

Altius Health Plans

www.altiushealthplans.com

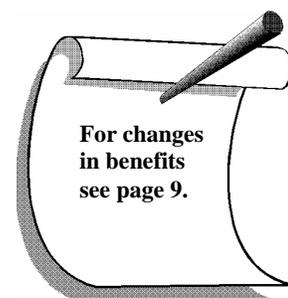


2005

A Health Maintenance Organization

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

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



Enrollment code for this Plan:

9K1 Self Only

9K2 Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

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

RI 73-564



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services Web site on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Web site at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James

Director



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

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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.

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

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

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

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

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

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

Table of Contents

Table of Contents	1
Introduction	3
Plain Language	3
Stop Health Care Fraud!	3
Preventing medical mistakes	5
Section 1. Facts about this HMO plan	7
How we pay providers	7
Your Rights	7
Service Area	8
Section 2. How we change for 2005	9
Program-wide changes	9
Changes to this Plan	9
Section 3. How you get care	10
Identification cards	10
Where you get covered care	10
• Plan providers	10
• Plan facilities	10
What you must do to get covered care	10
• Primary care	10
• Specialty care	11
• Hospital care	11
Circumstances beyond our control	12
Services requiring our prior approval	12
Section 4. Your costs for covered services	14
Copayments	14
Deductible	14
Coinsurance	14
Your catastrophic protection out-of-pocket maximum	14
Section 5. Benefits – OVERVIEW (<i>See page 9 for how our benefits changed this year and page 75 for a benefits summary.</i>)	15
Section 5(a) Medical services and supplies provided by physicians and other health care professionals	17
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals	29
Section 5(c) Services provided by a hospital or other facility, and ambulance services	35
Section 5(d) Emergency services/accidents	39
Section 5(e) Mental health and substance abuse benefits	41
Section 5(f) Prescription drug benefits	43
Section 5(g) Special features	47
• Flexible benefits option	47
• Services for deaf, hard of hearing, and non-English speaking members	47
• High risk pregnancies	47
• Travel benefit/services overseas	47
Section 5(h) Dental benefits	48
Section 5(i) Non-FEHB benefits available to Plan members	52

Section 6. General exclusions – things we don’t cover	53
Section 7. Filing a claim for covered services	54
Section 8. The disputed claims process	56
Section 9. Coordinating benefits with other coverage	58
When you have other health coverage	58
What is Medicare?	58
• Should I enroll in Medicare?	59
• The Original Medicare Plan (Part A or Part B)	59
• Medicare Advantage	61
TRICARE and CHAMPVA	61
Workers’ Compensation	61
Medicaid	62
When other Government agencies are responsible for your care	62
When others are responsible for injuries	62
Section 10. Definitions of terms we use in this brochure	63
Section 11. FEHB Facts	65
Coverage information	65
• No pre-existing condition limitation	65
• Where you can get information about enrolling in the FEHB Program	65
• Types of coverage available for you and your family	65
• Children’s Equity Act	66
• When benefits and premiums start	66
• When you retire	66
When you lose benefits	66
• When FEHB coverage ends	66
• Spouse equity coverage	67
• Temporary Continuation of Coverage (TCC)	67
• Converting to individual coverage	67
• Getting a Certificate of Group Health Plan Coverage	67
Section 12. Two Federal Programs complement FEHB benefits	69
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	69
The Federal Long Term Care Insurance Program	72
Index	74
Summary of benefits for Altius Health Plans - 2005	75
2005 Rate Information for Altius Health Plans	76
Wasatch Front and St. George:	76

Introduction

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

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-377-4161 or 801-323-6200 and explain the situation.

If we do not resolve the issue:

<p style="text-align: center;">CALL — THE HEALTH CARE FRAUD HOTLINE 202-418-3300</p> <p>OR WRITE TO: United States Office of Personnel Management Office of the Inspector General Fraud Hotline 1900 E Street NW Room 6400 Washington, DC 20415-1100</p>

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self-support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

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

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

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

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

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

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"

- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. 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/consumer.html. 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.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO plan

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

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 and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. We compensate contracted providers by either discount fee-for-service fee schedules or capitation agreements. **It is your responsibility to verify that the provider you use is a Plan provider. Except for emergency and out-of-area urgent care, we will not pay for care or services from non-Plan providers or facilities unless it has been authorized by us. If you use a non-Plan provider or facility without authorization from us, you may be responsible for all charges.**

Altius Health Plans is a Mixed Model Plan (MMP). This means the doctors provide care in contracted medical centers or in their own offices. Approximately 1,250 Primary Care Physicians and 2,150 specialists participate in this Plan.

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Altius Health Plans is a State of Utah licensed Health Maintenance Organization.
- Altius Health Plans (formerly PacifiCare of Utah) has been in existence for over 25 years.
- Altius Health Plans is a for-profit, wholly-owned subsidiary of Coventry Health Care, Inc.

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

Service Area

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

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

Juab – 84628, 84639, 84640, 84645, 84648

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

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

Section 2. How we change for 2005

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

Program-wide changes

- In Section 9, we revised the Medicare Primary Payer Chart and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program – *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

- Your share of the non-Postal premium will increase by 3.6% for Self Only or 4% for Self and Family.
- We have added Iron county to our service area. See “Service Area” in Section 1.
- We have clarified the list of services that we consider to be major diagnostic labs and radiology tests. See Sections 5(a) and 5(c) for details.
- We have clarified that you pay 10% of Plan Allowance for services provided by a speech therapist in a surgical center, hospital or other facility. See Section 5(a) for details.
- We have clarified the benefits in Vision Services. See Section 5(a) for details.
- We no longer list the drugs that require prior authorization in this brochure because the prior authorization list is reviewed on a quarterly basis and may change due to new drugs, new generics, new therapies, new guidelines from the Food and Drug Administration (FDA), or other factors. To obtain a list of drugs that require prior authorization, or to obtain a list of injectable medications that require prior authorization, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at www.altiushealthplans.com. See Section 5(f) for details.
- We have clarified that when a new generic medication is approved by the FDA, our Pharmacy and Therapeutics Committee may classify it as “non-formulary.” Non-formulary generics are subject to the non-formulary copayment listed in Section 5(f).
- We have clarified that for mail-order drugs, Express Scripts may fill your prescription with a preferred generic equivalent if it is available, unless your physician has indicated “Dispense as Written.” See Section 5(f) for details.
- We have clarified that 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. See Section 5(f) for details.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

