic copayment plus the difference in cost between the brand-name drug and the generic. For mail-order drugs, Express Scripts may fill your prescription with a preferred generic equivalent if it is available, unless your physician has indicated “Dispense as Written” (DAW). If a preferred generic equivalent is not available, or if your physician specifically indicates “Dispense as Written” (DAW), you will pay the applicable preferred brand-name or non-preferred (non-formulary) copayment. Note: If your physician writes a prescription for a non-preferred (non-formulary) generic, you may ask your pharmacist for an equivalent preferred brand-name drug.
- If your physician prescribes a medication that needs to be dispensed in two different strengths or dosage forms, you will be responsible for the appropriate copayment for each dispensed prescription.
- When a new generic medication is approved by the FDA, our Pharmacy and Therapeutics Committee may classify it as “non-preferred” (non-formulary). Non-preferred generics are subject to the non-preferred copayment listed in this section. Note: If your physician writes a prescription for a non-preferred generic, you may ask your pharmacist for an equivalent preferred brand-name drug.

- **Why use preferred generic drugs?** Preferred 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 preferred 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.

- **Preferred Injectables.** Similar to other prescription drugs, injectable and intravenous (IV) therapy drugs are categorized as

---

“preferred” or “non-preferred” by our Pharmacy and Therapeutics Committee. If your injectable or IV medication is not listed on our Preferred Drug List, call our Customer Service Department at 1-800-377-4161 or 801-323-6200 to find out if it is covered and whether it is preferred or non-preferred.

- **Direct Source Injectables.** Direct source injectables are certain injectable and intravenous (IV) therapy drugs, including those that are administered by a medical professional, that are covered only when they are purchased through designated pharmacy vendors. We have selected vendors who provide these drugs at the lowest cost, which may help lower your out-of-pocket expenses. To obtain a current list of direct source injectable and IV drugs and designated vendors, please visit our Web site at [www.AltiusHealthPlans.com](http://www.AltiusHealthPlans.com) or call our Customer Service Department. This list may be changed periodically.

If your physician orders a direct source injectable or IV drug for you, the medication can be shipped either to your physician’s office or directly to your home. You are responsible to pay your coinsurance to the pharmacy vendor.

In many cases, your physician may write a prescription for your injectable or IV therapy drug rather than order it for you. When you obtain a prescription for an injectable or IV therapy drug, call our Customer Service Department or visit our Web site to see if you must order it through a designated vendor.

Most of the injectable and IV therapy drugs that must be purchased through a designated vendor are available through CuraScript Pharmacy. CuraScript will ship your injectable or IV therapy drug and supplies directly to your home or physician’s office within 48 hours of ordering. The supplies for administering your medication will be included without cost to you.

In addition, CuraScript offers toll-free, 24-hour customer service, 365 days a year. Support services for you, your caregivers, and your physicians are offered by a trained staff of nurses and pharmacists who can answer questions about your medications and diseases that they treat.

To find out how to order from CuraScript Pharmacy, please call 1-800-278-0980.

