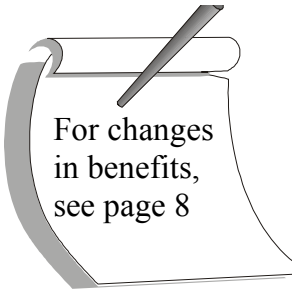
Altius Health Plans

www.altiushealthplans.com

2003

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 7 for requirements.

Enrollment codes for this Plan:

9K1 Self Only
9K2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees Health Benefits Program

RI 73-564

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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the 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 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 healthcare 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 202-606-0191 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
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 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 will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of Altius Health Plans under our contract (CS 2839) with the Office of Personnel Management (OPM), 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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and are summarized on page 8. 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 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 us at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) 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 you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 1-800-377-4161 or 801-323-6200 and explain the situation.
    - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE
202-418-3300

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

- 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 or with OPM if you are retired.
- 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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. We compensate contracted providers by either discount fee-for-service fee schedules or capitation agreements. **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 1,140 Primary Care Physicians and 2,350 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 website 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 website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Altius Health Plans is a State of Utah licensed Health Maintenance Organization.
- Altius Health Plans (formerly PacifiCare of Utah) has been in existence for over 24 years.
- Altius Health Plans is a private for-profit corporation.

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

Service Area

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

The counties of Box Elder, Cache, Carbon, Davis, Morgan, Salt Lake, 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 you care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have received prior plan approval.

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

Section 2. How we change for 2003

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

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 9.9% for Self Only or 9.7% for Self and Family.
- You are encouraged but no longer required to select a primary care physician.
- You can now self refer to Plan specialists; you don't need a referral from a primary care physician. (Section 3)
- We have changed our medical and prescription drug Prior Authorization Lists. (Sections 3 and 5(f))
- We have expanded our service area to include all of Sanpete County.
- Your copayments for most dental services have increased. (Section 5(h))
- Your copayment for office visits to a specialist has increased to $15 each visit. You still pay $10 for each visit to a primary care physician.
- We have clarified the Vision Services benefit to show that we do not cover extra charges for deluxe or designer frames, progressive lenses, scratch resistance lens costing, and oversize lenses, tinting, antireflective coating and UV lenses unless prescribed by an ophthalmologist. (Section 5(a))
- We have clarified the Organ/Tissue Transplants benefit by removing the references to the National Transplant Program. With the exception of intestinal transplants, all transplant services that we cover are available in the Salt Lake area. (Section 5(b))
- We have further clarified that it is your responsibility to verify that the provider you use is a Plan provider. We will not pay for services provided by a non-Plan provider or facility without our prior authorization. This does not apply to emergency and out-of-area urgent care. If you use a non-Plan provider or facility without our prior authorization, you may be responsible for the charges.
- Your copayment for preferred name brand drugs at a Plan pharmacy has increased to $20 ($40 for mail order), and your copayment for non-formulary drugs at a Plan pharmacy has increased to $40 ($80 for mail order). (Section 5(f))

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 website 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 website. If you have questions about plan providers, call us at 1-800-377-4161 or 801-323-6200 or visit our website at www.altiushealthplans.com.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, 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 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 can help arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  – terminate our contract with your specialist for other than cause; or

  – drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  – reduce our service area and you enroll in another FEHB Plan,

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

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

• Hospital care

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility. **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.

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 (excluding Imitrex, insulin, glucagon kits and bee sting kits)
- 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 and SPECT Scans

- Plastic Surgery and related procedures (cosmetic procedures are not covered)
- Radiation Oncology Services
- Skilled Nursing Facility Admissions
- Transportation (non-urgent)
- We require prior authorization for certain prescription drugs. See section 5(f) for a list of these drugs.

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 emergent services and within two to five business days for routine services. If we deny the request for prior authorization, we will notify your provider by telephone. We will also send a letter to you and to your provider with an explanation of the denial.

Emergent hospital admissions do not require prior authorization, but we must be notified as soon as reasonably possible. If you, a friend, or family member does not let us know, it could result in no coverage for all services received after your condition is stabilized.