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

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, we encourage you and each family member to choose a primary care physician, although you are not required to do so. However, choosing a primary care physician is beneficial since your primary care physician can provide and help coordinate your health care. Your primary care physician will know your overall medical history, help you to make informed decisions, and focus on preventive care to help you stay healthy. If you have been seeing a primary care physician, or you would like to choose a primary care physician, make sure he/she is listed in the provider directory. If you need help choosing a primary care physician, call us at 1-800-377-4161 or 801-323-6200.

- **Primary care**

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

- **Specialty care**

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

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician can work with your specialist to develop a treatment plan that recommends you to see the specialist for a certain number of visits. Your Plan provider will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician can help decide what treatment you need. If he or she decides to refer you to or recommends that you see a specialist, let him or her know that you would like to see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - reduce our service area and you enroll in another FEHB Plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us at 1-800-377-4161 or 801-323-6200 or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility. **Please note:** It is your responsibility to verify that your physician has arranged for your care in a Plan facility. We will not pay for services provided by a non-Plan facility without our prior authorization. See “Services requiring our prior approval” in this section.

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 1-800-377-4161 or 801-323-6200. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

For certain services, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

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

- All Services from non-Plan Providers, including hospitals, surgical centers, and other facilities (except emergency care and out-of-area urgent care)
- Behavioral Health Services (inpatient and outpatient) – including neuro-psychological testing and treatment, mental health services, alcohol and substance abuse treatments
- Cardiac-Pulmonary Rehabilitation (outpatient)
- Chiropractic Services (after initial consultation)
- Durable Medical Equipment
- Genetic Counseling – evaluation and testing
- Health Education Services
- Home Health Care
- Infertility evaluations and treatment
- Injectable Medications, including certain intravenous (IV) therapy and chemotherapy drugs. See Sections 5(a) (Treatment therapies) and 5(f) for details.
- Inpatient Facility Admissions
- Inpatient Rehabilitation Admissions
- Medical Coverage of Dental Services
- Medical Nutrition Therapy
- Osteopathic Manipulative Treatment

- Outpatient Surgeries
- Outpatient Therapy – occupational, physical, speech, biofeedback, and hyperbaric oxygen therapy services
- Pain Management Services
- PET Scans
- Plastic Surgery and related procedures (cosmetic procedures are not covered)
- Skilled Nursing Facility Admissions
- Transportation (non-urgent)
- We require prior authorization for certain prescription drugs. To obtain a list of these drugs, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at www.altiushealthplans.com.

Your primary care or specialty care physician must request prior authorization for you by calling or faxing us directly. Once we have received all required information, we will authorize or deny services as soon as possible, but within 24 hours for urgent services and within two to five business days for routine services. If we deny the request for prior authorization, we will notify your provider by telephone. We will also send a letter to you and to your provider with an explanation of the denial.

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

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

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

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

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

Section 4. Your costs for covered services

You must share the costs of some services. You are responsible for:

Copayments

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

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

Deductible

We do not have a deductible.

Coinsurance

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

Example: In our Plan, you pay 50% of our allowance for infertility services and durable medical equipment.

Your catastrophic protection out-of-pocket maximum

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

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

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

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

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and page 75 for a benefits summary.)

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

Section 5(a) Medical services and supplies provided by physicians and other health care professionals	17
Diagnostic and treatment services	17
Lab, X-ray and other diagnostic tests	18
Preventive care, adult	19
Preventive care, children	20
Maternity care	20
Family planning	21
Infertility services	21
Allergy care	22
Treatment therapies	22
Physical and occupational therapies	23
Speech therapy	23
Hearing services (testing, treatment, and supplies)	23
Vision services (testing, treatment, and supplies)	24
Foot care	24
Orthopedic and prosthetic devices	25
Durable medical equipment (DME)	26
Home health services	27
Chiropractic	27
Alternative treatments	27
Educational classes and programs	28
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals	29
Surgical procedures	29
Reconstructive surgery	31
Oral and maxillofacial surgery	31
Organ/tissue transplants	32
Anesthesia	33
Section 5(c) Services provided by a hospital or other facility, and ambulance services	35
Inpatient hospital	35
Outpatient hospital or ambulatory surgical center	37
Extended care benefits/Skilled nursing care facility benefits	37
Hospice care	38
Ambulance	38
Section 5(d) Emergency services/accidents	39
Emergency within our service area	40
Emergency outside our service area	40
Ambulance	40
Section 5(e) Mental health and substance abuse benefits	41
Mental health and substance abuse benefits	41
Section 5(f) Prescription drug benefits	43
Covered medications and supplies	45
Section 5(g) Special features	47
Flexible benefits option	47
Services for deaf, hard of hearing, and non-English speaking members	47
High risk pregnancies	47
Travel benefit/services overseas	47

Section 5(h) Dental benefits	48
Accidental injury benefit	48
Dental benefits.....	48
Section 5(i) Non-FEHB benefits available to Plan members	52
Summary of benefits for Altius Health Plans - 2005.....	75
2005 Rate Information for Altius Health Plans	76