---

*Prescription drug benefits begin on the next page*

Benefit Description	You pay After the calendar year deductible...
<b>Covered medications and supplies</b>	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Contraceptive drugs</li> </ul>	<p><b>Preferred generic:</b> \$10 at a Plan pharmacy \$30 for mail order</p> <p><b>Preferred brand name:</b> \$25 at a Plan pharmacy \$75 for mail order</p> <p><b>Non-preferred (non-formulary):</b> \$50 at a Plan pharmacy \$150 for mail order</p> <p>Notes:</p> <ul style="list-style-type: none"> <li>• If there is no preferred generic equivalent available, you will still have to pay the applicable preferred brand-name or non-preferred copay.</li> <li>• If the Plan Allowance for the prescription is less than the copay, you will pay the Plan Allowance.</li> </ul>
<ul style="list-style-type: none"> <li>• Insulin, Symlin, insulin syringes, needles, glucose test strips and lancets</li> </ul>	<p><b>Preferred:</b> \$25 at a Plan pharmacy \$75 for mail order</p> <p><b>Non-preferred (non-formulary):</b> \$50 at a Plan pharmacy \$150 for mail order</p>
<ul style="list-style-type: none"> <li>• Injectable Imitrex, glucagon, insulin pens, Lovenox, and epinephrine kits such as Epi-Pen</li> </ul>	<p>\$25 at a Plan pharmacy (not available through mail order)</p>
<ul style="list-style-type: none"> <li>• Injectable medications (other than Insulin, Imitrex, glucagon, Lovenox, and epinephrine kits) and intravenous (IV) therapy drugs obtained through a Plan pharmacy or a Direct Source pharmacy vendor</li> </ul>	<p><b>Preferred:</b> 10% of Plan Allowance</p> <p><b>Non-preferred (non-formulary):</b> 20% of Plan Allowance</p> <p>(These drugs are not available through the ESI mail order service.)</p>
<ul style="list-style-type: none"> <li>• Disposable needles and syringes needed for injecting covered prescription drugs (other than insulin), when filled as a separate prescription</li> </ul>	<p>\$50 at a Plan pharmacy (not available through mail order)</p>
<ul style="list-style-type: none"> <li>• Drugs to treat sexual dysfunction, limited to 6 pills per month</li> </ul>	<p>50% of Plan Allowance at a Plan pharmacy</p>
<ul style="list-style-type: none"> <li>• Spacers (such as Aerochamber), limited to one per calendar year</li> </ul>	<p><b>Preferred:</b> \$10 at a Plan pharmacy</p> <p><b>Non-preferred (non-formulary):</b> \$50 at a Plan pharmacy</p>

*Covered medications and supplies – continued on next page*

Covered medications and supplies <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>● Diaphragms, limited to one every three months</li> </ul>	<p><b>Preferred:</b> \$25 at a Plan pharmacy</p> <p><b>Non-preferred (non-formulary):</b> \$50 at a Plan pharmacy</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Nonprescription medications, except those specifically listed in the Altius formulary</i></li> <li>● <i>Drugs obtained at a non-Plan pharmacy, except for out-of-the-area emergencies</i></li> <li>● <i>Medical supplies, such as dressing and antiseptics</i></li> <li>● <i>Experimental medications</i></li> <li>● <i>Fertility medications</i></li> <li>● <i>Disposable needles and syringes not required for injecting covered prescribed medication</i></li> <li>● <i>Natural progesterone (including suppositories and creams)</i></li> <li>● <i>Smoking cessation products and medications prescribed for smoking cessation</i></li> <li>● <i>Skin patches for motion sickness</i></li> <li>● <i>Medications or nutritional supplements for weight loss</i></li> <li>● <i>Medications or nutritional supplements for weight gain for non-medical indications</i></li> <li>● <i>Immunizations and medications required exclusively for foreign travel</i></li> <li>● <i>Hair growth products</i></li> <li>● <i>Medications for cosmetic indications</i></li> <li>● <i>Medications to enhance athletic performance</i></li> <li>● <i>Medications for the treatment of nail fungus</i></li> </ul>	<p><i>All charges</i></p>

**Section 5(g) Special features**

Feature	Description
<p><b>Flexible benefits option</b></p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>● We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>● Alternative benefits are subject to our ongoing review.</li> <li>● By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>● The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> <li>● Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<p><b>Services for deaf, hard of hearing, and non-English speaking members</b></p>	<p>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.</p> <p>When interpreter services are needed in the provider’s office, contact the provider’s office directly.</p>
<p><b>High risk pregnancies</b></p>	<p>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 Altius Baby Care prenatal case manager. A prenatal case 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.</p>
<p><b>Travel benefit/services overseas</b></p>	<p>Services outside of our service area are limited to emergency and urgent care only. See Section 5(d) for <i>Emergency services/accidents</i>.</p>

**Section 5(h) Dental benefits**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
<b>Accidental injury benefit</b>	
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.	\$20 per office visit to a primary care physician \$30 per office visit to a specialist \$30 for an after-hours or urgent care visit to a primary care physician or specialist 10% of Plan Allowance in a surgical center, hospital, or other facility
<i>Not covered: Implants</i>	<i>All charges</i>

**Dental benefits**

We have no other dental benefits.

