Altius Health Plans

www.altiushealthplans.com

Customer Service (800) 377-4161

2015

A Health Maintenance Organization (high and standard options) and a high deductible health plan.

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 16
- Summary of benefits: Page 140

Serving:

- Utah - Statewide
- Idaho - Southwest and Eastern Parts of Idaho
- Wyoming - Uinta County

Enrollment in this plan is limited. You must live or work in our geograhic service area to enroll. See page 15 for requirements.

Enrollment code for this Plan

9K1 High Option - Self Only
9K2 High Option - Self and Family
DK4 Standard Option - Self Only
DK5 Standard Option - Self and Family
9K4 HDHP Option - Self Only
9K5 HDHP Option - Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

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

The Office of Personnel Management (OPM) has determined that the Altius Health Plans' prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. 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 cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that 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 many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period October 15 through December 7 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, 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 for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048).

Table of Contents

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. Customer service may be reached at 1-800-377-4161 or through our website: www.altiushealthplans.com. The address for the Altius 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, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 16. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uacQuestion-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits this plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- 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.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

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:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits 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.

- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- 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 (800) 377-4161 or (801) 323-6200 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295 OR go to www.opm.gov/oig

You can also 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)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have such as to latex.
- 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.
- Contact your doctor or pharmacist if you have any questions.

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 or nutrional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. 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. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs neither your FEHB plan nor you will incur cost to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you us Altius Health Plans preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that 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 Benefits,* 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
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including children of same sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance/life-events

- **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 2015 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 2014 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

- **Upon divorce**

  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 for you. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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 website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

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

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. 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 age 26, regardless of marital status, etc. You may not elect TCC if you are fired from your Federal or Tribal 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premiums, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB coverage.

- **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 or Tribal 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.

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

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, a Standard 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 and Standard Options

- There is no deductible for our High and Standard Option plans.
- Most services provided by physicians and other health care professionals, including physician services that are provided while you are in a hospital, may be subject to a copayment or coinsurance.
- Comprehensive dental coverage is included in our High Option.
- The Standard Option does not include dental coverage (except for dental services that are necessary as a result of an accidental injury to sound, natural teeth).
- We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed:
  - High Option: $4,500 for Self Only or $4,500 for Family coverage.
  - Standard Option: $5,000 for Self Only or $5,000 for Family coverage.
  - High Deductible Health Plan (HDHP): $5,000 for Self Only or $10,000 for Family coverage.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

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 2,328 Primary Care Physicians and 3,930 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 out Customer Service Department at 800-377-4161 or 801-323-6200, or visit our website at 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. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

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, not received VA or Indian Health Services (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependant 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 20% 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. 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

Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $6,450 for Self Only enrollment, or $12,900 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 website at www.altiushealthplans.com.

- Health education resources — preventive guidelines, patient safety tips, wellness and disease information, prescription drug interaction, 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 information — 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, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) 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 licensed Health Maintenance Organization in Utah, Idaho and Wyoming.
- Altius Health Plans has been in existence for more than 30 years.
- Altius Health Plans is a for-profit, wholly owned subsidiary of Coventry Health Care, Inc. an Aetna Company.

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

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescriptions drug utilization) to any of our treating physicians or dispensing pharmacies.

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:

Utah - The counties of Beaver, Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Garfield, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, San Juan, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Weber, Wayne, portions of Emery and Grand as defined by the following zip codes: Emery – 84513, 84516, 84518, 84521, 84522, 84523, 84528, 84537; Grand – 84515, 84532

Idaho - The counties of Ada, Adams, Bannock, Bear Lake, Bingham, Bonneville, Canyon, Caribou, Elmore, Franklin, Gem, Jefferson, Madison, Oneida, Payette, Power, and Washington

Wyoming - Uinta County

You must receive your care from providers who contract with us. If you receive care outside our service area, we will pay only for urgent or 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. Changes for 2015

Do not rely **only** 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 High Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 146.
- Increasing the Non-Preferred (non-formulary) pharmacy copayment to:
  - Retail (30 day supply) 40% coinsurance, $60 minimum copay/$240 maximum copay
  - Mail order (90 days supply) 40% coinsurance, $180 minimum copay/$720 maximum copay
- Aetna Dental Network will replace Coventry Dental network for high option dental benefits

Changes to the Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 146.
- Increasing the Non-Prefered (non-formulary) pharmacy copayment to :
  - Retail (30 day supply) 50% coinsurance, $60 minimum copay/$240 maximum copay
  - Mail order (90 days supply) 50% coinsurance, $180 minimum copay/$720 maximum copay

Changes to the High Deductible Health Plan only

- Your share of the non-Postal premium will stay the same for Self Only or stay the same for Self and Family. See page 146.
- The monthly premium pass-through for the HSA increased from $52.08 Self Only and $104.15 Family to $54.16 Self Only and $108.33 Family
- The annual HRA credit increased from $625 Self Only and $1,250 Family to $650 Self Only and $1,300 Family
- Increasing deductible from $1,250 self only, $2,500 family to $1,300 self only, $2,600 family

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 website: www.altiushealthplans.com.

Where you get covered care

You must receive care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance based on your benefit plan selection. This plan is Open Access which means you may receive covered services from any participating provider without a required referral from your primary care physician. Some services may require prior approval from the Plan.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. If you have questions about Plan providers, call us at 1-800-377-4161 or 801-323-6200 or visit our website at www.altiushealthplans.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website. If you have questions about Plan providers, call us at 1-800-377-4161 or 801-323-6200 or visit our website at www.altiushealthplans.com.

What you must do to get covered care

It depends on the type of care you need. You and each family member are encouraged to choose a primary care physician. It is important to establish a relationship with a physician who will provide most of your health care. Your primary care physician may also assist in arranging other services, such as diagnostic tests or specialty care.

- **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.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us at 1-800-377-4161 or 801-323-6200 and we will help you select a new one.

- **Specialty care**

Although we encourage you to select a primary care physician (PCP), you do not need a referral or approval from your PCP to see one of our Plan specialists. Here are some other things you should know about specialty care:

- If your current specialist does not participate with us, you must receive treatment from a specialist who does for services to be covered. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your specialist will develop a treatment plan for you. Prior authorization may be required for certain services. Please refer to page 18 for services and/or supplies that require prior authorization from the Plan.

- If you are seeing a specialist and your specialist leaves the Plan, you may 1) contact your primary care physician for a recommended replacement or 2) contact Altius customer service for a list of participating specialty providers. In some situations, 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;
  - 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 and received prior authorization for your care in a Plan facility and . 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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, 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 and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

These provisions apply only to the benefits of the hospitalized person. 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 cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since our Plan does not have a primary care physician requirement, you may need to obtain our approval before you receive certain services. The pre-service claim approval processes for inpatient hospital admissions (called precertification or prior authorization) and for other services, are detailed in this Section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a denial or reduction of benefits if you do not obtain precertification, prior approval or a referral.

- **Inpatient hospital admission**

  Precertification or prior authorization is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

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

  - All services from a non-plan provider, including hospitals, surgical centers, and other facilities (except emergency care and out-of-area urgent care)
  - Brachytherapy
  - Capsule Endoscopy
  - Cardiac nuclear medicine scans
  - Cochlear Implants
  - Cognitive function testing, psychological testing, and behavioral assessment
  - Computed Tomography Angiograms (CTA)
  - Durable Medical Equipment (DME), including Prosthetics, Orthotics and Corrective Appliances
  - Examinations performed under general anesthesia
  - Eyeglasses and Contact Lenses (after cataract surgery, or for other specified conditions as specified in your medical benefits brochure)
  - Genetic testing
  - Health Education Services
  - Home Health Care
  - Home Infusion Services
  - Hospice Services (inpatient and outpatient)
  - Hyperbaric Oxygen Therapy Services
  - Implantable medications and devices
  - Injectable medications (excluding Emitter, insulin, glucagon kits and bee sting kits)
  - Inpatient facility admissions
  - Inpatient Rehabilitation Admissions
  - Intima media thickness testing (AMT)
  - Intraoperative electrophysiological monitoring
  - Magnetic Resonance Angiogram (MRA)
  - Magnetoencephalography (MEG)
  - Medical coverage of dental services
  - Medical nutrition therapy
  - Inpatient Mental health/substance abuse services – Contact MHNet @ 1-800-701-8663 – please see Section 5(e) Mental health and substance abuse benefits
  - Nuclear medicine scans
  - Neuropsychological Testing
  - Occupational Therapy
  - Orthotics, prosthetics, and corrective appliances
  - Pain Management Services
  - Physical Therapy, including evaluation

- Plastic Surgery and related procedures (cosmetic procedures, acne surgery, and similar)
- Positron-Emission Tomography (PET) scans
- Prolotherapy
- Proton Beam Therapy
- Skilled Nursing Facility Admissions
- Sleep Studies
- Speech Therapy, including evaluation
- Surgical procedures at an outpatient facility or surgical center
- Telemedicine services
- Three-dimension imaging
- Transplant services, including initial evaluation and donor testing
- 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 1-800-377-4161 or 801-323-6200, or visit our website at www.altiushealthplans.com.

Your primary 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.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 1-800-377-4161 or 801-323-6200 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

  For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

  If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

  If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-377-4161. You may also call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800-377-4161. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

We do not require prior authorization for inpatient maternity admissions. 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 also be notified if you or your baby requires a stay longer than 48 hours of a regular delivery or 96 hours after a cesarean delivery. All extended hospital stays are reviewed for medical necessity.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

   If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

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

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

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

High Option Example: When you see a primary care physician, you pay a copayment of $20 per office visit; and when you see a specialist, you pay a copayment of $30 per office visit.

Standard Option Example: When you see a primary care physician, you pay a copayment of $20 per office visit; and when you see a specialist, you pay a copayment of $35 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 and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

- **High Option:** This Plan has no deductible
- **Standard Option:** This Plan has no deductible
- **High Deductible Health Plan:** The calendar year deductible is $1,300 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 $2,600. 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.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

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.)

Differences between our Plan allowance and the bill

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.

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.

Your catastrophic protection out-of-pocket maximum

High Option

After your copayments and/or coinsurance total $4,500 for self only or $4,500 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.