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION FOR SOME SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians	\$10 per office visit to a primary care physician
<ul style="list-style-type: none"> • In a physician's office • Office medical consultations • Second surgical opinion 	\$15 per office visit to a specialist \$20 for an after-hours or urgent care visit to a primary care physician or specialist
Professional services of physicians	\$20 per visit
<ul style="list-style-type: none"> • In an urgent care center 	
Professional services of physicians	10% of Plan Allowance
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	

Lab, X-ray and other diagnostic tests	You pay
<p>Minor diagnostic tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EEG 	<p>Nothing in a physician's office or at an independent lab if performed in conjunction with an office visit</p> <p>10% of Plan Allowance in a hospital or other facility</p>
<p>Major diagnostic labs and radiology tests, such as:</p> <ul style="list-style-type: none"> • 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 • Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes • Cytogenetic studies 	<p>10% of Plan Allowance</p>

Preventive care, adult	You pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Fasting lipid profile (total cholesterol, LDL, HDL, triglycerides) • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy screening – every five years starting at age 50 – Colonoscopy screening – every 10 years starting at age 50 – Double contrast barium enema – every five years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine pap test <p>Note: The office visit is covered if pap test is received on the same day; see “Diagnostic and treatment services” above.</p> <ul style="list-style-type: none"> • Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> – 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 • Osteoporosis screening <ul style="list-style-type: none"> – for women age 65 and older – for women age 60 though 64 who are at increased risk for osteoporosis 	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a hospital or other facility</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel</i></p>	<p><i>All charges</i></p>
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p>
<p><i>Not covered: Immunizations exclusively for travel</i></p>	<p><i>All charges</i></p>

Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) 	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a hospital or other facility</p>
<i>Not covered: Immunizations exclusively for travel</i>	<i>All charges</i>
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care • Obstetrical care in an observation setting <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need prior authorization for normal delivery; see page 13 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 <u>routine</u> nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Note: For newborn circumcision, see surgery benefits in Section 5(b). • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See hospital benefits in Section 5(c) and surgery benefits in Section 5(b). 	<p>10% of Plan Allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Routine sonograms to determine fetal age, size or sex</i> • <i>Home delivery</i> 	<i>All charges</i>

Family planning	You pay
<p>A range of voluntary family planning services, such as:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See “Surgical procedures” in Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) <p>Note: We cover oral contraceptives and diaphragms under the prescription drug benefit; see Section 5(f).</p>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Predictive genetic testing and/or counseling</i> 	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) 	<p>50% of Plan Allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Fertility Medications</i> • <i>Infertility services after voluntary sterilization</i> 	<p><i>All charges</i></p>

Allergy care	You pay
<ul style="list-style-type: none"> • Testing and treatment 	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p>
<ul style="list-style-type: none"> • Allergy serum • Allergy injections 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 32.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy and IV antibiotic therapy <p>Note: We cover home IV infusion and antibiotic therapy administered by a home health agency under the home health services benefit.</p> <p>Note: We require prior authorization for certain injectable and IV therapy drugs, including some chemotherapy drugs. To obtain a list of injectable and IV drugs that require prior authorization, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at www.altiushealthplans.com. Injectable and IV drugs are covered under the prescription drug benefit when you purchase them from a pharmacy.</p> <ul style="list-style-type: none"> • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit. We require prior authorization for growth hormone. We will ask your physician to submit information that establishes that the GHT is medically necessary. You must verify that your physician has received prior authorization from us for growth hormone; otherwise, we will cover GHT services only from the date that your physician submits the information. If your physician does not request prior authorization, or if we determine that GHT is not medically necessary, we will not cover the GHT or related services and supplies. To verify prior authorization, you may call your physician and ask for the prior authorization number we provided, or you may call us directly at 801-323-6200 or 1-800-377-4161. See “Services requiring our prior approval” in Section 3.</p>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours or urgent care visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>

Physical and occupational therapies	You pay
<p>60 visits per condition per year for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. We cover physical and occupational therapy under the home health services benefit when provided by a home health agency as part of an authorized home treatment plan.</p> <ul style="list-style-type: none"> • 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 	<p>\$15 per office visit</p> <p>\$20 for an after-hours visit</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Therapy that we determine will not significantly improve your condition • Exercise programs 	<p><i>All charges</i></p>
Speech therapy	
<p>60 visits per condition per year</p> <p>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.</p>	<p>\$15 per office visit</p> <p>\$20 for an after-hours visit</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
Hearing services (testing, treatment, and supplies)	
<p>Hearing testing for children and adults in a provider's office</p>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p>
<p>Inpatient hearing examination for a newborn child covered under a family enrollment</p>	<p>10% of Plan Allowance</p>
<p><i>Not covered: Hearing aids, including testing, examinations, and fittings for them</i></p>	<p><i>All charges</i></p>

Vision services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses (including professional services for such fitting) to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	50% of Plan Allowance
<ul style="list-style-type: none"> Annual eye refractions and exams performed by an optometrist <p>Note: See “Preventive care, children” for eye exams for children</p>	\$10 per office visit; \$20 for after-hours visit
<ul style="list-style-type: none"> Eye exams performed by an ophthalmologist 	\$15 per office visit; \$20 for after-hours or urgent care visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Extra charges for designer or deluxe frames</i> <i>Extra charges for progressive lenses</i> <i>Scratch resistant lens coating</i> <i>Oversize lenses, tinting, antireflective coating, and U-V lenses, unless prescribed by an ophthalmologist for eyeglasses that are necessary to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts)</i> <i>Eyeglasses or contact lenses for refractive purposes</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy, LASIK, and other refractive surgery</i> 	<i>All charges</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p> <p>Note: See “Orthopedic and prosthetic devices” for information on podiatric shoe inserts.</p>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p>