**Section 5(i) Health education resources and account management tools**

Special features	Description
<p><b>Health education resources</b></p>	<p>For information to help you take command of your health, visit the Health Information section of our Web site at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a>. This section is organized in simple, user-friendly sections:</p> <ul style="list-style-type: none"> <li>– <b>About Your Health</b> – for information about a specific condition or general preventive guidelines.</li> <li>– <b>Patient Safety</b></li> <li>– <b>WebMD</b> – our link to this health site also provides wellness and disease information to help improve health.</li> </ul> <p><b>Prescription Drug</b> educational materials are also accessible through our Web site. A link to our pharmacy benefit manager, Express Scripts, Inc. (ESI), will take you to the following information:</p> <ul style="list-style-type: none"> <li>– Detailed information about a wide range of prescription drugs</li> <li>– A drug interaction tool to help you easily determine if a specific drug can interact adversely with another prescription drug, with over-the-counter drugs, or with herbs and vitamins</li> <li>– Facts about why FDA-approved generic drugs should be a first choice for effective, economical treatment</li> </ul> <p>We also publish newsletters to keep you informed on a variety of issues related to your good health. Visit our Web site at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a> for back editions of these publications, <i>Living Well</i> and <i>Healthy Outlook</i>.</p> <p>In addition, we augment our health education tools with access to our <b>Nurse Advisor Services</b>. Experienced RNs are available 24x7x365 to assist you at 1-888-662-2297.</p>
<p><b>Account management tools</b></p>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through our password-protected, self-service functionality, <b>My Online Services</b>, at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a>.</p> <p>You will receive an Explanation of Benefits (EOB) after every claim.</p> <p>If you have an <b>HSA</b>,</p> <ul style="list-style-type: none"> <li>– You will receive a quarterly statement from Corporate Benefit Services of America (CBSA) outlining your account balance and activity.</li> <li>– You may also access your account on-line through <b>My Online Services</b> at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a>.</li> </ul> <p>If you have an <b>HRA</b>,</p> <ul style="list-style-type: none"> <li>– You will receive a quarterly statement from Corporate Benefit Services of America (CBSA) outlining your account balance and activity.</li> <li>– You may also access your account online through <b>My Online Services</b> at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a>.</li> </ul>
<p><b>Consumer choice information</b></p>	<p>As a member of this HDHP, you must use Plan providers for all of your care except emergency and out-of-area urgent care. Our provider search function on our Web site, <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a>, is updated every week. It lets you easily search for a participating physician based on the criteria you choose, such as provider specialty, gender, secondary languages spoken, or hospital affiliation. You can even specify the maximum distance you're willing to travel and, in most instances, get driving directions and a map to</p>

	<p>the offices of identified providers.</p> <p>Pricing information for medical care is available at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a>. There, you will find our <b>Health Services Pricing Tools</b>, or Average Unit Cost Comparison, which provides average cost information for some of the most common categories of service. The easy-to-understand information is sorted by categories of service, including physician office visits, diagnostic tests, surgical procedures, and hospitalization.</p> <p>Pricing information for prescription drugs is available through our link to the Web site of our pharmacy benefit manager, ESI, which you can access through <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a>. Through a password-protected account, you will have the ability to estimate prescription costs before ordering.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a> &gt;&gt;Altius FlexChoice.</p>
<p><b>Care support</b></p>	<p>Patient safety information is available online at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a> &gt;&gt; Health Information.</p> <p>Our complex case management programs offer special assistance to members with intricate, long-term medical needs. Our disease management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arrange for participation in these programs, or you can simply contact our Customer Service Department at 1-800-377-4161 or 801-323-6200.</p> <p>We'll send a message to the e-mail address you provide on a scheduled basis, reminding you to arrange for screening tests. This service is available at <a href="http://www.AltiusHealthPlans.com">www.AltiusHealthPlans.com</a> &gt;&gt; Health Information &gt;&gt; Wellness Reminders.</p>