Standard Option

After your copayments and/or coinsurance total $5,000 for self only or $5,000 per family in any calendar year, you do not have to pay any more for covered services for the remainder of the calendar year.

High Deductible Health Plan

After your deductibles, copayments, and/or coinsurance total $5,000 for self only 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 and/or coinsurance. If you have a question about when the out-of-pocket maximum is reached, please call our Customer Service Department at 1-800-377-4161 or 801-323-6200.

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.

When Government facilities bill us

Facilities of the Department Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High and Standard Option Benefits Overview

This plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

Note: This benefits section is divided into subsections. Please read ***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 website at www.altiushealthplans.com.

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.
- Care received from a non-Plan provider is not covered unless you have prior approval from the Plan.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- There is no deductible for our High and Standard Option plans.
- 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 OBTAIN PRIOR AUTHORIZATION FOR CERTAIN 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	
Note: We say "No Deductible" when the calendar year deductible does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In a physician's office • Office medical consultations • Second surgical opinion	$20 per office visit to a primary care physician $30 per office visit to a specialist $40 for an after-hours or urgent care visit to a primary care physician or specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours or urgent care visit to a primary care physician or specialist
Professional services of physicians • In an urgent care center	$40 per visit	$40 per visit
Injectable, implantable, and intravenous (IV) therapy drugs provided in a physician's office or in an urgent care center Note: Certain injectable, implantable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see *Direct Source Injectables and Implantable Medications* in Section 5(f). Note: We cover routine immunizations under the preventive care benefits for adults and children. We cover allergy serum under the *Allergy care* benefit.	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs
Professional services of physicians • During a hospital stay • In a skilled nursing facility	10 % of Plan Allowance	15% of Plan Allowance

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Minor diagnostic tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing in a physician's office or an independent lab if performed in conjunction with an office visit 10% of plan allowance in a hospital or other facility	Nothing in a physician's office or an independent lab if performed in conjunction with an office visit 15% of plan allowance in a hospital or other facility
Major diagnostic labs and radiology tests, such as: • CAT scans, MRIs, MRAs, and electron beam scans • PET and SPECT scans • Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance • Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures) • Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes • Cytogenetic studies	10% of Plan Allowance	15% of Plan Allowance
Preventive care, adult	**High Option**	**Standard Option**
Annual routine physical exam Routine screenings, such as: • Total Blood Cholesterol • Fasting lipid profile (total cholesterol, LDL, HDL, triglycerides) • Colorectal Cancer Screening, including: • Fecal occult blood test • Sigmoidoscopy screening - every five years starting at age 50 • Colonoscopy screening - every 10 years starting at age 50 • Routine Prostate Specific Antigen (PSA) test - annually for men age 40 and older Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing	Nothing
Well woman care, including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence. • Osteoporosis screening - for women age 65 and older - for women age 60 though 64 who are at increased risk for osteoporosis Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC). Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing	Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics, the Centers for Disease Control, and local government public health authorities • Well-child care charges for routine examinations, immunizations and care (up to age 26) • Examinations, such as: – Eye exams through age 17 to determine the need for vision correction – Hearing exams through age 17 to determine the need for hearing correction	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing	Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Delivery • Postnatal care • Obstetrical care in an observation setting	Nothing	Nothing
Breast feeding support, supplies, and counseling for each birth	Nothing	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 20 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. Please refer to *Section 5(c). Services provided by a hospital or other facility, and ambulance services* for inpatient maternity benefit coverage.		
Not covered: • *Home delivery*	*All charges*	*All charges*

Benefit Description	You pay	
Family planning	**High Option**	**Standard Option**
Contraceptive counseling.	Nothing	Nothing
A range of voluntary family planning services, such as: • Voluntary sterilization (See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Predictive genetic testing and/or counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterine insemination (IUI)	50% of Plan Allowance	50% of Plan Allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *– in vitro fertilization* *– embryo transfer, including transport, collection, and preparation costs; gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility Medications* • *Infertility services after voluntary sterilization*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$20 per office visit to a primary care physician $30 per office visit to a specialist $40 for an after-hours visit to a primary care physician or specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours visit to a primary care physician or specialist
• Allergy serum • Allergy injections	Nothing	Nothing

Allergy care - continued on next page

Benefit Description	You pay	
Allergy care (cont.)	**High Option**	**Standard Option**
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 43. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) • Intravenous (IV)/Infusion Therapy and IV antibiotic therapy 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, implantable and IV drugs; see below for the cost of the drugs. Note: We cover home IV infusion and antibiotic therapy administered by a home health agency under the *Home health services* benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. *See Section 3 - Other services under You need prior Plan approval for certain services.*	\$20 per office visit to a primary care physician \$30 per office visit to a specialist \$40 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	\$20 per office visit to a primary care physician \$40 per office visit to a specialist \$40 for an after-hours or urgent care visit to a primary care physician or specialist 15% of Plan Allowance in a surgical center, hospital, or other facility
• Injectable, implantable and IV therapy drugs provided in a physician's office or in an urgent care center Note: We require prior authorization for certain injectable, implantable and IV therapy drugs, including some chemotherapy drugs and growth hormone. To obtain a list of injectable, implantable 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 website at www.altiushealthplans.com.	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs
Note: Certain injectable, implantable and intravenous (IV) drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see *Direct Source Injectables and Implantable Medications* in Section 5(f).		

Benefit Description	You pay	
Physical, speech, and occupational habilitative and rehabilitative therapies	**High Option**	**Standard Option**
• Limited to a combined benefit of habilitative and rehabilitative physical, occupational, and speech therapy of 60 provider office and/or out-patient facility visits per condition, per member, per calendar year. Note: We cover physical and occupational therapy under the *Home health services* benefit when provided by a home health agency as part of an authorized home treatment plan.	$30 per office visit $40 after-hours / urgent care $30 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility 10% when preformed in an inpatient facility	$40 per office visit $40 after-hours / urgent care $40 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility 15% when preformed in an inpatient facility
• 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	$30 per office visit $30 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility	$40 per office visit $40 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility
Not covered: • *Long-term habilitative and/or rehabilitative therapy* • *Therapy that we determine will not significantly improve your condition* • *Exercise programs*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Nothing	Nothing
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	50% of Plan Allowance	50% of Plan Allowance
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*

Benefit Description	You pay	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One pair of eyeglasses or contact lenses (including professional services for such fitting) to treat aphakia, or correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	50% of Plan Allowance	50% of Plan Allowance
• Eye exams performed by an optometrist Note: See *Preventive care, children* for eye exams for children	Nothing	Nothing
• Eye exams performed by an ophthalmologist	$30 per Specialist office visit $40 for after-hours or urgent care visit	$40 per Specialist office visit $40 for after-hours or urgent care visit
Not covered: • *Extra charges for designer or deluxe frames* • *Extra charges for progressive lenses* • *Scratch resistant lens coating* • *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)* • *Eyeglasses or contact lenses for refractive purposes, and related professional services such as fitting* • *Eye exercises and orthoptics* • *Radial keratotomy, LASIK, astigmatism correction (Limbal Relaxing Procedure), and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$20 per office visit to a primary care physician $30 per office visit to a specialist $40 for an after-hours visit to a primary care physician or specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours visit to a primary care physician or specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot Orthotics, except for members with severe diabetes*	*All charges*	*All charges*

Benefit Description	You pay	
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	50% of Plan Allowance	50% of Plan Allowance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices, unless medically necessary* • *Replacement of prosthetic devices and corrective appliances unless it is needed because 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*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen systems and oxygen tanks • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors	50% of Plan Allowance	50% of Plan Allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• Insulin pumps	50% of Plan Allowance	50% of Plan Allowance
• Oxygen concentrators • Medically necessary accessories and supplies such as hoses, tubes, oxygen and ostomy supplies Note: Call us at 1-800-377-4161 or 801-323-6200 as soon as your Plan physician prescribes 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.	Nothing	Nothing
Not covered: • *Durable medical equipment, corrective appliances, prostheses and artificial aids, including supplies and accessories, are excluded when primarily used for convenience, comfort, or in the absence of an illness or injury. Routine periodic servicing, such as cleaning and regulating is not covered.* • *Replacement of 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.*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, oral medications, and injectable, implantable and intravenous (IV) therapy (this does not include the cost of injectable and IV drugs; see below for the cost of the injectable, implantable and IV drugs) • Home visits made by a physician • Home rehabilitative therapy, including physical therapy and occupational therapy when significant improvement can be expected • Home speech therapy • Home visits by a medical social worker	$30 per visit	$40 per visit
• Injectable, implantable and IV therapy drugs Note: Certain injectable, implantable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see *Direct Source Injectables and Implantable Medications* in Section 5(f).	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**High Option**	**Standard Option**
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
Coverage is limited to 20 visits per calendar year. Services include: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$20 per office visit to a primary care physician $30 per office visit to a specialist $40 for an after-hours visit to a primary care physician or specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours visit to a primary care physician or specialist
Alternative treatments	**High Option**	**Standard Option**
Biofeedback therapy for the treatment of certain conditions • Anesthesia • Pain relief	$20 per office visit to a primary care physician $30 per office visit to a specialist $40 for an after-hours visit to a primary care physician or specialist 10% of Plan Allowance in a surgical center, hospital, or other facility	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours visit to a primary care physician or specialist 15% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: • *Acupuncture* • *Acupressure* • *Naturopathic or homeopathic services* • *Massage therapy* • *Hypnotherapy*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: • Tobacco Cessation programs, including individual/group/telephone counseling, physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. (See section 5(f.) Prescription Drug Benefits) • Obesity education	• Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.	• Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
	• Nothing	• Nothing
Coverage is limited to classes and programs that we authorize for the care and treatment of an illness or injury, such as: • Diabetes self-management • Asthma management • Medical nutrition therapy and/or diet counseling: - for a member who, based on our criteria, is a candidate for surgical treatment of morbid obesity - 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	$20 per office visit to a primary care physician $30 per office visit to a specialist Nothing in a hospital or other facility	$20 per office visit to a primary care physician $40 per office visit to a specialist Nothing in a hospital or other facility
Not covered: • *Literature such as books, journals, or subscriptions, unless included in an educational program that we approve* • *Medical nutrition therapy and/or diet counseling intended primarily for weight loss, unless the member meets our criteria for surgical treatment of morbid obesity* • *Health education services that are not closely related to the care and treatment of an illness or injury*	*All charges*	*All charges*