Foot care – continued on next page

Foot care <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> • <i>Foot orthotics</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome 	<p>50% of Plan Allowance</p>
<ul style="list-style-type: none"> • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy <p>Note: See Sections 5(b) and 5(c) for coverage of the surgery to insert the device.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices, unless medically necessary</i> • <i>Replacement of prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's physical condition</i> 	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment</p> <p>Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps 	50% of Plan Allowance
<ul style="list-style-type: none"> • Oxygen concentrators • Medically necessary accessories and supplies such as hoses, tubes, oxygen and ostomy supplies <p>Note: Call us at 1-800-377-4161 or 801-323-6200 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Durable medical equipment, corrective appliances, prostheses and artificial aids, including supplies and accessories, are excluded when primarily used for convenience, comfort, or in the absence of an illness or injury. Routine periodic servicing, such as cleaning and regulating is not covered.</i> • <i>Replacement of durable medical equipment, prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's condition</i> 	<i>All charges</i>

Home health services	You pay
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications • Home visits made by a physician • Home rehabilitative therapy, including physical therapy and occupational therapy when significant improvement can be expected • Home speech therapy • Home visits by a medical social worker 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> 	<i>All charges</i>
Chiropractic	
<p>Coverage is limited to 20 visits per calendar year. Services include:</p> <ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p>
Alternative treatments	
<p>Biofeedback therapy that we have pre-authorized for the treatment of certain conditions</p>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>

Alternative treatments – continued on next page

Alternative treatments <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Acupuncture</i> • <i>Acupressure</i> • <i>Naturopathic or homeopathic services</i> • <i>Massage therapy</i> • <i>Hypnotherapy</i> • <i>Biofeedback that we have not pre-authorized</i> 	<p><i>All charges</i></p>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self-management • Asthma Management <p>Note: We cover educational classes provided by a hospital as a hospital benefit; see Section 5(c).</p>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p>

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must use a Plan facility. It is your responsibility to verify that your physician has scheduled your surgery in a Plan facility. We will not pay for services provided by a non-Plan provider or facility without our prior authorization.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRIOR AUTHORIZATION OF SURGICAL PROCEDURES.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

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Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as:	\$10 per office visit to a primary care physician
• Operative procedures	\$15 per office visit to a specialist
• Treatment of fractures, including casting	\$20 for an after-hours or urgent care visit to a primary care physician or specialist
• Removal of tumors and cysts	10% of Plan Allowance in a surgical center, hospital, or other facility
• 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”)	

Surgical procedures – continued on next page

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Treatment of burns • Surgical treatment of morbid obesity based on criteria that we have established • Routine circumcision of a newborn • Insertion of internal prosthetic devices. See Section 5(a) – “Orthopedic and prosthetic devices” for device coverage information <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours or urgent care visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see “Foot care”</i> 	<p><i>All charges</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance of breasts – treatment of any physical complications – breast prostheses, lymphedema pumps, surgical bras and replacements (See “Orthopedic and prosthetic devices” in Section 5(a)) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours or urgent care visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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; 	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours or urgent care visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>

Oral and maxillofacial surgery – continued on next page

Oral and maxillofacial surgery (<i>continued</i>)	You pay
<ul style="list-style-type: none"> • 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 	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>\$20 for an after-hours or urgent care visit to a primary care physician or specialist</p> <p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants 	<p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Autologous tandem transplants for testicular or other germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute- or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>10% of Plan Allowance in a surgical center, hospital, or other facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>Travel expenses, lodging, and meals</i> 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>10% of Plan Allowance</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	<p>10% of Plan Allowance</p>

Anesthesia – continued on next page

Anesthesia (continued)	You pay
Professional services provided in – <ul style="list-style-type: none"> • Office 	\$10 per office visit to a primary care physician \$15 per office visit to a specialist \$20 for an after-hours or urgent care visit to a primary care physician or specialist

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. It is your responsibility to verify that your physician has arranged for your care in a Plan facility. We will not pay for services provided by a non-Plan facility without our prior authorization.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRIOR AUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

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Benefit Description	You pay
Inpatient hospital	
Room and board, such as: <ul style="list-style-type: none"> • 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

Inpatient hospital - continued on next page

Inpatient hospital <i>(continued)</i>	You pay
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • 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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, long-term care facilities schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>

Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • 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 • Educational programs for asthma or diabetes self-management <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Nothing
<p>Major diagnostic labs and radiology tests, such as:</p> <ul style="list-style-type: none"> • 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 • Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes • Cytogenetic studies 	10% of Plan Allowance
<i>Not covered: Personal comfort items</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	
<p>Skilled nursing facility (SNF) /Extended care benefits: 30 days per member per calendar year</p> <ul style="list-style-type: none"> • Professional services – physicians and general nursing care • Medical supplies and medications • Medical equipment ordinarily provided by a skilled nursing facility • Room and board 	Nothing
<i>Not covered: Custodial care, personal, comfort or convenience items</i>	<i>All charges</i>

Hospice care	You pay
<ul style="list-style-type: none"> • 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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing</i> • <i>Homemaker services</i> • <i>Specialized, customized equipment</i> 	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate 	\$50 copayment per incident
<p><i>Not covered: Medical transportation for the convenience of you or your family</i></p>	<i>All charges</i>

Section 5(d) Emergency services/accidents

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

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

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What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area:

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

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

Emergencies outside our service area:

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

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

Section 5(e) Mental health and substance abuse benefits

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

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

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

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers on an outpatient basis • Intensive outpatient treatment 	\$15 per visit
<ul style="list-style-type: none"> • Diagnostic tests • Medication management 	<p>\$10 per office visit to a primary care physician</p> <p>\$15 per office visit to a specialist</p>