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 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 cost of some services.

You are responsible for:

•Copayments

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

Example: When you see 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 negotiated fee that you must pay for your care.

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

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments

After your copayments and/or coinsurance total $2,000 per person or $4,000 per family enrollment in any calendar year, you do not have to pay any more for covered services for the remainder of the calendar year. However, copayments and/or coinsurance for the following services do not count toward your 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 8 for how our benefits changed this year and page 62 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 website at www.altiushealthplans.com

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In a physician's office • Office medical consultations • Second surgical opinion	$10 per office visit to a primary care physician $15 per office visit to a specialist $20 for an after-hours or urgent care visit to a primary care physician or specialist
Professional services of physicians • In an urgent care center	$20 per visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	10% of Plan Allowance
Lab, X-ray and other diagnostic tests	
Minor diagnostic tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EEG	Nothing in a physician's office or at an independent lab if performed in conjunction with an office visit 10% of Plan Allowance in a hospital or other facility
Major diagnostic labs and x-rays, such as: • Cat Scans and MRIs • PET and SPECT Scans • Angiography	10% of Plan Allowance

Preventive care, adult	You pay
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Fasting lipoprotein profile (total cholesterol, LDL, HDL, triglycerides) – once every 5 years starting at age 20 • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Colonoscopy – once every 10 years starting at age 50 – Double contrast barium enema (DCBE) – once every 5-10 years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment,* above. • Routine mammogram –covered for women age 35 and older, as follows: – From age 35 through 39, one during this five year period – From age 40 through 64, one every calendar year – At age 65 and older, one every two consecutive calendar years	$10 per office visit to a primary care physician $15 per office visit to a specialist $20 for an after-hours visit to a primary care physician or specialist 10% of Plan Allowance in a hospital or other facility
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over	$10 per office visit to a primary care physician $15 per office visit to a specialist $20 for an after-hours visit to a primary care physician or specialist
Not covered: Immunizations exclusively for travel	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (to age 22) • Examinations, such as: – Eye exams through age 17 to determine the need for vision correction. – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (to age 22)	$10 per office visit to a primary care physician $15 per office visit to a specialist $20 for an after-hours visit to a primary care physician or specialist 10% of Plan Allowance in a hospital or other facility

Preventive care, children – continued on next page

Preventive care, children *(continued)*	**You pay**
Not covered: Immunizations exclusively for travel	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Obstetrical care in an observation setting	10% of Plan Allowance
Note: Here are some things to keep in mind: • You do not need prior authorization for normal delivery; see page 12 for other circumstances, such as extended stays for your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Note: For newborn circumcision, see Surgery benefits (Section 5b). • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Home delivery*	*All charges*
Family planning	
A range of voluntary family planning services, such as: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) Note: We cover oral contraceptives and diaphragms under the prescription drug benefit; see section 5(f).	$10 per office visit to a primary care physician $15 per office visit to a specialist $20 for an after-hours visit to a primary care physician or specialist
Not covered: • *Reversal of voluntary surgical sterilization* • *Predictive genetic testing and/or counseling*	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterine insemination (IUI)	50% of Plan Allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *invitro fertilization* – *embryo transfer, gamete GIFT and zygote zift* – *zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility Medications* • *Infertility services after voluntary sterilization*	*All charges*
Allergy care	
Testing and treatment	$10 per office visit to a primary care physician $15 per office visit to a specialist $20 for an after-hours visit to a primary care physician or specialist
Allergy serum Allergy Injections	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 26. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy and IV antibiotic therapy Note: We cover home IV infusion and antibiotic therapy administered by a home health agency under the home health services benefit. • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. We require prior authorization for growth hormone. 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.	$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
Physical and occupational therapies	
• 60 visits per condition per year for the services of each of the following: – qualified physical therapists – occupational therapists Note: We only cover these therapies to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. We cover physical and occupational therapy under the home health services benefit when provided by a home health agency as part of an authorized home treatment plan. • Outpatient Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility for up to 12 weeks for Phase II and Phase III combined.	$15 per office visit; $20 for after-hours visit 10% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: • *Long-term rehabilitative therapy* • *Therapy that we determine will not significantly improve your condition* • *Exercise programs*	*All charges*
Speech therapy	
60 visits per condition per year Note: We cover speech therapy under the home health services benefit when provided by a home health agency as part of an authorized home treatment plan.	$15 per office visit; $20 for after-hours visit