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 prior authorization.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST OBTAIN PRIOR AUTHORIZATION FOR CERTAIN SURGICAL PROCEDURES**. Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay	
Note: We say "No Deductible" when the calendar year deductible does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Removal of tumors and cysts • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Correction of congenital anomalies (see *Reconstructive surgery*) • Treatment of burns • Routine circumcision of a newborn • Insertion of internal prosthetic devices. See Section 5(a) – *Orthopedic and prosthetic devices* for device coverage information 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.	\$20 per office visit to a primary care physician \$30 per office visit to a specialist \$40 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	\$20 per office visit to a primary care physician \$40 per office visit to a specialist \$40 for an after-hours or urgent care visit to a primary care physician or specialist 15% of Plan Allowance in a surgical center, hospital, or other facility
• Injectable, implantable and intravenous (IV) drugs administered in conjunction with a surgery in a physician's office or in an urgent care center	10% of Plan Allowance	15% of Plan Allowance

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Surgical treatment of morbid obesity (bariatric surgery), subject to all of the following criteria: - 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 - 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 - 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 - 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 - 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.	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses, and surgical bras (See *Orthopedic and prosthetic devices* in Section 5(a))	$20 per office visit to a primary care physician $30 per office visit to a specialist $40 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	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours or urgent care visit to a primary care physician or specialist 15% of Plan Allowance in a surgical center, hospital, or other facility

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
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.	$20 per office visit to a primary care physician $30 per office visit to a specialist $40 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	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours or urgent care visit to a primary care physician or specialist 15% of Plan Allowance in a surgical center, hospital, or other facility
• Injectable, implantable and intravenous (IV) drugs administered in conjunction with a surgery in a physician's office or in an urgent care center	10% of Plan Allowance	20% of Plan Allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures	$20 per office visit to a primary care physician $30 per office visit to a specialist $40 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	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours or urgent care visit to a primary care physician or specialist 15% of Plan Allowance in a surgical center, hospital, or other facility
• Injectable, implantable and intravenous (IV) drugs administered in conjunction with a surgery in a physician's office or in an urgent care center	10% of Plan Allowance	20% of Plan Allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*

Benefit Description	You pay	
Organ/tissue transplants	**High Option**	**Standard Option**
Altius Health Plans requires you to receive services from contracted physicians, hospitals and other providers. To receive plan benefits, members must: - Receive transplant services through the Altius or Coventry Transplant Networks. - Call the plan as soon as the possibility of a transplant is discussed. When you call, you will be given information about the program, including a list of participating providers and facilities. These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic (donor) transplants for	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reccurence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologuous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility
Mini-transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures: • Allogenic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institues of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services tif you participate in a clinical trial. • Allogenic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, Reduced Intensity Conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility
National Transplant Program (NTP)	10% of Plan Allowance in a surgical center, hospital, or other facility	15% of Plan Allowance in a surgical center, hospital, or other facility
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expense for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.		
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *Travel expenses, lodging, and meals*	*All charges*	*All charges*

Benefit Description	You pay	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	10% of Plan Allowance	15% of Plan Allowance
Professional services provided in – • Office	$20 per office visit to a primary care physician $30 per office visit to a specialist $40 for an after-hours or urgent care visit to a primary care physician or specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours or urgent care visit to a primary care physician or specialist

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 your physician has arranged for your care in a Plan facility. We will not pay for services provided by a non-Plan facility without prior authorization.
- 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).
- **YOUR PHYSICIAN MUST OBTAIN PRIOR AUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay	
Note: We say "No Deductible" when the calendar year deductible does not apply.		
Inpatient hospital services	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing after $200 per admission copay	15% of Plan Allowance Inpatient maternity services - Nothing after a $200 per admission copay
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing after $200 per admission copay	15% of Plan Allowance Inpatient maternity services - Nothing after a $200 per admission copay
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*	*All charges*

Inpatient hospital services - continued on next page

Benefit Description	You pay	
Inpatient hospital services (cont.)	**High Option**	**Standard Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Minor diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics 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.	10% of Plan Allowance	15% of Plan Allowance
Major diagnostic labs and radiology tests, such as: • CAT scans, MRIs, MRAs, and electron beam scans • PET and SPECT scans • Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance • Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures) • Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes • Cytogenetic studies	10% of Plan Allowance	15% of Plan Allowance
Not covered: • *Personal comfort items*	*All charges*	*All charges*

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF) / Extended care benefits: 30 days per member per calendar year • Professional services – physicians and general nursing care • Medical supplies and medications • Medical equipment ordinarily provided by a skilled nursing facility • Room and board	Nothing after $200 per admission copay	15% of Plan Allowance
Not covered: • *Custodial care, personal, comfort or convenience items*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
• Services for pain and symptom management • Short-term inpatient care and procedures necessary for pain control • Respite care may be provided only on an occasional basis and may not be provided longer than five days • Home visits made by a physician, nurse, home health aide, social worker or therapist with no limit on number of visits • General medical equipment and supplies related to the terminal illness	Nothing	15% of Plan Allowance
Not covered: • *Independent nursing* • *Homemaker services* • *Specialized, customized equipment*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate	$100 copayment per trip	$100 copayment per trip
Not covered: • *Medical transportation for the convenience of you or your family*	*All charges*	*All charges*

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.
- 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 1-800-377-4161 or 801-323-6200. For a current list of Plan providers and Plan urgent care facilities, you may also visit our website at 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.

- **Urgent Care outside our service area:**

If you are traveling outside our service area and experience an urgent medical condition, Coventry Health Care National Network providers are also available to you. You can locate a Coventry Health Care National Network provider by calling 1-800-639-9154 or use the "Search for a Coventry Health Care National Network provider" link on our Provider Search page at www.altiushealthplans.com

Benefit Description	You pay	
Note: We say "No Deductible" when the calendar year deductible does not apply		
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$40 copayment per office visit	$40 copayment per office visit
• Injectable, implantable and intravenous (IV) therapy drugs provided in a physician's office or in an urgent care center	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$200 copayment per visit	$250 copayment per visit
Not covered: • *Elective care or non-emergency care in a hospital emergency room* • *Follow-up care in a hospital emergency room, unless we have given prior authorization*	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$40 copayment per office visit	$40 copayment per office visit
• Injectable, implantable and intravenous (IV) therapy drugs provided in a physician's office or in an urgent care center	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs	20% of Plan Allowance for preferred drugs 30% of Plan Allowance for non-preferred drugs
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$200 copayment per visit	$250 copayment per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**High Option**	**Standard Option**
Professional ground ambulance, air ambulance, and/or paramedic services when medically appropriate. Note: See 5(c) for non-emergency service.	$100 copayment per trip	$100 copayment per trip
Not covered: • *Medical transportation for the convenience of you or your family* • *Death-related transportation*	*All charges*	*All charges*

Section 5(e). Mental health and substance abuse 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.
- 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 INPATIENT SERVICES.** Benefits are payable only when we determine the care is medically necessary to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
- You must contact Mental Health Network (MHNet) at 1-800-701-8663 for prior authorization of all inpatient 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.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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 medically necessary treatment plan in favor of another.

Benefit Description	You Pay	
Note: We say "No Deductible" when the calendar year deductible does not apply.		
Mental health and substance abuse benefits	**High Option**	**Standard Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is medically necessary 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.	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	$20 per office visit	$20 per office visit
• Intensive outpatient treatment	$20 per office visit	$20 per office visit
• Diagnostic tests • Medication management	$20 per office visit	$20 per office visit
• Services provided by a hospital or other facility on an inpatient basis (room and board), including partial hospitalization	Nothing after $200 per admission copay	15% of Plan Allowance
• Professional services by providers such as psychiatrists, psychologists, or clinical social workers provided on an inpatient basis	10% of Plan Allowance	15% of Plan Allowance

Mental health and substance abuse benefits - continued on next page

Benefit Description	You Pay	
Mental health and substance abuse benefits (cont.)	**High Option**	**Standard Option**
Not covered: Services we have not approved.		

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 the next page.
- 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.
- Members must make sure their physicians obtain prior approval/authorizattions for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- 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 physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your 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 59 of this booklet. If you need prescription medications while outside of the service area, contact ESI/Medco for the nearest Plan pharmacy, or you may pay for your prescription and ESI/Medco will reimburse you according to your benefits. To find out about Plan pharmacies, or get reimbursement for a covered drug, contact: ESI/Medco's Customer Service Department at 1-800-378-7040.
  - 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/Medco's Customer Service Department at 1-800-378-7040 to get an order form. 3) Mail your prescription with the completed order form to ESI/Medco. Prescriptions are mailed within fourteen days, directly to your house or office in a labeled envelope to ensure privacy and safety. ESI/Medco 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 Injectable and Implantable Medications on page 58.*

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 reserve the right to include only one manufacturer's product on our formulary when the same or similar drug (that is, a drug with the same active ingredient), supply, or equipment is made by two or more different manufacturers. We also reserve the right to include only one dosage or form of a drug on the Altius formulary when the same drug is available in different dosages or forms (for example, dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product or products and/or other forms or dosages of products that are not listed on the Altius formulary will be excluded from coverage. We list the most commonly requested formulary drugs on our Prescription Drug List. To order a Prescription Drug List, call our Customer Service Department at 1-800-377-4161 or 801-323-6200, or visit our website at www.altiushealthplans.com. The Prescription 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 Prescription 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 and implantable medications and devices, 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 or implantable medications that require prior authorization, please call our Customer Service Department at 1-800-377-4161 or 801-323-6200, or visit our website at 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, your physician may contact our Prior Authorization Department at 877-215-4100. 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 ESI/Medco 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. Byetta, Victoza, Bydureon, Insulin and Symlin are the only injectable medications available through the ESI/Medco mail order service. Non-maintenance medications are not available through the ESI/Medco mail order service. Examples of non-maintenance medications include, but are not limited to: antibiotics, pain management, muscle relaxants, anti-migraine, medications for sleep or anxiety, acne preparations, creams and ointments.
  - 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, ESI/Medco 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.
  - Specialtiy Medications: A group of medications which are typically high-cost drugs and include but are not limited to those with oral, topical, inhaled, inserted or imlanted and injected routes of administration. Specialty Medications are designated as such in the formulary. Included characteristics of Speciaty Medications are by they following definitions and structure:
    - Drugs which are used to treat and diagnose rare or complex diseases;

- Drugs which require close clinical monitoring and management;
- Drugs which frequently require special handling; or
- Drugs which may have limited access or distribution.