---

## Non-FEHB benefits available to Plan members

---

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection 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](http://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 Web site. 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.
- **My ePHIT:** This online health and fitness tool now has a component for teens and children so the entire family can plan and carry out a health and wellness program specific to their needs.
- **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.
- **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.
- **AltiusExtra Discount Dental:** Altius high deductible plan members can receive 20 to 40% off their dental care. This is not dental insurance. No forms. No hoops to jump through. Just make an appointment and save when you receive services from a participating dentist. See the AltiusExtra Discount Dental brochure for fees and dentists.
- **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.
- **Safe Beginnings:** Enhancing the safety and health of your child just got easier! Safe Beginnings lets you shop online or through their mail order catalog and receive a 20% discount on child safety products.
- **Day Spas:** You’ll enjoy a tranquil world that leaves you fantastically refreshed, rejuvenated, pampered, and revitalized at one of our participating day spas. Savings and services vary at each location.
- **Sunglasses:** Sunglasses provide the protection you need from bright sun and glare as well as complete UV protection from harmful rays. Protect your family’s eyes with non-prescription sunglasses from our participating providers and receive up to 25% off retail prices.

We continually expand our value-added benefit program throughout the year. Visit our Web site at [www.AltiusHealthPlans.com](http://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 13.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals (see Section 3) or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- 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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

---

## Section 7 Filing a claim for covered services

---

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

### **Medical and hospital benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 801-323-6200 or 1-800-377-4161.

When you must file a claim – such as for services you receive outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

#### **Submit your claims to:**

Altius Health Plans  
Claims Department  
P.O. Box 7147  
London, KY 40742

### **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

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. Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within six months from the date of our decision; and</li><li>Send your request to us at: Altius Health Plans, Appeals Department, 10421 South Jordan Gateway, Suite 400, South Jordan, UT 84095; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>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.</li></ol>
<b>3</b>	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"><li>A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li><li>Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li><li>Copies of all letters you sent to us about the claim;</li><li>Copies of all letters we sent to you about the claim; and</li><li>Your daytime phone number and the best time to call.</li></ul>

*Disputed claims process – continued on next page*

## The disputed claims process (*continued*)

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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

### 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.

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, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 2 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 or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

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

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

When we are the secondary payer to another health insurance plan, we will pay the copayments, coinsurance, and/or deductibles that the primary plan shows that you owe for covered services, up to our regular benefit. We will not pay more than our allowance. We will not pay for any service that is not a covered Plan benefit.

When the primary carrier (not Medicare) applies the claim to your deductible, we will consider the claim according to your Plan benefits and pay as primary. You will be responsible for the copayments and coinsurance for the services that have been rendered.

For Plan benefits that have a limited number of days or visits (such as skilled nursing facility care, physical therapy, or chiropractic), we will count a day or visit if we pay a benefit amount on the applicable service.

However, when we coordinate benefits with automobile “no fault” coverage, we will reduce our payment by the minimum personal injury protection coverage required by State law, or the actual amount of coverage you have, whichever is greater. We will not pay more than our allowance. You still need to use Plan providers and follow all prior authorization rules of this Plan. In this case, we do not waive the copayments and coinsurance you have under this Plan.

### What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage plans in this section.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information

regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan provider, or prior authorized by us as required.

**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 claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 801-323-6200 or 1-800-377-4161.
- If your Plan provider does not participate in Medicare, you will have to file a claim with Medicare.