Hearing services (testing, treatment, and supplies)	You pay
• Hearing testing for children and adults in a provider's office	$10 per office visit to a primary care physician $15 per office visit to a specialist $20 for an after-hours visit to a primary care physician or specialist
• Inpatient hearing examination of a newborn child covered under a family enrollment	10% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: • *Hearing aids, including testing, examinations, and fittings for them.*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	50% of Plan Allowance
• Annual eye refractions and exams performed by an optometrist Note: See Preventive care, children for eye exams for children	$10 per office visit; $20 for after-hours visit
• Eye exams performed by an ophthalmologist	$15 per office visit; $20 for after-hours or urgent care visit
Not covered: • *Extra charges for designer or deluxe frames* • *Extra charges for progressive lenses* • *Scratch resistant lens coating* • *Oversize lenses, tinting, antireflective coating, and U-V lenses, unless prescribed by an ophthalmologist* • *Eyeglasses or contact lenses for refractive purposes* • *Eye exercises and orthoptics* • *Radial keratotomy, LASIK, and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit to a primary care physician $15 per office visit to a specialist $20 for an after-hours visit to a primary care physician or specialist

Foot care – continued on next page

Foot care *(continued)*	**You pay**
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	50% of Plan Allowance
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy Note: See Sections 5(b) and 5(c) for coverage of the surgery to insert the device.	Nothing
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices unless medically necessary* • *Replacement of prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's physical condition*	*All charges*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds • wheelchairs • crutches • walkers • blood glucose monitors • insulin pumps	50% of Plan Allowance
• oxygen concentrators	Nothing

Durable Medical Equipment – continued on next page

Durable medical equipment (DME) *(continued)*	**You pay**
Medically necessary accessories and supplies such as hoses, tubes, oxygen and ostomy supplies Note: Call us at 1-800-377-4161 or 801-323-6200 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing
Not covered: • *Durable medical equipment, corrective appliances, prostheses and artificial aids, including supplies and accessories, are excluded when primarily used for convenience, comfort, or in the absence of an illness or injury. Routine periodic servicing, such as cleaning and regulating is not covered* • *Replacement of prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's condition*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications • Home visits made by a physician • Home rehabilitative therapy, including physical therapy and occupational therapy when significant improvement can be expected • Home speech therapy • Home visits by a medical social worker	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	
Coverage is limited to 20 visits per calendar year. Services include: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$10 per office visit to a primary care physician $15 per office visit to a specialist $20 for an after-hours visit to a primary care physician or specialist

Alternative treatments	You pay
No Benefit	*All charges*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management • Asthma Management Note: We cover educational classes provided by a hospital as a hospital benefit; see section 5(c).	$10 per office visit to a primary care physician $15 per office visit to a specialist

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care 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.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Removal of tumors and cysts • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Correction of congenital anomalies (see reconstructive surgery) • Treatment of burns • 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 braces and prosthetic devices for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$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
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes • All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast – treatment of any physical complications – breast prostheses, lymphedema pumps, surgical bras and replacements (See Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit 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
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$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
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogenic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	10% of Plan Allowance in a surgical center, hospital, or other facility
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Travel expenses, lodging, and meals*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	10% of Plan Allowance
Professional services provided in – • Hospital outpatient department • Ambulatory surgical center • Skilled Nursing Facility	10% of Plan Allowance

Anesthesia – continued on next page

Anesthesia *(continued)*	**You pay**
Professional services provided in – • 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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. 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 covered 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.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • ward, semiprivate, or intensive care accommodations • general nursing care • meals and special diets NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • 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