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<ul style="list-style-type: none"> Services provided by a hospital or other facility on an inpatient basis (room and board), including partial hospitalization 	Nothing
<ul style="list-style-type: none"> Professional services by providers such as psychiatrists, psychologists, or clinical social workers provided on an inpatient basis 	10% of Plan Allowance
<p><i>Not covered: Services we have not approved</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges</i>

Preauthorization

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

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

Mental Health and Substance Abuse Catastrophic Protection Out-Of-Pocket Maximums

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

Limitation

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

Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 45.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR CERTAIN DRUGS.**
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed practitioner who has the legal authority to prescribe medications.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication.
 - At a pharmacy: To get your prescription filled, present your Altius membership card to any Plan pharmacy. You will pay the prescription drug copayment listed on page 45 of this booklet. If you need prescription medications while outside of the service area, contact Express Scripts, Inc (ESI) for the nearest Plan pharmacy, or you may pay for your prescription and ESI will reimburse you according to your benefits. To find out about Plan pharmacies, or get reimbursement for a covered drug, contact: Express Scripts, Inc, Customer Service Department at 1-800-698-0149.
 - By mail: 1) Get a prescription for your maintenance medication with the maximum refills allowed from your Plan provider (see “Prescription Mail Services” below for a definition of a maintenance medication). 2) Contact ESI’s Customer Service Department at 1-800-698-0149 to get an order form. 3) Mail your prescription with the completed order form to Express Scripts, Inc. Prescriptions are mailed within fourteen days, directly to your house or office in a labeled envelope to ensure privacy and safety. ESI has a pharmacist available to you 24 hours a day to answer your questions.
- **We use a formulary.** The Altius formulary is a list of “preferred” prescription drugs that are identified by our team of physicians and pharmacists (Pharmacy and Therapeutics Committee) to be the best overall value based on quality, safety, effectiveness, and cost. Our formulary includes nearly all covered generic drugs, and specific brand-name drugs selected by the Committee. We list the most commonly requested formulary drugs on our Preferred Drug List. To order a Preferred Drug List, call our Customer Service Department at 1-800-377-4161 or 801-323-6200, or visit our Web site at www.altiushealthplans.com. The Preferred Drug List is subject to review and modification on a quarterly basis.

We also cover non-preferred (non-formulary) drugs prescribed by your Plan physician. However, we encourage you to use preferred drugs, especially preferred generics, whenever possible because they will cost you less. Refer to your Preferred Drug List, and check with your physician or pharmacist to find out if a preferred generic is available, or if a lower-cost alternative might work for you.

- **Prior Authorization.** We require prior authorization for certain drugs. We also require prior authorization for injectable medications, including certain drugs used for intravenous (IV) therapy and chemotherapy. To obtain a list of drugs that require prior authorization, or to obtain a list of injectable medications that require prior authorization, please call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or visit our Web site at www.altiushealthplans.com. The prior authorization drug list is reviewed by our Pharmacy and Therapeutics Committee and may change from time to time due to new drugs, new generics, new therapies, new guidelines from the Food and Drug Administration (FDA), or other factors.

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

- **These are the dispensing limitations.**

- Your pharmacist will fill up to a maximum 30-day supply of medications prescribed by a Plan provider, unless otherwise stated by us, State law, Federal law, or as determined by the manufacturer’s package size. You will pay one copayment for each prescription filled, even if your prescription provides less than a 30-day supply.
 - Some medications have specific limits on how much of the medication you can get with each prescription or refill. This is to ensure that you receive the recommended and proper dose and length of drug therapy for your condition. Quantity level limits are reviewed by the Pharmacy and Therapeutics Committee and are based on maximum dosage levels indicated by the drug manufacturer and the FDA. **Your physician must get authorization for any amount of your prescription that exceeds the quantity level limit.**
 - Prescription Mail Services: You can get a 90-day supply of maintenance medications through the mail service. A maintenance medication is a prescription that is recommended by the 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. With the exception of insulin (in vials only), injectable medications are not available through mail order. Non-maintenance medications are not available through mail order. Examples of non-maintenance medications include, but are not limited to: antihistamines, antibiotics, pain management, muscle relaxants, anti-migraine, medications for sleep or anxiety, acne preparations, creams and ointments.
 - The amount of medication dispensed to you should last for a specific time period as prescribed by your physician. At least 75% of that time must pass before you can get a refill, either at a pharmacy or, when applicable, through the mail. For example: if your prescription provides a 30-day supply, you can refill your prescription no sooner than 23 days after the prescription was filled ($30 \text{ days} \times 75\% = 23 \text{ days}$).
 - You may ask your pharmacist for a preferred generic equivalent if it is available, unless your physician specifically requires a name brand and indicates “Dispense as Written” on your prescription. For mail-order drugs, Express Scripts may fill your prescription with a preferred generic equivalent if it is available, unless your physician has indicated “Dispense as Written.” If a preferred generic equivalent is not available, or if your physician specifically requires a name brand, you will pay the name brand copayment. Note: If your physician writes a prescription for a non-preferred (non-formulary) generic, you may ask your pharmacist for an equivalent preferred name brand 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-formulary.” Non-formulary generics are subject to the non-formulary copayment listed in this section. Note: If your physician writes a prescription for a non-preferred (non-formulary) generic, you may ask your pharmacist for an equivalent preferred name brand drug.
- **Why use preferred generic drugs?** Preferred generic drugs are therapeutically equivalent to brand-name drugs, but they cost less. They have the same active ingredients, and are required by the U.S. Food and Drug Administration to meet the same quality standards for safety, strength, and effectiveness. You pay your lowest copay when you use preferred generic drugs.
 - **When you have to file a claim.** If you are outside of the service area and need a prescription, contact Express Scripts for Plan pharmacies outside of the service area. If one is not available, then Express Scripts will reimburse you. Keep your receipts and mail them along with a reimbursement form. Call Express Scripts at 1-800-698-0149 for the reimbursement form and instructions.