**We waive some costs if the Original Medicare Plan is your 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 and coinsurances you have under this Plan. However, if Medicare denies coverage for a service or supply, we will not waive the copayment or coinsurance for that service or supply.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

If you enroll in a Medicare Advantage plan, the following options are available to you:

**This Plan and another plan's Medicare Advantage plan:** You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

**Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

### Primary Payer Chart

A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and ... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>	✓	

\* Workers' Compensation is primary for claims related to your condition under Workers' Compensation

## **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

**Suspended FEHB coverage to enroll in TRICARE or CHAMPVA:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

## **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.

**Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

## **When other Government agencies are responsible for your care**

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

## **When others are responsible for injuries**

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

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

---

## Section 10 Definitions of terms we use in this brochure

---

<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. See page 15.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Care provided for personal needs, personal hygiene, or for assistance in daily activities that can, according to generally accepted medical standards, be performed by non-licensed persons who have no medical training. Custodial care that lasts 90 days or more is sometimes known as Long term care.
<b>Experimental or investigational services</b>	<p>A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.</p> <p>A drug, device, or biological product or medical treatment or procedure is experimental or investigational if:</p> <ol style="list-style-type: none"><li>1. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or</li><li>2. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.</li></ol> <p>Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product, or medical treatment or procedure.</p> <p>FDA-approved drugs, devices, or biological products used for their intended purposes and labeled indications and those that have received FDA approval subject to postmarketing approval clinical trials, and devices classified by the FDA as “Category B Non-experimental/investigational Devices” are not considered experimental or investigational when used for the intended purposes and labeled indications as approved by FDA, provided those purposes and indications would otherwise be eligible for Plan benefits.</p>
<b>Hospital</b>	A facility that is legally licensed as a general hospital or a specialty hospital.

<b>Medical necessity</b>	<p>We determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:</p> <ol style="list-style-type: none"> <li>1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury;</li> <li>2. Consistent with standards of good medical practice in the United States;</li> <li>3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider;</li> <li>4. Not part of or associated with scholastic education or vocational training of the patient; and</li> </ol> <p>In the case of inpatient care, cannot be provided safely on an outpatient basis.</p> <p>The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.</p>
<b>Plan allowance</b>	<p>Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. 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 you.</p> <p>With respect to Plan Providers and Facilities, this amount is based on the applicable contractual payment schedule (fee schedule) negotiated with the Provider or facility. Plan Providers and Facilities accept the Plan allowance as payment in full.</p>
<b>Provider</b>	<p>Any person, organization, health facility or institution legally licensed to deliver or furnish health care services.</p>
<b>Skilled nursing facility</b>	<p>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.</p>
<b>Urgent medical problems</b>	<p>Those problems resulting from an unforeseen illness or injury that do not place life in jeopardy, but require prompt treatment.</p>
<b>Us/We</b>	<p>Us and We refer to Altius Health Plans.</p>
<b>You</b>	<p>You refers to the enrollee and each covered family member.</p>

---

## High Deductible Health Plan (HDHP) Definitions

---

<b>Deductible</b>	<p>A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.</p>
<b>Health Reimbursement Arrangement (HRA)</b>	<p>A health reimbursement arrangement (HRA) is an employer-funded account that is set up to reimburse qualified medical expenses incurred by you and your dependents (including your spouse) who are enrolled in your employer-sponsored plan, up to a maximum dollar amount for a coverage period. The HRA is not portable if you leave the Federal government or switch to another plan. See the chart beginning on page 57.</p>
<b>Health Savings Account (HSA)</b>	<p>A health savings account (HSA) is a trust or custodial account that is set up with a qualified trustee to pay or reimburse certain medical expenses incurred by you, your spouse, and dependents you may claim for tax purposes (even if they are not enrolled in your health plan). You must be enrolled in a high deductible health plan (HDHP) and meet certain other eligibility requirements to qualify for an HSA. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan. See the chart beginning on page 57.</p>

---

## Section 11 FEHB Facts

---

### Coverage information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

See [www.opm.gov/insure/health](http://www.opm.gov/insure/health) for enrollment as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next Open Season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when 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.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the

FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2005 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

### **When you lose benefits**

- **When FEHB coverage ends**

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

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

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

- **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. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be

eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, [www.opm.gov/insure](http://www.opm.gov/insure).