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, long-term care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Minor diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics • Educational programs for asthma or diabetes self-management NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Major diagnostic labs and x-rays, such as: • Cat Scans and MRIs • PET and SPECT Scans • Angiography	10% of Plan Allowance
Not covered: Personal comfort items	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF)/Extended care benefits: 30 days per member per calendar year • Professional services – physicians and general nursing care • Medical supplies and medications • Medical equipment ordinarily provided by a skilled nursing facility • Room and board	Nothing
Not covered: Custodial care, personal, comfort or convenience items	*All charges*

Hospice care	You pay
• Services for pain and symptom management • Short-term inpatient care and procedures necessary for pain control • Respite care may be provided only on an occasional basis and may not be provided longer than five days • Home visits made by a physician, nurse, home health aide, social worker or therapist with no limit on number of visits • General medical equipment and supplies related to the terminal illness	Nothing
Not covered: • *Independent nursing* • *Homemaker services* • *Specialized, customized equipment*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	$50 copayment per incident
Not covered: Medical transportation for the convenience of the member or family	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure 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.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

- **Emergencies within our service area:**

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

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

- **Emergencies outside our service area:**

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

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 copayment per office visit
• Emergency care as an outpatient at a hospital, including doctors' services (copayment is waived if you are admitted to the hospital)	$50 copayment per visit
Not covered: • *Elective care or non-emergency care in a hospital emergency room* • *Follow-up care in a hospital emergency room, unless we have given prior authorization*	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 copayment per office visit
• Emergency care as an outpatient at a hospital, including doctors' services (copayment is waived if you are admitted to the hospital)	$100 copayment per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ground ambulance, air ambulance, and/or paramedic services when medically appropriate. See 5(c) for non-emergency service.	$50 copayment per incident
Not covered: • *Medical transportation for the convenience of you or your family* • *Death-related transportation*	*All charges*

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

IMPORTANT

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

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

- 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.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for any other illness or conditions
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers on an outpatient basis • Intensive outpatient treatment	$15 per visit
• Diagnostic tests • Medication management	$10 per office visit to a primary care physician $15 per office visit to a specialist
• Services provided by a hospital or other facility on an inpatient basis (room and board), including partial hospitalization	Nothing
• Professional services by providers such as psychiatrists, psychologists, or clinical social workers provided on an inpatient basis	10% of Plan Allowance

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all the following authorization processes: You must contact Horizon Behavioral Services at 1-800-701-8663 for prior authorization of all inpatient and outpatient mental health/substance abuse services, information about contracted mental health providers and/or immediate access to care. You may call 24 hours a day, seven days a week.
Mental Health and Substance Abuse 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.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.

IMPORTANT

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 pages 36 and 37 of this booklet. If you need prescription medications while outside of the service area, contact Express Scripts, Inc (ESI) for the nearest Plan pharmacy, or you may pay for your prescription and ESI will reimburse you according to your benefits. To find out about Plan pharmacies, or get reimbursement for a covered drug, contact: Express Scripts, Inc, Customer Service Department at 1-800-698-0149.
  - By mail: 1) Get a prescription for your maintenance medication with the maximum refills allowed from your Plan provider (see "Prescription Mail Services" below for a definition of a maintenance medication). 2) Contact ESI's Customer Service Department at 1-800-698-0149 to get an order form. 3) Mail your prescription with the completed order form to Express Scripts, Inc. Prescriptions are mailed within fourteen days, directly to your house or office in a labeled envelope to ensure privacy and safety. ESI has a pharmacist available to you 24 hours a day to answer your questions.
- **We use a formulary**. The Altius formulary is a list of "preferred" prescription drugs that are identified by our team of physicians and pharmacists (Pharmacy and Therapeutics Committee) to be the best overall value based on quality, safety, effectiveness, and cost. Our formulary includes all covered generic drugs, and specific brand-name drugs selected by the Committee. We list the most commonly requested formulary drugs on our Preferred Drug List. To order a Preferred Drug List, call our Customer Service Department at 1-800-377-4161 or 801-323-6200. The Preferred Drug List is subject to review and modification on a quarterly basis.