Prescription drug benefits begin on the next page

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i> • Contraceptive drugs 	<p>Preferred generic: \$10 at a Plan pharmacy \$20 for mail order</p> <p>Preferred name brand: \$20 at a Plan pharmacy \$40 for mail order</p> <p>Non-formulary: \$40 at a Plan pharmacy \$80 for mail order</p> <p>Note: If there is no preferred generic equivalent available, you will still have to pay the name brand copay.</p>
<ul style="list-style-type: none"> • Insulin, insulin syringes, needles, glucose test strips and lancets 	<p>Preferred: \$20 at a Plan pharmacy \$40 for mail order</p> <p>Non-formulary: \$40 at a Plan pharmacy \$80 for mail order</p>
<ul style="list-style-type: none"> • Injectable Imitrex, Glucagon, Lovenox, and Epi-Pen 	<p>\$20 at a Plan pharmacy (not available through mail order)</p>
<ul style="list-style-type: none"> • Injectable medications (other than Insulin, Imitrex, Glucagon, Lovenox, and Epi-Pen) obtained through a Plan pharmacy • Disposable needles and syringes needed for injecting covered prescribed medication other than insulin 	<p>\$40 at a Plan pharmacy (not available through mail order)</p>
<ul style="list-style-type: none"> • Drugs to treat sexual dysfunction, limited to 6 pills per month 	<p>50% of Plan Allowance at a Plan pharmacy</p>
<ul style="list-style-type: none"> • Aerochamber, limited to one per calendar year 	<p>\$20 at a Plan pharmacy</p>
<ul style="list-style-type: none"> • Diaphragms, limited to one every three months 	<p>\$20 at a Plan pharmacy</p>

Medications and supplies – continued on next page

Medications and supplies <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nonprescription medications, except those specifically listed in the Altius formulary</i> • <i>Drugs obtained at a non-Plan pharmacy, except for out-of-the-area emergencies</i> • <i>Medical supplies, such as dressing and antiseptics</i> • <i>Experimental medications</i> • <i>Fertility medications</i> • <i>Disposable needles and syringes not required for injecting covered prescribed medication</i> • <i>Natural progesterone (including suppositories and creams)</i> • <i>Smoking cessation products and medications prescribed for smoking cessation</i> • <i>Skin patches for motion sickness</i> • <i>Medications or nutritional supplements for weight loss or weight gain for non-medical indications</i> • <i>Immunizations and medications required exclusively for foreign travel</i> • <i>Hair growth products</i> • <i>Medications for cosmetic indications</i> • <i>Insulin pens and insulin pen needles</i> • <i>Medications to enhance athletic performance</i> 	<p><i>All charges</i></p>

Section 5(g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf, hard of hearing, and non-English speaking members	<p>If you need interpreter services for an appointment with a Customer Service Representative, you must arrange for these services by calling 801-323-6200 or 1-800-377-4161.</p> <p>When interpreter services are needed in the provider's office, contact the provider's office directly.</p>
High risk pregnancies	<p>If you or your Plan provider feel that your pregnancy may be a difficult one, or that you may be at risk for complications, you or your PCP may ask us to assign you an Altius Baby Care prenatal case manager. A prenatal case manager is a Registered Nurse with special training in maternity care. Your case manager will ask you questions about your medical history and then tell you what you can do to keep yourself and your baby healthy. Your case manager will also work with your provider to plan a course of treatment for you and will check with you from time to time to see how you are doing.</p>
Travel benefit/services overseas	<p>Services outside of our service area are limited to emergency and urgent care only. See Section 5(d) for Emergency services/accidents.</p>

Section 5(h) Dental benefits

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

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

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Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$10 per office visit to a primary care physician \$15 per office visit to a specialist \$20 for an after-hours or urgent care visit to a primary care physician or specialist 10% of Plan Allowance in a surgical center, hospital, or other facility
<i>Not covered: Implants</i>	<i>All charges</i>

Dental benefits

Dental benefits are administered by Monarch Dental Associates. Refer to your dental provider directory for a list of participating dental providers. The dental provider directory can also be found online at www.altiushealthplans.com. If you have any questions about dental providers or about dental claims (that are not related to accidental injury), please call Monarch Dental Associates at 801-220-0940 or 1-877-221-0940. For questions about your dental benefits, you may call our Customer Service Department at 801-323-6200 or 1-800-377-4161, or you may call Monarch directly.

<p>Preventive & diagnostic</p> <p>Initial examination, including full series x-rays</p> <p>Recall examinations, including bite wing x-rays</p> <p>Single films</p> <p>Prophylaxis and fluoride treatment (child)</p> <p>Prophylaxis (adult)</p> <p>Preventive education</p>	<p>Nothing</p>
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Dental benefits – continued on next page

Dental benefits <i>(continued)</i>	You pay
Sealant – per tooth	\$9
Emergency treatment	
Palliative during office hours	\$16
After hours or as provided by the Monarch dentist on call	\$60
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 posterior or Composite anterior for permanent or primary teeth	
Amalgam	
1 surface	\$15
2 surfaces	\$21
3 surfaces	\$27
4 or more surfaces	\$41
Composite (anterior)	
1 surface	\$21
2 surfaces	\$35
3 surfaces	\$53
4 or more surfaces	\$70
Periodontics	
Deep scaling, root planing and curettage per quadrant	\$77
Periodontal consultation	\$41
Gingivectomy per quadrant	\$120
Muco-osseous surgery per quadrant	\$270
Gingivectomy per tooth (to three teeth)	\$20