- **Temporary Continuation of Coverage (TCC)**

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

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

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal 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](http://www.opm.gov/insure). It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

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

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

---

## Section 12 Two Federal Programs complement FEHB benefits

---

### Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### • What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. Note: The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. Note: The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

#### Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. Note: The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

#### • Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled for 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

**What is SHPS?**

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

**Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDS accounts. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

**• How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005, until March 15, 2006, to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006. The [FSAFEDS Calculator](http://www.FSAFEDS.com) at [www.FSAFEDS.com](http://www.FSAFEDS.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

**• What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 15 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out-of-pocket expenses include:

- Copayments
- Coinsurance
- Deductibles (HDHP Option)
- Eyeglasses and contact lenses
- Orthodontics (braces)
- Vision correction surgery

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note: While you will see insurance premiums listed**

**in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at [www.irs.gov/pub/irs-pdf/p502.pdf](http://www.irs.gov/pub/irs-pdf/p502.pdf). The FSAFEDS Web site also has a comprehensive list of eligible expenses at [www.FSAFEDS.com/fsafeds/eligibleexpenses.asp](http://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp). If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions

● **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

<b>Annual Tax Savings Example</b>	<b>With FSA</b>	<b>Without FSA</b>
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
<b>Your tax savings:</b>	<b>\$576</b>	<b>-\$0-</b>

**Note:** This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

● **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

**Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

**Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your

situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.FSAFEDS.com](http://www.FSAFEDS.com), or contact SHPS directly via e-mail or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: [FSAFEDS@shps.net](mailto:FSAFEDS@shps.net)
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

## The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an Open Season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