- **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 ESI/Medco for Plan pharmacies outside of the service area. If one is not available, then ESI/Medco will reimburse you. Keep your receipts and mail them along with a reimbursement form. Call ESI/Medco at 1-800-378-7040 for the reimbursement form and instructions.
- **Preferred Injectable and Implantable Medications.** 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, implantable or IV medication is not listed on our Prescription 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.
- **Specialty / Direct Source Injectable and Implantable Medications.** Direct source injectable and implantable medications are certain injectable, implantable 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 specialty / direct source injectable, implantable and IV drugs and designated vendors, please visit our website at www.altiushealthplans.com or call our Customer Service Department. This list may be changed periodically.

If your physician orders a direct source injectable , implantable 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, implantable or IV therapy drug rather than order it for you. When you obtain a prescription for an injectable, implantable or IV therapy drug, call our Customer Service Department or visit our website to see if you must order it through a designated vendor.

Most of the injectable, implantable and IV therapy drugs that must be purchased through a designated vendor are available through the ESI/Medco specialty pharmacy, Accredo.ESI/Medco will ship your injectable, implantable 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, ESI/Medco 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 your direct source injectable, implantable and IV drugs from the ESI/Medco specialty pharmacy, Accredo, please call 1-800-378-7040.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*	**Preferred generic:** $7 at a Plan pharmacy $7 for mail order **Preferred brand name:** $25 at a Plan pharmacy $50 for mail order **Non-preferred (non-formulary):** 40% coinsurance - $60 minimum, $240 maximum at a plan pharmacy 40% coinsurance - $180 minimum, $720 maximum for mail order Notes: • If there is no preferred generic equivalent available, you will still have to pay the applicable preferred brand-name or non-preferred copay. • If the Plan Allowance for the prescription is less than the copay, you will pay the Plan Allowance.	**Preferred generic:** $7 at a Plan pharmacy $7 for mail order **Preferred brand name:** $35 at a Plan pharmacy $70 for mail order **Non-preferred (non-formulary):** 50% coinsurance - $60 minimum, $240 maximum at a plan pharmacy 50% coinsurance - $180 minimum, $720 maximum for mail order Notes: • If there is no preferred generic equivalent available, you will still have to pay the applicable preferred brand-name or non-preferred copay. • If the Plan Allowance for the prescription is less than the copay, you will pay the Plan Allowance.
Women's contraceptive drugs and devices Note: Over-the-counter contraceptives drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing	Nothing
• Insulin, Byetta, Symlin, insulin syringes, needles, glucose test strips and lancets	**Preferred:** $25 at a Plan pharmacy $50 for mail order **Non-preferred (non-formulary):** 40% coinsurance - $60 minimum, $240 maximum at a plan pharmacy 40% coinsurance - $180 mimimum, $720 maximum for mail order	**Preferred:** $35 at a Plan pharmacy $70 for mail order **Non-preferred (non-formulary):** 50% coinsurance - $60 minimum, $240 maximum at a plan pharmacy 50% coinsurance - $180 mimimum, $720 maximum for mail order

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Injectable Imitrex, glucagon, insulin pens, Lovenox, and epinephrine kits such as Epi-Pen	$25 at a Plan pharmacy (not available through mail order)	$35 at a Plan pharmacy (not available through mail order)
• Injectable medications (other than Insulin, Imitrex, glucagon, Lovenox, and epinephrine kits), implantable medications and intravenous (IV) therapy drugs obtained through a Plan pharmacy or a Direct Source pharmacy vendor	**Preferred:** 20% of Plan Allowance **Non-preferred (non-formulary):** 30% of Plan Allowance (not available through mail order)	**Preferred:** 20% of Plan Allowance **Non-preferred (non-formulary):** 30% of Plan Allowance (not available through mail order)
• Disposable needles and syringes needed for injecting covered prescription drugs (other than insulin), when filled as a separate prescription	$50 at a Plan pharmacy (not available through mail order)	$60 at a Plan pharmacy (not available through mail order)
• Drugs to treat sexual dysfunction, limited to 4 pills per month	50% of Plan Allowance at a Plan pharmacy	50% of Plan Allowance at a Plan pharmacy
• Spacers (such as Aerochamber), limited to one per calendar year	**Preferred:** $25 at a Plan pharmacy **Non-preferred (non-formulary):** 40% coinsurance - $60 minimum, $270 maximum at a Plan pharmacy	**Preferred:** $35 at a Plan pharmacy **Non-preferred (non-formulary):** 50% coinsurance - $60 minimum, $270 maximum at a Plan pharmacy
Not covered: • *Nonprescription medications, except those specifically listed in the Altius formulary* • *Drugs obtained at a non-Plan pharmacy, except for out-of-the-area emergencies* • *Medical supplies, such as dressing and antiseptics* • *Experimental medications* • *Fertility medications* • *Disposable needles and syringes not required for injecting covered prescribed medication* • *Bioidentical hormone powders* • *Medications or nutritional supplements for weight gain for non-medical indications* • *Immunizations and medications required exclusively for foreign travel* • *Hair growth products* • *Medications for cosmetic indications* • *Medications to enhance athletic performance* • *Replacement of lost, stolen, or damaged prescription drugs*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Note: Physician prescribed over-the-counter or prescription drugs are approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 39).	*All charges*	*All charges*

Section 5(g). 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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- 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 on the High Option.
- 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.
- The Standard Option includes accidental dental injury benefits only. There are no other dental benefits for the Standard Option.

Benefit Desription	You Pay	
Note: We say "After Deductible" when the calendar year deductible applies.		
Accidental injury benefit	**High Option**	**Standard Option**
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 $40 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	$20 per office visit to a primary care physician $40 per office visit to a specialist $40 for an after-hours or urgent care visit to a primary care physician or specialist 15% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: • *Implants*	*All charges*	*All charges*

Dental benefits

Dental benefits are administered by Coventry Dental. 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. If you have any questions about dental providers, dental benefits, or dental claims (that are not related to accidental injury) please contact Coventry Dental 1-866-690-4908.

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

Dental benefits continued on next page

Dental Benefits	You Pay
Service	**High Option**
Oral evaluation	
- Periodic oral examination – one per member every six months - Limited oral evaluation – problem focused - Comprehensive oral evaluation	$5 Note: You pay an additional $5 for prophylaxis (dental cleaning). See *Preventive* benefits.
- Comprehensive periodontal evaluation	$47
Radiographs - Intraoral full series x-rays – one per member every three years - Intraoral periapical and occlusal x-rays - Bitewing x-rays - Panoramic x-ray – one per member every three years	Nothing
Preventive	
• Prophylaxis and fluoride treatment (child) – one per member every six months • Prophylaxis (adult) – one per member every six months	$5 Note: You pay an additional $5 for the oral examination/evaluation. See *Oral evaluation* benefits on the previous page.
• Sealant – per tooth (through age 14)	$10
Emergency treatment - During office hours	
• Palliative treatment of dental pain	$18
• Office visit for observation – no other services performed	$26
• Specialist consultation	$26
After hours	$69
Emergency services required when a member is over 100 miles from home and a Plan dentist is not available.	All charges in excess of $50
Restorative Routine fillings – Amalgam or Resin-based composite for permanent or primary teeth	
Amalgam	
- 1 surface	$17
- 2 surfaces	$24
- 3 surfaces	$31
- 4 or more surfaces	$47
Resin-based composite – anterior	
- 1 surface	$24
- 2 surfaces	$40
- 3 surfaces	$61
- 4 or more surfaces	$81

Service - continued on next page

Dental Benefits	You Pay
Service (cont.)	**High Option**
Resin-based composite – posterior	
- 1 surface	$63
- 2 surfaces	$85
- 3 surfaces	$106
- 4 or more surfaces	$122
Periodontics	
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
Oral surgery	
Extractions (routine)	$41
Surgical removal of erupted tooth	$70
Impacted teeth – soft tissue	$75
Impacted teeth – partial bony	$112
Impacted teeth – full bony	$155
Endodontics	
Pulp cap	$23
Vital pulpotomy	$35
Root canal, single canal	$137
- two canals	$166
- three canals	$204
Crowns – 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
Recement crown	$23
Removable dentures	
Complete denture (upper or lower)	$488

Service - continued on next page

Dental Benefits	You Pay
Service (cont.)	**High Option**
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
Preventive appliances	
Space maintainer – unilateral	$60
Space maintainer – bilateral	$63
Habit-breaking appliance	$114
The following services are limited: • Replacement of prosthetic appliances less than five years old is covered only when good dental care dictates and such replacement is prescribed by a Plan dentist. • Single unit gold restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials.	
Not covered: • *Implants* • *Bridges* • *Surgical grafting procedures* • *Treatment for developmental malformations such as enamel hypoplasia and fluorsis (brown and white stains on teeth)* • *Maxillary and mandibular malformations and anodontia* • *General anesthetic* • *Cosmetic or orthodontic treatment* • *Full mouth rehabilitation, periodontal splints, restoration of tooth structure lost from attrition and restoration for misalignment of the teeth* • *Dental treatment for temporomandibular (jaw) joint disorders and related diseases* • *Replacement of lost or stolen dentures, bridges or other dental appliances* • *Topical application of fluoride for adults*	*All charges*

Section 5(h). Special features

Feature	Description
Feature	**High Option**
Incentive for Completing Health Risk Assessments	The Altius Health Risk Assessment (HRA) is a confidential online questionnaire that takes less than 20 minutes to complete. Participants answer questions about nutrition, weight, physical activity, stress, safety and mental health. Upon completion, the Health Risk Assessment generates an evaluation of your current health status. Assessments are completely confidential and easy to access. Based on the results of your Assessment, you are provided the opportunity to be directed to personalized coaching programs to help acheive personal health goals. Programs may include but are not limited to, weight management, tobacco cessation, nutrition improvement, physical activity improvement, stress managment, cholesterol management, blood pressure management. When you complete your Atlius on-line Health Risk Assessment within 90 days of your effective date, Altius will provide you with a $50 Health Reimbursement Credit. You must be 18 years or older and currently enrolled in an Altius Health Plan in order to complete the assessment. Visit our website, www.altiushealthplans.com, to complete the questionaire and to receive your results. You may also call our Customer Service Department at 1-800-377-4161 or 801-323-6200 for additional information.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf, hard of hearing, and non-English speaking members	If you need interpreter services for an appointment with a Customer Service Representative, you must arrange for these services by calling 1-800-377-4161 or 801-323-6200. When interpreter services are needed in the provider's office, contact the provider's office directly.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
High risk pregnancies	If you or your Plan provider feel that your pregnancy may be a difficult one, or that you may be at risk for complications, you or your PCP may ask us to assign you a 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.
Travel benefit/services overseas	Services outside of our service area are limited to emergency and urgent care only. See Section 5(d) for *Emergency services/accidents.*

High Deductible Health Plan Benefits

See page 16 for how our benefits changed this year and page 143 for a benefits summary.