  We also cover non-preferred drugs prescribed by your Plan doctor. However, we encourage you to use preferred drugs, especially generics, whenever possible because they will cost you less. Refer to your Preferred Drug List, and check with your doctor or pharmacist to find out if a generic is available, or if a lower-cost alternative might work for you.
- **These are the dispensing limitations.**
  - Your pharmacist will fill up to a maximum 30-day supply of medications prescribed by a plan provider, unless otherwise stated by us, State law, Federal law, or as determined by the manufacturer's package size. You will pay one copayment for each prescription filled, even if your prescription provides less than a 30-day supply.
  - 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 Food & Drug Administration (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 daily basis. Examples include, but are not limited to, medications for blood pressure, asthma, antidepressants, diabetes, hormone replacement and birth control. With the exception of insulin (in vials only), injectable medications are not available through mail order. Non-maintenance medications are not available through mail order. Examples of non-maintenance medications include, but are not limited to: antihistamines, antibiotics, pain management, muscle

relaxants, anti-migraine, medications for sleep or anxiety, acne preparations, creams and ointments.

- You must use at least 75% of your current prescription before you can get a refill, either at a pharmacy or, when applicable, through the mail.

- You may ask your pharmacist for a generic equivalent if it is available, unless your physician specifically requires a name brand and indicates "Dispense as Written" on your prescription. If a generic equivalent is not available, or if your physician specifically requires a name brand, you will pay the name brand copayment.

- **Why use generic drugs?** Generic drugs are therapeutically equivalent to brand-name drugs, but they cost less. They have the same active ingredients, and are required by the U.S. Food and Drug Administration to meet the same quality standards for safety, strength, and effectiveness. You pay your lowest copay when you use generic drugs.
- **When you have to file a claim**. If you are outside of the service area and need a prescription, contact Express Scripts for Plan pharmacies outside of the service area. If one is not available, then Express Scripts will reimburse you. Keep your receipts and mail them along with a reimbursement form. Call Express Scripts at 1-800-698-0149 for the reimbursement form and instructions.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not Covered* • Contraceptive drugs	**Generic:** $10 at a pharmacy $20 for mail order **Preferred name brand:** $20 at a pharmacy $40 for mail order **Non-formulary:** $40 at a pharmacy $80 for mail order Note: If there is no generic equivalent available, you will still have to pay the name brand copay.
• Insulin, insulin syringes, needles, glucose test strips and lancets	**Preferred:** $20 at a pharmacy $40 for mail order **Non-formulary:** $40 at a pharmacy $80 for mail order
• Imitrex, Glucagon, Lovenox, and Epi-Pen	$20 at a pharmacy (not available through mail order)
• 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	$40 at a pharmacy (not available through mail order)

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You pay**
• Drugs to treat sexual dysfunction, limited to 6 pills per month (see Prior Authorization below).	50% of Plan Allowance
• Aerochamber, limited to one per calendar year	$20 copayment
• Diaphragms, limited to one every three months	$20 copayment

Prior Authorization Requirements

Your physician must get prior authorization for the following specific medications:

- Accutane
- Aggrenox
- Celebrex (twice daily dosing)
- Clarinex
- DDAVP (ages 1-18)
- Differin (ages >26)
- Diflucan (strengths other than 150 mg; not covered for toe nail infection)
- fluoxetine (doses above 60mg/day)
- Gleevec
- Lamisil
- Nexium
- OxyContin
- Prilosec
- Prozac (doses above 60mg/day)
- Rebetol
- Regranex
- Relenza
- Retin A (ages >26)
- Sporanox (not covered for toe nail infection)
- Tamiflu
- Tazorac (ages >26)
- tretinoin (ages >26)

Your physician must also get prior authorization for the following:

- Drugs to treat sexual dysfunction when medically necessary
- Injectable medications (except Insulin, Imitrex, Glucagon, Lovenox, and Epi-Pen)
- Any amount of a prescription that exceeds the maximum dosage level indicated by the drug manufacturer and the FDA

Note: For authorization, physicians must fax the request form to us. Each request will be answered by a return fax.