Dental benefits – continued on next page

Dental benefits (continued)	You pay
Oral surgery	
Extractions (routine) 1 st tooth	\$36
Each additional tooth	\$29
Surgical removal of erupted tooth	\$61
Impacted teeth – soft tissue	\$65
Impacted teeth – partial bony	\$97
Impacted teeth – full bony	\$135
Endodontics	
Pulp cap	\$20
Vital pulpotomy	\$30
Root Canal, Single canal	\$119
Two canals	\$144
Three canals	\$177
Crowns & Bridges	
Crown build up with pins	\$35
Preformed post and build up	\$59
Stainless steel crown	\$67
Porcelain fused to metal crown per unit	\$306
Porcelain fused to precious metal per unit	\$386
Removable dentures	
Complete denture (upper or lower)	\$424
Partial denture – cast frame	\$474
Teeth & clasp, extra per unit	\$40
Stayplates	\$169
Repairs, full or partial dentures, simple or one involved tooth	\$38
Each additional tooth	\$11
Relines, per denture	\$142

Dental benefits – continued on next page

Dental benefits <i>(continued)</i>	You pay
<p>Preventive appliances</p> <p>Space maintainer – unilateral</p> <p>Lingual holding arch</p> <p>Habit-breaking appliance</p>	<p>\$52</p> <p>\$55</p> <p>\$99</p>
<p>The following services are limited:</p> <ul style="list-style-type: none"> • 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 	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Implants</i> • <i>Surgical grafting procedures</i> • <i>Treatment for developmental malformations such as enamel hypoplasia and fluorosis (brown and white stains on teeth)</i> • <i>Maxillary and mandibular malformations and anodontia</i> • <i>General anesthetic</i> • <i>Composite resin on posterior teeth</i> • <i>Cosmetic or orthodontic treatment</i> • <i>Full mouth rehabilitation, periodontal splints, restoration of tooth structure lost from attrition and restoration for misalignment of the teeth</i> • <i>Dental treatment for temporomandibular (jaw) joint disorders and related diseases</i> • <i>Replacement of lost or stolen denture, bridges or other dental appliances</i> • <i>Services not specified as covered</i> 	<p><i>All charges</i></p>

Section 5(i) Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward out-of-pocket maximums.

Value-Added Benefits:

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

No Computer? No Problem!

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

Overview of the “AltiusExtra” Services:

- **Optical Discounts:** 10-30% discounts on prescription and non-prescription eyewear and other products from participating Altius Optical providers.
- **LASIK Vision Eye Surgery:** AltiusExtra has contracted with multiple LASIK centers to provide more choice and greater convenience at competitive prices.
- **Vitamins, Minerals and Nutritional Supplements:** A complete line of quality vitamins and minerals at significantly discounted prices delivered right to your door!
- **Hearing Aids:** These state-of-the-art hearing aids are smaller and less noticeable than ever before and available at significant discounts for Altius members. For more information call Beltone at 1-800-BEL-TONE.
- **Cosmetic Dentistry:** Advances in teeth whitening technology along with the cost savings available with AltiusExtra, a brighter smile is more attainable and affordable than ever before.
- **Cosmetic Surgery:** There is virtually no part of the body that can’t be enhanced and improved by cosmetic surgery. Thanks to new techniques in surgery and anesthesia, many procedures are easier, less painful, and recovery is faster.
- **Massage Therapy:** Therapeutic massage is an enjoyable, non-invasive way to improve health, fitness, and general wellness.
- **Health Club Membership:** The health clubs participating with AltiusExtra offer discounts on individual and family memberships.
- **Cosmetic Dermatology:** Cosmetic Dermatology offers new ways to help skin look better.
- **Shopping:** Check this out for health related products, books, videos, personal exercise equipment, plus links to other shopping sites.

We continually expand our value-added benefit program throughout the year. Visit our Web site at www.altiushealthplans.com, for details on the most up-to-date value-added programs!

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services requiring our prior approval* on page 12.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals (see Section 3) or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Telephone consultations;
- Services or supplies given by a health care provider who lives in the same household as the patient;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

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

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

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

Submit your claims to:

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

Prescription drugs

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

Submit your claims to:

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

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

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

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

Submit your claims to:

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

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within six months from the date of our decision; andSend your request to us at: Altius Health Plans, Appeals Department, 10421 South Jordan Gateway, Suite 400, South Jordan, UT 84095; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p>

Disputed claims process – continued on next page.

The disputed claims process *(continued)*

Send OPM the following information:

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

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

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

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

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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 sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

- a) We haven't responded yet to your initial request for care or prior authorization, then call us at 1-800-377-4161 or 801-323-6200 and we will expedite our review; or
- b) We denied your initial request for care or prior authorization, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage”.

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

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

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

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

- **Should I enroll in Medicare?**

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

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

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

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs, (but coverage through private prescription drug plans will be available starting in 2006).

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 801-323-6200 or 1-800-377-4161.
- If your Plan provider does not participate in Medicare, you will have to file a claim with Medicare.

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

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

Primary Payer chart begins on next page.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
B. 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 payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
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

• Medicare Advantage

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) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) 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). When we pay as secondary, we will waive any copayments or coinsurance you have under this plan. However, if your Medicare Advantage plan denies coverage for a service or supply, we will not waive the copayment or coinsurance for that service or supply. 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 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.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

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.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
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.
Experimental or investigational services	<p>A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.</p> <p>A drug, device, or biological product or medical treatment or procedure is experimental or investigational if:</p> <ol style="list-style-type: none">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; or2. 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. <p>Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product, or medical treatment or procedure.</p> <p>FDA-approved drugs, devices, or biological products used for their intended purposes and labeled indications and those that have received FDA approval subject to postmarketing approval clinical trials, and devices classified by the FDA as “Category B Non-experimental/investigational Devices” are not considered experimental or investigational when used for the intended purposes and labeled indications as approved by FDA, provided those purposes and indications would otherwise be eligible for Plan benefits.</p>
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.