Section 5. High Deductible Health Plan Benefits

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 *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 1-800-377-4161 or 801-323-6200, or on our website at 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 credit an equal amount to your HRA based upon your eligibility. Your full HRA credit will be available on your effective date of enrollment.

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), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are 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 for more details).

Health Savings Accounts (HSAs)

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 and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2015, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $54.16 per month for a Self Only enrollment or $108.33 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 $3,350 for an individual and $6,650 for a family enrollment. See maximum contribution information on page 74. 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 a Coventry Consumer Choice (C3) HSA powered and administered by Health Equity
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- 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 (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by an HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 11), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, 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 2015, we will give you an HRA credit of $650 per year for a Self Only enrollment and $1,300 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 Coventry Consumer Choice (C3).
- 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.

• **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

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	Health Equity is the non-bank custodian and preferred HSA administrator for this Plan. Health Equity has a relationship with Charles Schwab to manage the investment options for memers with a C3 HSA. Members can contact Health Equity directly for assistance at 866-855-4066.	Coventry Consumer Choice (C3) is the HRA administrator for this Plan. 1-800-722-1758
Fees	Set-up fee is paid by the HDHP.	None.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare Part A or Part B • Not be claimed as a dependent on someone else's tax return • Not have received VA and/or Indian Health Services (IHS) benefits in the last three months • Complete and return all banking paperwork 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.	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	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.
• **Self Only enrollment**	For 2015, a monthly premium pass through of $54.16 will be made by the HDHP directly into your HSA each month.	For 2015, your HRA annual credit is $650 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2015, a monthly premium pass through of $108.33 will be made by the HDHP directly into your HSA each month.	For 2015, your HRA annual credit is $1,300 (prorated for mid-year enrollment).
Contributions/ credits		The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	The maximum that can be contributed to your HSA is an annual contribution of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,350 for an individual and $6,650 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death and disability. 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). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 77.	
• **Self Only enrollment**	You may make an annual maximum contribution of $2,700.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $5,350.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit card • Withdrawal form	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.

Distributions/ withdrawals • **Medical**	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. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change), • 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, and • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	Funds are not available until: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change); and • The HDHP receives record of your enrollment and initially establishes your HRA account. • The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. 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.

Annual rollover	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 maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, 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. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective data is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

  If you have not named beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA 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, physician prescribed 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 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 website at www.irs.gov and click on "Forms and Publications." Note: Although physician prescribed 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 20% 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 on page 73 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
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or 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.

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. We will not pay for services provided by a non-participating provider with prior approval from the Plan.
- 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.
- **YOUR PHYSICIAN MUST OBTAIN PRIOR AUTHORIZATION FOR CERTAIN 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
Note: Deductible does not apply to preventive services.	
Preventive care, adult	**High Option**
Routine screenings, such as: • Total Blood Cholesterol • Fasting lipid profile (total cholesterol, LDL, HDL, triglycerides) • Colorectal Cancer Screening, including: • Fecal occult blood test • Sigmoidoscopy screening - every five years starting at age 50 • Colonoscopy screening - every 10 years starting at age 50 • Routine Prostate Specific Antigen (PSA) test - annually for men age 40 and older Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing
Well woman, including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence • Osteoporosis screening - for women age 65 and older - for women age 60 though 64 who are at increased risk for osteoporosis	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing
Routine mammogram — covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar yea • At age 65 and older, one every two consecutive calendar years	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing
Not covered • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel*	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics, the Centers for Disease Control, and local government public health authorities. • Well-child care charges for routine examinations, immunizations and care (up to age 26) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing
Not covered • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel*	*All charges*

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 79) and are not subject to the calendar year deductible.
- The deductible is $1,300 per person or $2,600 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.
- Your physician must obtain 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…
Deductible before Traditional medical coverage begins	**High Option**
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $1,300 per person or $2,600 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. We will not pay for services received from a non-participating provider without prior Plan approval.
- The deductible is $1,300 for Self Only enrollment and $2,600 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.
- **YOUR PHYSICIAL MUST OBTAIN 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…
Diagnostic and treatment services	**High Option**
Professional services of physicians • In a physician's office • Office medical consultations • Second surgical opinion	$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 • In an urgent care center	$30 per visit
Injectable, implantable and intravenous (IV) therapy drugs provided in a physician's office or in an urgent care center Note: Certain injectable, implantable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see *Direct Source Injectable and Implantable Medications* in Section 5(f). Note: We cover routine immunizations under the preventive care benefits for adults and children. We cover allergy serum under the *Allergy care* benefit.	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
Professional services of physicians • During a hospital stay • In a skilled nursing facility	10% of Plan Allowance

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests	**High Option**
Minor diagnostic tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing in a physician's office or at an independent lab if performed in conjunction with an office visit 10% of Plan Allowance in a hospital or other facility
Major diagnostic labs and radiology tests, such as: • CAT scans, MRIs, MRAs, and electron beam scans • PET and SPECT scans • Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance • Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures) • Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes • Cytogenetic studies	10% of Plan Allowance
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Obstetrical care in an observation setting Note: Here are some things to keep in mind: • You do not need prior authorization for normal delivery; see page 19 for other circumstances, such as extended stays for your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Note: Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	10% of Plan Allowance

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	**High Option**
• We cover ultrasounds and lab tests under the minor diagnostic services benefit. See *Lab, x-ray and other diagnostic tests* in this section. • We cover services related to complications of pregnancy the same as for any other illness.	10% of Plan Allowance
Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk.	Nothing
Breastfeeding support, supplies and counseling for each birth	Nothing
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Home delivery*	*All charges*
Family planning	**High Option**
Contraceptive counseling	Nothing
A range of voluntary family planning services, such as: • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Intrauterine devices (IUDs)	Nothing
• Injectable contraceptive drugs (such as Depo-Provera) Note: We cover oral contraceptives and diaphragms under the prescription drug benefit; see Section 5(f).	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Predictive genetic testing and/or genetic counseling.*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI)	50% of Plan Allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, including transport, collection and preparation costs; gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**High Option**
• *Fertility Medications* • *Infertility services after voluntary sterilization*	*All charges*
Allergy care	**High Option**
• Testing and treatment	$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
• Allergy serum • Allergy injections	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 94. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) • Intravenous (IV)/Infusion Therapy and IV antibiotic therapy 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, implantable and IV drugs; see below for the cost of the drugs. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit informaton that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that be determine are medically necessary. See *Section 3. How you get care - Other services.* Note: We cover home IV infusion and antibiotic therapy administered by a home health agency under the *Home health services* benefit.	$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
• Injectable, implantable and 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

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	**High Option**
Note: We require prior authorization for certain injectable, implantable and IV therapy drugs, including some chemotherapy drugs and growth hormone. To obtain a list of injectable, implantable 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 website at www.altiushealthplans.com. Note: Certain injectable, implantable and intravenous (IV) drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see *Direct Source Injectable and Implantable Medications* in Section 5(f).	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
Physical, speech, and occupational habilitative and rehabilitative therapies	**High Option**
• Limited to a combined benefit of habilitative and rehabilitative physical, occupational, and speech therapy of 60 provider office and/or out-patient facility visits per condition, per member, per calendar year. Note: We cover physical and occupational therapy under the *Home health services* benefit when provided by a home health agency as part of an authorized home treatment plan	$30 per office visit $30 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility
• 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	$30 per office visit $30 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility
Not covered: • *Long-term habilitative and rehabilitative therapy* • *Therapy that we determine will not significantly improve your condition* • *Exercise programs*	*All charges*
Speech therapy	**High Option**
60 visits per condition per year Note: We cover speech therapy under the *Home health services* benefit when provided by a home health agency as part of an authorized home treatment plan.	$30 per office visit $30 per outpatient visit to a rehabilitation center, surgical center, hospital, or other facility
Not covered: • *Speech therapy for psychosocial and/or developmental delays, such as but not limited to, childhood stuttering*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Nothing
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	10% of Plan Allowance
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• One pair of eyeglasses or contact lenses (including professional services for such fitting) to treat aphakia or correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	50% of Plan Allowance
• Eye exams performed by an optometrist Note: See *Preventive care, adults and children* for eye exams	You pay nothing
• Eye exams performed by an ophthalmologist	$30 per office visit
Not covered: • *Extra charges for designer or deluxe frames* • *Extra charges for progressive lenses* • *Scratch resistant lens coating* • *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)* • *Eyeglasses or contact lenses for refractive purposes, and related professional services such as fitting* • *Eye exercises and orthoptics* • *Radial keratotomy, LASIK, astigmatism correction (Limbal Relaxing Procedure), and other refractive surgery*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$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
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot Orthotics, except for members with severe diabetes*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.*	50% of Plan Allowance
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy Note: See Sections 5(b) and 5(c) for coverage of the surgery to insert the device.	10% of Plan Allowance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices, unless medically necessary*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	**High Option**
• *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*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen systems and oxygen tanks • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps	50% of Plan Allowance
• Oxygen concentrators; and • Medically necessary accessories and supplies such as hoses, tubes, oxygen and ostomy supplies	10% of Plan Allowance
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.	
Not covered: • *Durable medical equipment, corrective appliances, prostheses and artificial aids, including supplies and accessories, are excluded when primarily used for convenience, comfort, or in the absence of an illness or injury. Routine periodic servicing, such as cleaning and regulating is not covered.* • *Replacement of 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.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, oral medications, and injectable and intravenous (IV) therapy (this does not include the cost of injectable, implantable and IV drugs; see next page for the cost of the injectable, implantable and IV drugs) • Home visits made by a physician • Home rehabilitative therapy, including physical therapy and occupational therapy when significant improvement can be expected • Home speech therapy • Home visits by a medical social worker	10% of Plan Allowance
• Injectable, implantable and IV therapy drugs Note: Certain injectable, implantable and intravenous (IV) therapy drugs are covered only when they are purchased through designated pharmacy vendors. For details, please see *Direct Source Injectable and Implantable Medications* in Section 5(f).	10% of Plan Allowance for preferred drugs 20% of Plan Allowance for non-preferred drugs
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	**High Option**
Coverage is limited to 20 visits per calendar year. Services include: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$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	**High Option**
Biofeedback therapy for the treatment of certain conditions • Anesthesia • Pain Relief	$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
Not covered: • *Acupuncture*	*All charges*