Not covered: • *Nonprescription medications* • *Drugs obtained at a non-Plan pharmacy, except for out-of-the-area emergencies* • *Medical supplies, such as dressing and antiseptics* • *Experimental medications* • *Fertility medications* • *Disposable needles and syringes not required for injecting covered prescribed medication* • *Natural progesterone (including suppositories and creams)* • *Smoking cessation products and medications prescribed for smoking cessation* • *Skin patches for motion sickness* • *Medications or nutritional supplements for weight loss or weight gain for non-medical indications* • *Immunizations and medications required exclusively for foreign travel* • *Hair growth products* • *Medications for cosmetic indications* • *Insulin pens and insulin pen needles* • *Medications to enhance athletic performance*	*All Charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf, hard of hearing, and non-English speaking members	If you need interpreter services for an appointment with a Customer Service Representative, you must arrange for these services by calling 801-323-6200 or 1-800-377-4161. When interpreter services are needed in the provider's office, contact the provider's office directly.
High risk pregnancies	If you or your Plan provider feel that your pregnancy may be a difficult one, or that you may be at risk for complications, you or your PCP may ask us to assign you an 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.
Travel benefit/ services overseas	Services outside of our service area are limited to emergency and urgent care only. See Section 5(d) for Emergency services/accidents.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Plan dentists must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- 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.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$10 per office visit 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
Not covered: Implants	*All charges*
Dental benefits	
Preventive & diagnostic Initial examination, including full series x-rays Recall examinations, including bite wing x-rays Single films Prophylaxis and fluoride treatment (child) Prophylaxis (adult) Preventive education	Nothing
Sealant – per tooth	$9
Emergency treatment	
Palliative during office hours	$16
After hours or as provided by the Altius 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

Dental benefits – continued on next page

Dental benefits *(continued)*	**You pay**
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
Oral surgery	
Extractions (routine) 1st 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

Dental benefits – continued on next page

Dental benefits *(continued)*	**You pay**
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
Preventive appliances	
Space maintainer – unilateral	$52
Lingual holding arch	$55
Habit-breaking appliance	$99
The following services are limited: • Replacement of prosthetic appliances less than five years old is covered only when good dental care dictates and such replacement is prescribed by a Plan dentist • Single unit gold restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials	
Not covered: • *Implants* • *Surgical grafting procedures* • *Treatment for developmental malformations such as enamel hypoplasia and fluorosis (brown and white stains on teeth)* • *Maxillary and mandibular malformations and anodontia* • *General anesthetic* • *Composite resin on posterior teeth* • *Cosmetic or orthodontic treatment* • *Full mouth rehabilitation, periodontal splints, restoration of tooth structure lost from attrition and restoration for misalignment of the teeth*	*All Charges*

Dental benefits – continued on next page

Dental benefits *(continued)*	**You pay**
• *Dental treatment for temporomandibular (jaw) joint disorders and related diseases* • *Replacement of lost or stolen denture, bridges or other dental appliances* • *Services not specified as covered*	*All Charges*

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

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

Value-Added Benefits:

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

No Computer? No Problem!

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

Overview of the "AltiusExtra" Services:

- **Optical Discounts:** 10-30% discounts on prescription and non-prescription eyewear and other products from participating Altius Optical providers.
- **Lasik Vision Eye Surgery:** AltiusExtra has contracted with multiple LASIK centers to provide more choice and greater convenience at competitive prices.
- **Vitamins, Minerals and Nutritional Supplements:** A complete line of quality vitamins and minerals at significantly discounted prices delivered right to your door!
- **Hearing Aids:** These state-of-the-art hearing aids are smaller and less noticeable than ever before and available at significant discounts for Altius members. For more information call Beltone at 1-800-BEL-TONE.
- **Smoking Cessation:** Express Scripts/Value Rx offers an 18% discount on CQ Nicoderm patches. You can also participate in a free personalized stop smoking program called "Committed Quitters".
- **Cosmetic Dentistry:** Advances in teeth whitening technology along with the cost savings available with AltiusExtra, a brighter smile is more attainable and affordable than ever before.
- **Cosmetic Surgery:** There is virtually no part of the body that can't be enhanced and improved by cosmetic surgery. Thanks to new techniques in surgery and anesthesia, many procedures are easier, less painful, and recovery is faster.
- **Massage Therapy:** Therapeutic massage is an enjoyable, non-invasive way to improve health, fitness, and general wellness.
- **Health Club Membership:** The health clubs participating with AltiusExtra offer discounts on individual and family memberships.
- **Cosmetic Dermatology:** Cosmetic Dermatology offers new ways to help skin look better.
- **Shopping:** Check this out for health related products, books, videos, personal exercise equipment, plus links to other shopping sites.
- **Regular member specials and drawings for free services are unique to AltiusExtra! This is a popular feature of Altius Extra and is on-track for expansion in 2003!**