---

## Index

---

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

- Accidental injury**.....25, 32, 47, 71, 78  
Allergy tests .....23, 69  
Allogeneic (donor) bone marrow transplant.....32, 78  
Alternative treatments .....28, 74  
Ambulance .....34, 36, 38, 80, 82, 85  
Anesthesia.....5, 30  
Autologous bone marrow transplant .....24, 33, 70, 79  
**Biopsy** .....30, 76  
Blood and blood plasma.....35, 81  
**Casts** .....34, 35, 81  
Catastrophic protection out-of-pocket maximum .....15, 97, 120, 121  
Changes for 2006 .....9  
Chemotherapy .....24, 70  
Chiropractic .....28, 74  
Cholesterol tests .....20, 63  
Circumcision.....22, 68  
Claims .....17, 99, 101, 111, 114  
Coinsurance ...6, 15, 99, 105, 108, 114  
Colorectal cancer screening .....20, 63  
Congenital anomalies.....30, 31, 76, 77  
Contraceptive drugs and devices.....22, 44, 68, 91  
Covered charges.....104  
Crutches .....27, 73  
**Deductible**.....6, 15, 65, 97, 105  
Definitions .....108  
Dental care .....47, 94, 120, 121  
Diagnostic services .19, 34, 39, 66, 81, 120, 121  
Disputed claims review .....46, 93  
Donor expenses .....33, 79  
Dressings.....34, 81  
Durable medical equipment .....27, 73  
**Effective date of enrollment** .....12  
Emergency ...6, 37, 38, 83, 84, 98, 99, 120, 121  
Experimental or investigational .....98  
Eyeglasses.....25, 71  
**Family planning** .....22, 68  
Fraud.....2, 3, 4  
**General exclusions** .....98  
General Exclusions .....17  
**Hearing services** .....25, 71  
Home health services.....27, 73  
Hospice care .....36, 82  
Hospital. 4, 5, 6, 12, 19, 27, 30, 31, 33, 34, 35, 38, 39, 47, 66, 73, 76, 77, 79, 80, 81, 84, 86, 94, 99, 104, 107, 120, 121  
**Immunizations** .....6, 21, 63  
Infertility .....15, 23, 69  
Injectable and IV therapy drugs 19, 23, 24, 28, 30, 31, 32, 37, 38, 41, 44, 66, 68, 70, 74, 77, 78, 84, 88, 91  
Inpatient hospital benefits.....99  
Insulin .....44, 91  
**Magnetic Resonance Imagings (MRIs)**.....20, 67  
Mammograms .....20, 67  
Maternity benefits .....22, 68  
Medicaid .....107  
Medically necessary 19, 22, 30, 34, 37, 39, 47, 66, 68, 76, 80, 83, 86, 88, 94, 98  
Medicare .....86, 103, 106  
    Original .....104  
Members  
    Associate .....122  
    Family .....15, 110  
Mental Health/Substance Abuse  
    Benefits .....39, 86  
**Newborn care** .....22, 68  
Non-FEHB benefits .....97  
Nurse  
    Licensed Practical Nurse (LPN)..27, 73  
**Occupational therapy** .....24, 70  
Ocular injury.....13, 25, 71  
Office visits.....6, 15  
Oral and maxillofacial surgical..32, 78  
Out-of-pocket expenses .....104, 114  
Oxygen .....27, 34, 35, 73, 81  
**Pap test** .....20, 63, 67  
Physician .....27, 30, 73, 76  
Precertification .....102  
Prescription drugs .....99, 120, 121  
Preventive care, adult .....20, 21, 63  
Preventive care, children .....21, 64  
Preventive services .....6  
Prior approval .....101, 102  
Prosthetic devices .....26, 72  
Psychologist.....39, 86  
**Radiation therapy** .....24, 70  
Room and board .....34, 80  
**Second surgical opinion** .....19, 66  
Skilled nursing facility care 19, 33, 36, 66, 79, 82  
Social worker .....39, 86  
Speech therapy .....25, 71  
Splints.....34, 81  
Subrogation .....107  
Substance abuse.....120, 121  
Surgery ...5, 13, 22, 24, 25, 26, 68, 70, 71, 72  
    Anesthesia.....35, 81  
    Oral .....32, 78  
    Outpatient .....35, 81  
    Reconstructive .....30, 31, 76, 77  
Syringes .....44, 91  
**Temporary Continuation of Coverage (TCC)** .....111  
Transplants .....24, 33, 70, 79  
Treatment therapies .....24, 70  
**Vision care** .....120, 121  
Vision services .....13, 25, 71  
**Wheelchairs** .....27, 73  
Workers Compensation .....107  
**X-rays** .....20, 34, 35, 67, 81

## **NOTES:**

## Summary of benefits for the High Option of Altius Health Plans - 2006

- **Do not rely on this chart alone.** All benefits 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
<b>Medical services provided by physicians:</b>		
• Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$15 specialist; \$20 for after-hours or urgent care	19
• In a hospital, surgical center, or other facility	10%	19, 30-33
<b>Services provided by a hospital:</b>		
• Inpatient	Nothing	34-35
• Outpatient	Nothing	35
<b>Emergency benefits:</b>		
• In-area	\$50 for emergency room services	37
• Out-of-area	\$100 for emergency room services	38
<b>Mental health and substance abuse treatment</b>		
	Regular cost sharing	39-40
<b>Prescription drugs:</b>		
• Retail pharmacy	30-day supply – \$10 preferred generic; \$20 preferred brand name; \$40 non-preferred	44
• Mail order	90-day supply – \$20 preferred generic; \$40 preferred brand name; \$80 non-preferred	44
• Injectable and intravenous (IV) therapy drugs	10% preferred; 20% non-preferred	Throughout Section 5
<b>Dental care</b>		
	See schedule of Dental Benefits	47-51
<b>Vision care</b>		
	Annual eye examinations and refractions performed by an optometrist – \$10 per office visit; \$20 for an after-hours visit Eye examinations and refractions performed by an ophthalmologist – \$15 per office visit; \$20 for after-hours or urgent care	21, 25
<b>Special features:</b> Flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies; travel benefit/ services overseas		
		46
<b>Protection against catastrophic costs (out-of-pocket maximum)</b>		
	Nothing after \$2,000/individual or \$4,000/family per year Some costs do not count toward this protection	15