Alternative treatments - continued on next page

Benefit Description	You pay After the calendar year deductible…
Alternative treatments (cont.)	**High Option**
• *Acupressure* • *Naturopathic or homeopathic services* • *Massage therapy* • *Hypnotherapy*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco Cessation programs, including individual/group/ telephone counseling, physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. (See section 5(f.) Prescription Drug Benefits) • Obesity education	• Nothing for counseling for up to two quit attempts per year.Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence. • Nothing
Coverage is limited to classes and programs that we authorize for the care and treatment of an illness or injury, such as: • Diabetes self-management • Asthma management • Medical nutrition therapy and/or diet counseling: - for a member who, based on our criteria, is a candidate for surgical treatment of morbid obesity - 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	$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
Not covered: • Literature such as books, journals, or subscriptions, unless included in an educational program that we approve • Medical nutrition therapy and/or diet counseling intended primarily for weight loss, unless the member meets our criteria for surgical treatment of morbid obesity	All charges

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 $1,300 for Self Only enrollment and $2,600 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.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Removal of tumors and cysts • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Correction of congenital anomalies (see *Reconstructive surgery*) • Treatment of burns • Routine circumcision of a newborn • Insertion of internal prosthetic devices. See Section 5(a) – *Orthopedic and prosthetic devices* for device coverage information . 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.	$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
• Injectable, implantable and intravenous (IV) drugs administered in conjunction with a surgery in a physician's office or in an urgent care center	10% of Plan Allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
• Surgical treatment of morbid obesity (bariatric surgery), subject to all of the following criteria: - 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; - 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; - 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; - 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 - 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.	10% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras (See *Orthopedic and prosthetic devices* in Section 5(a)) 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.	$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

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	**High Option**
• Injectable, implantable and intravenous (IV) drugs administered in conjunction with a surgery in a physician's office or in an urgent care center	10% of Plan Allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	$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
• Injectable, implantable and intravenous (IV) drugs administered in conjunction with a surgery in a physician's office or in an urgent care center	10% of Plan Allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
Altius Health Plans requires you to receive services from contracted physicians, hospitals and other providers. To receive Plan benefits, members must: - Receive transplant services through the Altius or Coventry Transplant Networks. - Call the Plan as soon as the possibility of a transplant is discussed. When you call, you will be given information about the program, including a list of participating providers and facilities. These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung	10% of Plan Allowance in a surgical center, hospital, or other facility

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
• Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	10% of Plan Allowance in a surgical center, hospital, or other facility
These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	10% of Plan Allowance in a surgical center, hospital, or other facility
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	10% of Plan Allowance in a surgical center, hospital, or other facility

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	10% of Plan Allowance in a surgical center, hospital, or other facility
Mini-transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures. • Allogenic transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis	10% of Plan Allowance in a surgical center, hospital, or other facility

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's PHN, pure red cell aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma	10% of Plan Allowance in a surgical center, hospital, or other facility
These **blood or marrow stem cell transplants** covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma	10% of Plan Allowance in a surgical center, hospital, or other facility

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	10% of Plan Allowance in a surgical center, hospital, or other facility
National Transplant Program (NTP)	10% of Plan Allowance in a surgical center, hospital, or other facility

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expense for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *Travel expenses, lodging, and meals*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	10% of Plan Allowance
Professional services provided in – • Office	$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

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.
- The deductible is $1,300 for Self Only enrollment and $2,600 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, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and 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.
- 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).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	10% of Plan Allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	10% of Plan Allowance

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	**High Option**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, long-term care facilities, and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics 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.	10% of Plan Allowance
Not covered: • *Personal comfort items*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Skilled nursing facility (SNF) /Extended care benefits: 30 days per member per calendar year • Professional services – physicians and general nursing care • Medical supplies and medications • Medical equipment ordinarily provided by a skilled nursing facility • Room and board	10% of Plan Allowance
Not covered: • *Custodial care, personal, comfort or convenience items*	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Hospice care	**High Option**
• Services for pain and symptom management • Short-term inpatient care and procedures necessary for pain control • Respite care may be provided only on an occasional basis and may not be provided longer than five days • Home visits made by a physician, nurse, home health aide, social worker or therapist with no limit on number of visits • General medical equipment and supplies related to the terminal illness	10% of Plan Allowance
Not covered: • *Independent nursing* • *Homemaker services* • *Specialized, customized equipment*	*All charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	10% of Plan Allowance
Not covered: • *Medical transportation for the convenience of you or your family*	*All charges*

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 $1,300 for Self Only enrollment and $2,600 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 website at 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.

- **Urgent Care outside our service area:**

If you are traveling outside our service area and experience an urgent medical condition, Coventry Health Care National Network providers are also available to you. You can locate a Coventry Health Care National Network provider by calling 1-800-369-9154 or use the "Search for a Coventry Health Care National Network provider" link on our Provider Search page at www.altiushealthplans.com

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$30 copayment per office visit
• Injectable, implantable 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
• Emergency care as an outpatient at a hospital, including doctors' services Note: Inpatient facility benefits apply if you are admitted to the hospital; see *Inpatient hospital* in Section 5(c).	$200 copayment per visit
Not covered: • *Elective care or non-emergency care in a hospital emergency room* • *Follow-up care in a hospital emergency room, unless we have given prior authorization*	*All charges*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$30 copayment per office visit
• Injectable, implantable 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
• Emergency care as an outpatient at a hospital, including doctors' services Note: Inpatient facility benefits apply if you are admitted to the hospital; see *Inpatient hospital* in Section 5(c).	$200 copayment per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Ambulance	**High Option**
• Professional ground ambulance, air ambulance, and/or paramedic services when medically appropriate. Note: See 5(c) for non-emergency service.	10% of Plan Allowance
Not covered: • *Medical transportation for the convenience of you or your family* • *Death-related transportation*	*All charges*

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

Important 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 $1,300 for Self Only enrollment and $2,600 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 INPATIENT SERVICES.** Benefits are payable only when we determine the care is medically necessary to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
- 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.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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 medically necessary treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits	**High Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is medically necessary 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	$20 per office visit
• Intensive outpatient treatment	$20 per office visit
• Diagnostic tests • Medication management	$20 per office visit

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits (cont.)	**High Option**
• 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
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's medical necessity. OPM will generally not order us to pay or provide one medically necessary treatment plan in favor of another.*	*All charges*

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 111.
- 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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- The deductible is $1.300 for Self Only enrollment and $2,600 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 physician or dentist, and in states allowing it, licensed or certified Physicians Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **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 111 of this booklet. If you need prescription medications while outside of the service area, ESI/Medco for the nearest Plan pharmacy, or you may pay for your prescription and ESI/Medco will reimburse you according to your benefits. To find out about Plan pharmacies, or get reimbursement for a covered drug, contact: ESI/Medco's Customer Service Department at 1-800-378-7040.

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/Medco's Customer Service Department at 1-800-378-7040 to get an order form. 3) Mail your prescription with the completed order form to ESI/Medco. Prescriptions are mailed within fourteen days, directly to your house or office in a labeled envelope to ensure privacy and safety. ESI/Medco has a pharmacist available to you 24 hours a day to answer your questions.

Through a Direct Source vendor: Certain injectable, implantable 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 Injectable and Implantable Medications* on page 110.

- **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 reserve the right to include only one manufacturer's product on our formulary when the same or similar drug (that is, a drug with the same active ingredient), supply, or equipment is made by two or more different manufacturers. We also reserve the right to include only one dosage or form of a drug on the Altius formulary when the same drug is available in different dosages or forms (for example, dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product or products and/or other forms or dosages of products that are not listed on the Altius formulary will be excluded from coverage. We list the most commonly requested formulary drugs on our Prescription Drug List. To order a Prescription Drug List, call our Customer Service Department at 1-800-377-4161 or 801-323-6200, or visit our website at www.altiushealthplans.com. The Prescription 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 Prescription 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 and implantable medications and devices, 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 or implantable medications that require prior authorization, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our website at 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, your physician may contact our Prior Authorization Department at 877-215-4100. 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 theESI/Medco 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. Byetta, Victoza, Bydureon,Insulin, and Symlin are the only injectable medications available through the ESI/Medco mail order service. Non-maintenance medications are not available through theESI/Medco mail order service. Examples of non-maintenance medications include, but are not limited to: antibiotics, pain management, muscle relaxants, anti-migraine, medications for sleep or anxiety, acne preparations, creams and ointments.

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, ESI/Medco 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.

Specialty Medications: A group of medications which are typically high-cost drugs and include but are not limited to those with oral, topical, inhaled, inserted or implanted, and injected routes of administration. Specialty Medications are designated as such in the fromulary. Included characteristics of Specialty Medications are by the following definitions and structure:

- Drugs which are used to treat and diagnose rare or complex diseases;
- Drugs which requir close clinical monitoring and management;
- Drugs which frequently require special handling; or
- Drugs which may have limited access or distribution.