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

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals (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;
- Alternative treatments such as acupuncture, acupressure, naturopathic or homeopathic services, hypnotherapy, and biofeedback;
- Procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- 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. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 801-323-6200 or 1-800-377-4161.

When you must file a claim -- such as for services you receive outside of 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 95950
South Jordan, UT 84095-0950

Prescription drugs

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

Submit your claims to:

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

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 31st of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within six months from the date of our decision; and (b) Send your request to us at: Altius Health Plans, Appeals Department, 10421 South Jordan Gateway, Suite 400, South Jordan, UT 84095; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Health Benefits Contracts Division 2, 1900 E Street, NW, Washington, D.C. 20415-3620.

The Disputed Claims process *(Continued)*

Send OPM the following information:

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

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

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

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

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or prior authorization, then call us at 1-800-377-4161 or 801-323-6200 and we will expedite our review; or

(b) We denied your initial request for care or prior authorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Benefits Contracts Division 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 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 also waive any copayments, and/or coinsurance you have under this Plan. For Plan benefits that have a limited number of days or visits (skilled nursing facility care, physical therapy, chiropractic, etc.), 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 and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits

with Medicare, depending on the type of Medicare managed care plan you have.

•The Original Medicare Plan (Part A or Part B)

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

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will 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 claims, 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 when you have the Original Medicare -- When Original Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

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

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a re-employed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

•Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that the Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

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

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE 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 a 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 a 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 illnesses caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

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

Section 10. Definitions of terms we use in this brochure

Calendar year

January1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

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

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.

An FDA-approved drug, device, or biological product or medical treatment or procedure is experimental or investigational if:

1) Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

2) Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

   Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

FDA-approved drugs, devices, or biological products used for their intended purposes and labeled indication 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.

Hospital

A facility that is legally licensed as a general hospital or a specialty hospital.

Medical necessity

Services that are (1) appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition and (2) within recognized standards of medical practice and (3) not primarily for the convenience of a Member or his or her family, physician or other Non-Contracted Provider.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. We determine our allowance as follows: The total dollar amount allowed by the Plan for Covered Services, including the amounts payable by the Plan and payable by 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.

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

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about 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 health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

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 Federal Employees Health Benefits (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 make any changes after retirement. Contact you employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1, 2003. If you joined this Plan during open season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply

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 website, 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 job, if you are a covered dependent and turn 22 or marry, etc.

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

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

•Converting to individual coverage

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

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

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

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

•Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Index

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

NOTES:

NOTES:

Summary of benefits for Altius Health Plans – 2003

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

Benefits	You pay	Page
Services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $15 specialist; $20 for after-hours or urgent care	15
• In a hospital, surgical center, or other facility.....	10%	15, 24-27
Services provided by a hospital:		
• Inpatient.....	Nothing	28-29
• Outpatient	Nothing	
Emergency benefits:		
• In-area.....	$50	32
• Out-of-area.....	$100	32
Mental health and substance abuse treatment	Regular cost sharing	33-34
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	35-37
Dental Care	See schedule of Dental Benefits	39-42
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	16, 20
Special Features: Flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies; travel benefit/ services overseas		38
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	13

2003 Rate Information for
ALTIUS HEALTH PLANS

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and 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. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Wasatch Front and St. George:							
Self Only	9K1	$109.30	$53.66	$236.82	$116.26	$129.03	$33.93
Self and Family	9K2	$249.62	$108.90	540.84	$235.95	$294.70	$63.82