## Summary of benefits for the HDHP of Altius Health Plans - 2006

- **Do not rely on this chart alone.** All benefits 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.
- In 2006, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$60 per month for Self Only enrollment or \$120 per month for Self and Family enrollment. For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$720 for Self Only and \$1,440 for Self and Family.
- All covered services listed below, except specified preventive care services, are subject to the calendar year deductible of \$1,100 for Self Only and \$2,200 for Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

Benefits	You pay (after deductible)	Page
<b>Medical preventive care</b> (specified services only)	Nothing (not subject to deductible)	63-64
<b>Medical services provided by physicians:</b>		
● Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$30 specialist; \$30 for after-hours or urgent care	66
● In a hospital, surgical center, or other facility	10%	66, 76-79
<b>Services provided by a hospital:</b>		
● Inpatient	10%	80-81
● Outpatient	10%	81
<b>Emergency benefits:</b>		
● In-area	\$100 for emergency room services	84
● Out-of-area	\$200 for emergency room services	84
<b>Mental health and substance abuse treatment</b>	Regular cost sharing	86-87
<b>Prescription drugs:</b>		
● Retail pharmacy	30-day supply – \$10 preferred generic; \$25 preferred brand name; \$50 non-preferred	91
● Mail order	90-day supply – \$30 preferred generic; \$75 preferred brand name; \$150 non-preferred	91
● Injectable and intravenous (IV) therapy drugs	10% preferred; 20% non-preferred	Throughout Section 5
<b>Dental care</b>	Accidental injury benefit only; regular cost sharing. No benefit for routine dental care.	94
<b>Vision care</b>	Annual eye examinations and refractions performed by an optometrist – \$20 per office visit; \$30 for an after-hours visit Eye examinations and refractions performed by an ophthalmologist – \$30 per office visit	71
<b>Special features:</b> Flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies; travel benefit/ services overseas		93
<b>Protection against catastrophic costs</b> (out-of-pocket maximum)	Nothing after \$5,000/Self Only or \$10,000/Family enrollment per year Some costs do not count toward this protection	16

## 2006 Rate Information for Altius Health Plans

**Non-Postal rates** apply to most non-Postal employees. 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 a special FEHB guide is published 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 who are not career postal employees. Refer to the applicable FEHB Guide.

### Wasatch Front and St. George:

Type of Enrollment	Code	<i>Non-Postal Premium Biweekly Government Share</i>	<i>Non-Postal Premium Biweekly Your Share</i>	<i>Non-Postal Premium Monthly Government Share</i>	<i>Non-Postal Premium Monthly Your Share</i>	<i>Postal Premium Biweekly USPS Share</i>	<i>Postal Premium Biweekly Your Share</i>
High Option Self Only	9K1	\$139.18	\$73.77	\$301.56	\$159.83	\$164.31	\$48.64
High Option Self and Family	9K2	\$316.08	\$152.44	\$684.84	\$330.29	\$373.15	\$95.37
HDHP Self Only	9K4	\$139.18	\$66.82	\$301.56	\$144.77	\$164.31	\$41.69
HDHP Self and Family	9K5	\$316.08	\$110.69	\$684.84	\$239.83	\$373.15	\$53.62