- **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 ESI/Medco or Plan pharmacies outside of the service area. If one is not available, then ESI/Medco will reimburse you. Keep your receipts and mail them along with a reimbursement form. Call ESI/Medco at 1-800-378-7040 for the reimbursement form and instructions.
- **Preferred Injectables and Implantable Medications.** Similar to other prescription drugs, injectable, implantable and intravenous (IV) therapy drugs are categorized as “preferred” or “non-preferred” by our Pharmacy and Therapeutics Committee. If your injectable, implantable or IV medication is not listed on our Prescription 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.
- **Specialty / Direct Source Injectable and Implantable Medications.** Direct source injectables and implantable medications are certain injectable, implantable 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, implantable and IV drugs and designated vendors, please visit our website at www.altiushealthplans.com or call our Customer Service Department. This list may be changed periodically.

If your physician orders a specialty / direct source injectable, implantable 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, implantable or IV therapy drug rather than order it for you. When you obtain a prescription for an injectable, implantable or IV therapy drug, call our Customer Service Department or visit our website to see if you must order it through a designated vendor.

Most of the injectable, implantable and IV therapy drugs that must be purchased through a designated vendor are available through the ESI/Medco specialty pharmacy, Accredo. ESI/Medco will ship your injectable, implantable 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, ESI/Medco 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 your direct source injectable, implantable and IV drugs from theESI/Medco specialty pharmacy, Accredo, please call 1-800-378-7040.

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Contraceptive drugs • **Note: Deductible does not apply to Preventive Medications**	**Preferred generic:** $7 at a Plan pharmacy $21 for mail order **Preferred brand name:** $25 at a Plan pharmacy $75 for mail order **Non-preferred (non-formulary):** $50 at a Plan pharmacy $150 for mail order Notes: • If there is no preferred generic equivalent available, you will still have to pay the applicable preferred brand-name or non-preferred copay. • If the Plan Allowance for the prescription is less than the copay, you will pay the Plan Allowance.
• Insulin, Byetta, Symlin, insulin syringes, needles, glucose test strips and lancets	**Preferred:** $25 at a Plan pharmacy $75 for mail order **Non-preferred (non-formulary):** $50 at a Plan pharmacy $150 for mail order
• Injectable Imitrex, glucagon, insulin pens, Lovenox, and epinephrine kits such as Epi-Pen	$25 at a Plan pharmacy (not available through mail order)
• Injectable medications (other than Insulin, Imitrex, glucagon, Lovenox, and epinephrine kits), implantable medications and intravenous (IV) therapy drugs obtained through a Plan pharmacy or a Direct Source pharmacy vendor	**Preferred:** 10% of Plan Allowance **Non-preferred (non-formulary):** 20% of Plan Allowance (not available through mail order)
• Disposable needles and syringes needed for injecting covered prescription drugs (other than insulin), when filled as a separate prescription	$50 at a Plan pharmacy (not available through mail order)
• Drugs to treat sexual dysfunction, limited to 4 pills per month	50% of Plan Allowance at a Plan pharmacy
• Spacers (such as Aerochamber), limited to one per calendar year	**Preferred:**

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	**High Option**
	$25 at a Plan pharmacy **Non-preferred (non-formulary):** $50 at a Plan pharmacy
Women's contraceptive drugs and devices	Nothing
Not covered: • *Nonprescription medications, except those specifically listed in the Altius formulary* • *Drugs obtained at a non-Plan pharmacy, except for out-of-the-area emergencies* • *Medical supplies, such as dressing and antiseptics* • *Experimental medications* • *Fertility medications* • *Disposable needles and syringes not required for injecting covered prescribed medication* • *Natural progesterone (including suppositories and creams)* • *Medications or nutritional supplements for weight gain for non-medical indications* • *Immunizations and medications required exclusively for foreign travel* • *Hair growth products* • *Medications for cosmetic indications* • *Medications to enhance athletic performance* • *Replacement of lost, stolen, or damaged prescription drugs* *Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 84).*	*All charges*

Section 5(g). 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.
- If you are enrolled in a Federal Employees Dental/Vision Program (FEDVIP) Dental Plan, your FEHB Plan will be your First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- The deductible is $1,250 for Self Only enrollment and $2,500 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.

Accidental injury benefit	You Pay after the calendar year deductible...
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
Not covered: • *Implants*	*All charges*

Dental benefits	You Pay
We have no other dental benefits	*All charges*

Section 5(h). Special features

Feature	Description
Feature	**High Option**
Incentive for Completing Health Risk Assessments	The Altius Health Risk Assessment (HRA) is a confidential online questionnaire that takes less than 20 minutes to complete. Participants answer questions about nutrition, weight, physical activity, stress, safety and mental health. Upon completion, the Health Risk Assessment generates an evaluation of your current health status. Assessments are completely confidential and easy to access. Based on the results of your Assessment, you are provided the opportunity to be directed to personalized coaching programs to help acheive personal health goals. Programs may include but are not limited to, weight management, tobacco cessation, nutrition improvement, physical activity improvement, stress managment, cholesterol management, blood pressure management. When you complete your Atlius on-line Health Risk Assessment within 90 days of your effective date, Altius will provide you with a $50 credit to be applied directly toward your deductible. You must be 18 years or older and currently enrolled in an Altius Health Plan in order to complete the assessment. Visit our website, www.altiushealthplans.com, to complete the questionaire and to receive your results. You may also call our Customer Service Department at 1-800-377-4161 or 801-323-6200 for additional information.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf, hard of hearing, and non-English speaking members	If you need interpreter services for an appointment with a Customer Service Representative, you must arrange for these services by calling 801-323-6200 or 1-800-377-4161. When interpreter services are needed in the provider's office, contact the provider's office directly.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
High risk pregnancies	If you or your Plan provider feel that your pregnancy may be a difficult one, or that you may be at risk for complications, you or your PCP may ask us to assign you a 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.
Travel benefit/services overseas	Services outside of our service area are limited to emergency and urgent care only. See Section 5(d) for *Emergency services/accidents.*

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

Special features	Description
Health education resources	For information to help you take command of your health, visit the Health Information section of our website at www.altiushealthplans.com. This section is organized in simple, user-friendly sections: • ***My Online Services*** – Get access to information and resources that allow you to securely manage spending accounts and claims, research doctors and hospital quality information, access information on wellness programs and send and receive secure messages from customer service. • ***About Your Health*** – for information about a specific condition or general preventive guidelines. • ***Patient Safety*** • ***WebMD*** – our link to this health site also provides wellness and disease information to help improve health. • ***My Rx Choices*** – educational materials are also accessible through our website. A link to our pharmacy benefit manager, Medco, will take you to the following information: • Detailed information about a wide range of prescription drugs • 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 • Facts about why FDA-approved generic drugs should be a first choice for effective, economical treatment In addition, we augment our health education tools with access to our ***Nurse Advisor Services***. Experienced RNs are available 24x7x365 to assist you at 1-888-662-2297.
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through our password-protected, self-service functionality, ***My Online Services***, at www.altiushealthplans.com. You will receive an Explanation of Benefits (EOB) after every claim. If you have an **HSA**, • You may access your account on-line through Health Equity at www.healthequity.com. If you have an **HRA**, • You will receive a quarterly statement from Coventry Consumer Choice (C3) outlining your account balance and activity. • You may also access your account online through ***My Online Services*** at www.altiushealthplans.com.
Consumer choice information	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 website, www.altiushealthplans.com, 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 the offices of identified providers.

	Pricing information for medical care is available through **My Online Services** at www.altiushealthplans.com. There you will find **My cost of Care**, an average unit cost comparison tool which provides average cost information, based on the area in which you reside, 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. Pricing information for prescription drugs is available through **My Online Services** at www.altiushealthplans.com. There you will find a link to **My Rx choices**, an online service provided by our pharmacy benefit manager, Medco. This secure tool allows you to estimate prescription costs before ordering, compare prescription alternatives including generics, find pharmacies in your area and access other educational information. To access My Rx Choices, log on to My Online services at www.altiushealthplans.com then go to Pharmacy benefits, then click on the Medco link.
Care support	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.

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. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-800-377-4161 or visit their website at www.altiushealthplans.com.

Staying Healthy - Wellness Incentive

Altius encourages our members to stay healthy. One easy way is to take our on-line Health Risk Assessment. It only takes about 10 minutes and the results will be very useful. You will receive immediate information on your current health status and suggestions on how you can approve. Altius members age 18 and older, who take advantage of our preventive services or complete our on-line Health Risk Assessment, will receive a $50 Heath Reimbursement credit to use for copays, coinsurance or other covered out of pocket expenses.Contact Customer Service at 1-800-377-4161 for more information on the wellness incentive.

Wellbeing Offerings

Altius offers a wide variety of WellBeing Programs designed to target your wellness needs. You'll find a summary of each program below.

- **Online Health Risk Assessment**

This tool analyzes your responses to questions about your health history and lifestyle, and provides suggestions for reducing or eliminating your risks.

- **Web MD/Health Information Library**

The Health Information Library provides a wealth of clinical and health-related information at your fingertips. You may search by health topic, keywords, or via the valuable links to find various health-related articles and information.

- **Adults/Teens/Kids Health Information**

KidsHealth is organized for 3 different audiences with thousands of articles, movies, tools and games written and presented for 3 distinct age groups.

- **Disease Management and Telephonic Coach Outreach Program**

Care support for members with any of the following health concerns: Asthma, CAD, HIV/AIDS, CHF, COPD, CKD, Diabetes, Hemophilia, High-Risk Pregnancy, Low Back Pain, Multiple Sclerosis, Sickle Cell Disease, Transplant.

Value-Added Benefits

"AltiusExtra" is a way for you to get more from your health plan. You and your family can access sizeable discounts on a wide variety of goods and services that may not be covered by your Altius health plan. In addition to ongoing discounts, many of the providers who participate in AltiusExtra offer specials and drawings for free services throughout the year. Discounts include: acupuncture, child safety, cosmetic dentistry, cosmetic dermatology, cosmetic surgery, health-related coupons, day spa, eyewear, fitness routines, relaxation help, health clubs, hearing aids, helmets, LASIK eye surgery, mail order contact lenses, massage therapy, medical alarm, sunglasses, tattoo removal, and weight management.