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 medical problems

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

Us/We

Us and We refer to Altius Health Plans.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

- **Children’s Equity Act**

OPM has implemented the Federal Employees Health Benefits Children’s Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 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 2004 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

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

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

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12. Two Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Program – *FSAFEDS*

- **What is an FSA?**

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

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

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

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

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

What is SHPS?

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

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

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

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

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006, to submit claims for eligible expenses.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 14 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

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

- Office visit copayments
- Coinsurance for physicians’ services provided in a hospital
- Dental copayments
- Eyeglasses and contact lenses
- Orthodontics (braces)
- Vision correction surgery

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see**

insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. Publication 502 can be found on the IRS Web site at www.irs.gov/pub/irs-pdf/p502.pdf. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

• **Tax savings with an FSA**

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

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

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

• **Tax credits and deductions**

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

Health care expenses

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

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

Dependent care expenses

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

Visit www.FSAFEDS.com and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

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

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

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via e-mail or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

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

The Federal Long Term Care Insurance Program

- **It's important protection**

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

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later. In order to qualify for coverage under the FLTCIP,** you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.

- **You don't have to wait for an Open Season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

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.

Accidental injury.....	23, 31, 48	Out-of-pocket expenses	59, 70
Allergy tests	22	Oxygen	26, 27, 36, 37
Allogeneic (donor) bone marrow transplant.....	32	Pap test	18, 19
Alternative treatments	27, 28	Physician	26, 29
Ambulance	35, 38, 40	Precertification	57
Anesthesia.....	6, 29	Prescription drugs.....	54, 61, 75
Autologous bone marrow transplant	22, 33	Preventive care, adult	19
Biopsy	29	Preventive care, children	20
Blood and blood plasma.....	37	Preventive services	7
Casts.....	36, 37	Prior approval	56, 57
Catastrophic protection out-of-pocket maximum	14, 75	Prosthetic devices	25
Changes for 2005	9	Psychologist.....	41
Chemotherapy	22	Radiation therapy.....	22
Chiropractic	27	Room and board	35
Cholesterol tests	19	Second surgical opinion	17
Circumcision	20	Skilled nursing facility care .	17, 33, 37
Claims	15, 54, 56, 60, 66, 70	Social worker.....	41
Coinurance	7, 14, 54, 61, 63, 70	Speech therapy	23
Colorectal cancer screening	19	Splints.....	36
Congenital anomalies.....	29, 31	Subrogation	62
Contraceptive drugs and devices	21, 45	Substance abuse.....	75
Covered charges.....	59	Surgery	6, 20, 23, 24, 25
Crutches	26	Anesthesia.....	37
Definitions	63	Oral	32
Dental care	48, 75	Outpatient	37
Diagnostic services	17, 36, 41, 75	Reconstructive	29, 31
Disputed claims review.....	47	Syringes	45
Donor expenses.....	33	Temporary Continuation of Coverage (TCC).....	66
Dressings.....	36	Transplants	22, 33
Durable medical equipment	26	Treatment therapies	22
Effective date of enrollment.....	11	Vision care.....	75
Emergency	7, 39, 40, 53, 54, 75	Vision services	24
Experimental or investigational	53	Wheelchairs	26
Eyeglasses.....	24	Workers Compensation	61
Family planning	21	X-rays	18, 36, 37
Fraud.....	3, 4		
General exclusions.....	53		
General Exclusions	15		
Hearing services	23		
Home health services.....	27		
Hospice care	38		
Hospital. 5, 6, 7, 11, 17, 26, 29, 31, 33, 35, 36, 37, 40, 42, 48, 54, 59, 61, 62, 75			
Immunizations	7, 19		
Infertility	14, 21		
Inpatient hospital benefits.....	54		
Insulin	45		
Magnetic Resonance Imagings (MRIs)	18		
Mammograms	18		
Maternity benefits	20		
Medicaid	62		
Medically necessary 17, 20, 22, 29, 35, 39, 41, 43, 48, 53			
Medicare	41, 58, 60		
Medicare Advantage	61		
Original	59, 61		
Members			
Associate.....	76		
Family	65		
Mental Health/Substance Abuse Benefits	41		
Newborn care.....	20		
Nurse			
Licensed Practical Nurse (LPN).....	27		
Occupational therapy	23		
Ocular injury.....	24		
Office visits.....	7, 14		
Oral and maxillofacial surgical.....	31		

Summary of benefits for Altius Health Plans - 2005

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

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$15 specialist; \$20 for after-hours or urgent care	17
• In a hospital, surgical center, or other facility	10%	17, 29-34
Services provided by a hospital:		
• Inpatient	Nothing	35-38
• Outpatient	Nothing	
Emergency benefits		
• In-area	\$50	40
• Out-of-area	\$100	40
Mental health and substance abuse treatment	Regular cost sharing	41-42
Prescription drugs	Prescription Drugs/30-day supply – \$10 copay generic/formulary, \$20 copay brand/formulary, \$40 copay non-formulary Prescription Mail Order/90-day supply – \$20 copay generic, \$40 copay brand name, \$80 copay non-formulary	45
Dental care	See schedule of Dental Benefits	48-51
Vision care	Annual eye examinations and refractions performed by an optometrist – \$10 per office visit; \$20 for an after-hours visit Eye examinations and refractions performed by an ophthalmologist – \$15 per office visit; \$20 for after-hours or urgent care	20, 24
Special features: Flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies; travel benefit/ services overseas		47
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$2,000/Self Only or \$4,000/Family enrollment per year Some costs do not count toward this protection	14

2005 Rate Information for Altius Health Plans

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	9K1	\$131.08	\$62.12	\$284.01	\$134.59	\$154.74	\$38.46
Self & Family	9K2	\$298.23	\$126.83	\$646.17	\$274.79	\$352.08	\$72.98