Individual Plans

Altius Health Plans also offers Individual Plan options for those family members who are not eligible for FEHB program benefits. Call 1-888-955-0098 for more information.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- All services from a non-plan provider, including hospitals, surgical centers, and other facilities (except emergency care and out-of-area urgent care) that we have not approved (see Section 3).
- 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 (see specifics regarding transplants)
- 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
- Services, drugs, or supplies you receive without charge while in active military service.
- Applied Behavior Analysis (ABA)

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. 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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, conact us at 801-323-6200 or 1-800-377-4161, or at our website at www.altiushealthplans.com.

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

- Covered member's name, date of birth, address, phone number 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:
Altius Health Plans
Claims Department
P.O. Box 7147
London, KY 40742

Prescription drugs

Call Altius Customer Service Department at 1-800-377-4161 or 801-323-6200 to get forms and instructions for reimbursement.

Submit your claims to:
ESI/ Medco Claims
P.O. Box 14236
Lexington, KY 40512

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:
ESI/Medco Claims
P.O. Box 14236
Lexington, KY 40512

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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.altiushealthplans.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Altius Health Plans, Appeals Department, 10421 South Jordan Gateway, Ste 400, South Jordan, UT 84095 or calling 1-800-377-4161.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Altius Health lans, appeals Department, 10421 S Jordan Gtwy. Ste 400, South Jordan, UT 84095 ; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4. In the case of a post-service claim, we have 30 days from the date we receive your request to:

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a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

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If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance Group 2, 1900 E Street NW, Washington, DC 20415-3620

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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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 file a lawsuit, 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 file a lawsuit 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.

The disputed claims process*(continued)*

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 you did not indicate that your claim was a claim for urgent care, then call us at 801-323-6200 or 800-377-4164. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. EasternTime.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation Programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

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

When we are the secondary payor 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.

- **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 TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) 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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan covers some of these costs, providing the plan determines the services are medically necessary. We encourage you to contact the plan to discuss specific services if you participate in a clinical trial.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

When you have Medicare

- **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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) 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. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. 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. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **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, (TTY: 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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 will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 801-323-6200 or 1-800-377-4161 or see our website at www.altiushealthplans.com.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

You can find more information about how our plan coordinates benefits with Medicare in the Altius Health Plans Benefit Brochure located at www.altiushealthplans.com or contact Altius Customer Service at 801-323-6200 or 1-800-377-4161.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about the other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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), (TTY: 1-877-486-2048) or at 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). However, 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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
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	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 23.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 23.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

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

Custodial care

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.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for those services.

Experimental or investigational service

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.

A drug, device, or biological product or medical treatment or procedure is experimental or investigational if:

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
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.

	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. 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.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Hospital	A facility that is legally licensed as a general hospital or a specialty hospital.
Medical necessity	We determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are: 1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury; 2. Consistent with standards of good medical practice in the United States; 3. Not primarily for the personal comfort or convenience of the patient, the family or the provider; 4. Not part of or associated with scholastic education or vocational training of the patient; and 5. In the case of inpatient care, cannot be provided safely on an outpatient basis. 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.
Plan allowance	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. 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.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
• **Pre-certification or Prior Authorization**	Pre-certification or prior authorization is the process by which we evaluate the medical necessity of specific services prior to you receiving those services.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Provider	Any person, organization, health facility or institution legally licensed to deliver or furnish health care services.
Skilled nursing facility	A qualified, licensed facility designated by us that has the staff and equipment to provide skilled nursing care, as well as other related health services.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-377-4161 or 801-323-6200. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Urgent medical problems

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

Us/We

Us and We refer to Altius Health Plans.

You

You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Deductible	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 23.
Health Reimbursement Arrangement (HRA)	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 73.
Health Savings Account (HSA)	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 73.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)**, can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program - FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26)

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26)
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full time to be eligible for DCFSA.
- If you are a new or newly eligible employee you have 60 days from you hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program - FEDVIP

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All vision plans will provide comprehensive eye examinations and coverage for your choice of either lenses and frames or contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental or www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program - FLTCIP

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557) or visit 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.

Notes

Notes

Summary of benefits for the High Option of Altius Health Plans - 2015

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. This is a summary of 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.

High Option Benefits	You pay	Page
Medical preventive care (specified services only)	Nothing	27
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $30 specialist; $40 for after-hours or urgent care	27
• In a hospital, surgical center, or other facility	10% coinsurance	27, 49-51
Services provided by a hospital:		
• Inpatient	$200 per admission copay	49-51
• Outpatient	10% coinsurance	49
Emergency benefits:		
• In-area	$200 for emergency room services	53
• Out-of-area	$200 for emergency room services	53
Mental health and substance abuse treatment:	Regular cost-sharing	55-56
Prescription drugs:		
• Retail pharmacy	30-day supply – $7 preferred generic; $25 preferred brand name; 40% coinsurance - $60 minimum, $240 maximum for non-preferred (non-formulary)	59-61
• Mail order	90-day supply – $7 preferred generic; $50 preferred brand name; 40% coinsurance - $180 minimum, $720 maximum for non-preferred (non-forumlary)	59-61
• Injectable and intravenous therapy drugs	20% preferred; 30% non-preferred	59-61
Dental care:	See schedule of Dental Benefits	62
Vision care:	Annual eye examinations and refractions performed by an optometrist – $20 per office visit; $40 for an after-hours visit	29,34
Special features:	Incentive for completing Health Risk Assessment (HRA), Nothing for flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies; travel benefit/services overseas	66-67

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,500/individual or $4,500/family per year. Some costs do not count toward this protection	23

Summary of benefits for the Standard Option of Altius Health Plans - 2015

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

Standard Option Benefits	You pay	Page
Medical preventive care (specified services only)	Nothing	27
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay:$20 primary care; $40 specialist; $40 after hours or urgent care	27
• In a hospital, surgical center, or other facility	15% coinsurance	27,49-51
Services provided by a hospital:		
• Inpatient	15% coinsurance	49-51
• Outpatient	15% coinsurance	49
Emergency benefits		
• In-area	$250 for emergency room services	53
• Out-of-area	$250 for emergency room services	53
Mental health and substance abuse treatment:	Regular cost-sharing	55-56
Prescription drugs:		
• Retail pharmacy	30-day supply - $7 preferred generic; $35 preferred brand name; 50% coinsurance - $60 minimum, $240 maximum non-preferred (non-formulary)	59-61
• Mail order	90-day supply - $7 preferred generic; $70 preferred brand name; 50% coinsurance - $180 minimum, $720 maximum non-preferred (non-formulary)	59-61
• Injectable and intravenous therapy drugs	20% preferred; 30% non-preferred	59-61
Dental care:	Accidental Dental Only	62
Vision:	Annual eye examinations and refractions performed by an optometrist - $20 per office visit; $40 for an after-hours visit	29-34
Special features:	Incentive for completing Health Risk Assessment (HRA), Nothing for flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies; travel benefit/services overseas	66-67

Standard Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/individual or $5,000/family per year. Some costs do not count toward this protection	23

Summary of benefits for the HDHP of Altius Health Plans - 2015

- **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 2015, for each month you are eligible for the Health Savings Account (HSA) premium pass through, we will contribute to your HSA $54.16 per month for Self Only enrollment or $108.33 per month for Self and Family enrollment. For the HSA, you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $1,300 for Self Only and $2,600 for Self and Family. For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $650 for Self Only and $1,300 for Self and Family.
- All covered services listed below, except specified preventive care services, are subject to the calendar year deductible of $1,300 for Self Only and $2,600 for Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

HDHP Benefits	You Pay	Page
Medical preventive care (specified services only)	Nothing (not subject to deductible)	79-80
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $30 specialist; $30 for after-hours or urgent care	79
• In a hospital, surgical center, or other facility	10%	76, 92-99
Services provided by a hospital:		
• Inpatient	10%	100-102
• Outpatient	10%	100-102
Emergency benefits:		
• In-area	$100 for emergency room services	104
• Out-of-area	$200 for emergency room services	104
Mental health and substance abuse treatment:	Regular cost sharing	100-101
Prescription drugs:		
• Retail pharmacy	30-day supply – $7 preferred generic; $25 preferred brand name; $50 non-preferred **NOTE**: Deductible does not apply to Preventive Medications	111-112
• Mail order	90-day supply – $21 preferred generic; $75 preferred brand name; $150 non-preferred	111-112
• Injectable and intravenous (IV) therapy drugs	10% preferred; 20% non-preferred	111-112

HDHP Benefits	You Pay	Page
Dental care:	Accidental injury benefit only: regular cost sharing. No benefit for routine dental care	113
Vision care:	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	87
Special features:	Incentive for completing Health Risk Assessment (HRA), Nothing for flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies; travel benefit/services overseas	114
Protection against catastrophic costs (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	13, 23

2015 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 *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services) NALC, NPMHU and NRLCA Career Postal Employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-2IN); and non-career employees see (RI 70-8PS).

Postal Category 1 rates apply to career employees who are members of the APWU, NALC, NPMHU, or NRLCA bargaining units.

Postal Category 2 rates apply to career non-bargaining unit, non-executive, non-law enforcement employees, and non-law enforcement Inspection Service and Forensics employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

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 *Guide to Federal Benefits*.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	9K1	$202.01	$97.67	$437.69	$211.62	$83.64	$97.67
High Option Self and Family	9K2	$448.57	$210.76	$971.90	$456.65	$179.61	$210.76
Standard Option Self Only	DK4	$169.07	$56.36	$366.32	$122.11	$44.52	$56.36
Standard Option Self and Family	DK5	$371.95	$123.98	$805.89	$268.63	$97.95	$123.98
HDHP Option Self Only	9K4	$126.56	$42.18	$274.20	$91.40	$33.33	$42.18
HDHP Option Self and Family	9K5	$262.19	$87.39	$568.07	$189.35	$69.04	$87.39