



Plan Specifications

Group Name:	Group Name
Plan Number:	SPA901-15-500/10/25/50MHCat
Proposed Effective Date:	
Eligible Employees:	EE
Agency / Consultant:	Agency / Consultant
Agent:	Agent
Altius Sales Representative:	Altius Sales Rep.

Plan Options

	90-15-0	Level 1	Level 2	Level 3	Level 4
Coinsurance:		10%	20%	30%	40%
Calendar Deductible: (Individual / Family)		\$0	\$250 / \$500	\$500 / \$1,000	\$1,000 / \$2,000
Out-of-Pocket-Maximum: (Individual / Family)		\$1,000 / \$2,000	\$2,000 / \$4,000	\$3,000 / \$6,000	4,000 / \$8,000
Office Visit Copay:		\$15	\$25	\$35	40% AD

Mental Health Benefit:	Catastrophic
Pharmacy Benefit:	\$10 / \$25 / \$50 w/ \$500 Family Deductible

ALTIUS PEAK ADVANTAGE PLAN

Medical Benefits Brochure SPA901-15-500/10/25/50MHCat

Group Name	Level 1 Participating Providers	Level 2 Participating Providers	Level 3 Participating Providers	Level 4 Non-participating Providers
COINSURANCE, DEDUCTIBLE, OUT-OF-POCKET & LIMITS				
		YOU PAY		
Coinsurance	10%	20%	30%	40%
Calendar Year Deductible – (Individual / Family) <small>Does not apply to Out-of-Pocket Maximum.</small>	\$0	\$250 / \$500	\$500 / \$1,000	\$1,000 / \$2,000
Out-of-Pocket Maximum – (Individual / Family) <small>Fixed dollar copays do not apply.</small>	\$1,000 / \$2,000	\$2,000 / \$4,000	\$3,000 / \$6,000	\$4,000 / \$8,000
Annual Maximum	None	None	None	\$200,000
Lifetime Maximum	\$3,000,000	\$3,000,000	\$2,000,000	\$1,000,000
Pre-Existing Condition Limitation	9 Months			12 Months
OUTPATIENT SERVICES				
		YOU PAY		
Office Visits – Primary and Specialty Care – Including annual adult physical examinations, well child care, preventative and post-exposure immunizations and vaccines, eye exams, and hearing screenings.	\$15	\$25	\$35	40%* AD
After-Hours Care / Urgent Care – Care received in a physician's office or urgent care facility.	\$25	\$35	\$45	40%* AD
Chiropractic Office Visits – Limited to 20 visits per member, per calendar year. (Prior authorization through CHP. Treatment plan required after 1 st visit).	\$25			Participating Providers Only
MAJOR Diagnostic Laboratory Tests and X-Rays – Including, but not limited to CAT scans and MRIs.	10%* AD	20%* AD	30%* AD	40%* AD
MINOR Diagnostic Laboratory Tests and X-Rays – Including, but not limited to Mammograms and Chest X-rays.	You Pay Nothing			40%* AD
Physiotherapy Services at a Provider's Office – Physical, occupational and speech therapy provided on an outpatient basis. Limited to a combined benefit of 20 provider's office and/or outpatient facility visits of each type per member, per calendar year.	\$15	\$25	\$35	40%* AD
Physiotherapy Services at an Outpatient Facility – Physical, occupational and speech therapy provided on an outpatient basis. Limited to a combined benefit of 20 provider's office and/or outpatient facility visits of each type per member, per calendar year.	10%* AD	20%* AD	30%* AD	40%* AD
EMERGENCY CARE				
		YOU PAY		
Emergency Room Care – When medically necessary, as determined by Altius. Includes all services provided in an Emergency Room setting; copay waived if admitted.	Providers for this benefit begin at Level 2 ☞	\$75	\$100	\$150
Ambulance / Paramedics – (including Air Ambulance) When medically necessary, as determined by Altius.	20%* After Level 2 Deductible			
INPATIENT / OUTPATIENT HOSPITAL SERVICES				
		YOU PAY		
Inpatient Hospital / Facility Services	Providers for this benefit begin at Level 2 ☞	20%* AD	30%* AD	40%* AD
Outpatient Hospital / Facility Services – Including, but not limited to, outpatient surgery, short stay surgical facilities for appropriate procedures, observation, chemotherapy, radiation therapy, dialysis, cardiovascular services, infusion therapy, endoscopy, and pulmonary services.	Providers for this benefit begin at Level 2 ☞	20%* AD	30%* AD	40%* AD
Additional Professional Services – Billed by facility – Anesthesia and facility based professional fees associated with inpatient / outpatient services such as radiologist, pathologist, hospitalist, etc.	Providers for this benefit begin at Level 2 ☞	20%* AD	30%* AD	40%* AD
Additional Professional Services – Billed by professional – Anesthesia and facility based professional fees associated with inpatient / outpatient services such as radiologist, pathologist, hospitalist, etc.	20%* After Level 2 Deductible			40%* AD
Inpatient / Outpatient Physician, Surgeon, Assistant Surgeon	10%* AD	20%* AD	30%* AD	40%* AD
Organ Transplant Services – Organ and tissue transplant services, including, but not limited to, Cornea, Kidney, Heart, Lung, Heart-Lung, Liver, Pancreas, and Bone Marrow transplants and related services.	Providers for this benefit begin at Level 2 ☞	20%* AD	30%* AD	Participating Providers Only
MATERNITY SERVICES				
		YOU PAY		
Pre-Natal and Post-Natal Care – Obstetrician or Certified Nurse Midwife – Routine pre-natal office visits, delivery (including surgeon and assistant surgeon), and post-natal care. Regular benefits apply for complications of pregnancy.	10%* AD	20%* AD	30%* AD	40%* AD
Inpatient Hospital / Facility Services	Providers for this benefit begin at Level 2 ☞	20%* AD	30%* AD	40%* AD

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* Applies to out-of-pocket maximum (OOPM), AD = after deductible, APD = after Pharmacy Deductible, AMHD = after Mental Health Deductible

ALTIUS PEAK ADVANTAGE PLAN

Medical Benefits Brochure SPA901-15-500/10/25/50MHCat

Group Name	Level 1 Participating Providers	Level 2 Participating Providers	Level 3 Participating Providers	Level 4 Non-participating Providers
INJECTABLES				
YOU PAY				
Injectable Medications – Facility – Injectable medications provided inpatient or outpatient through a hospital, surgical center, skilled nursing facility, or other facility setting.	Facility Benefit Level			40%*
Injectable Medications – Non-Facility – Injectable medications received at a physician's office, or home health provider	20%*			40%*
Injectable Medications – Pharmacy	20%*			Participating Providers Only
PRESCRIPTION DRUGS				
YOU PAY				
Deductible – You must satisfy a Pharmacy deductible before these benefits are paid. This deductible is separate from your regular medical deductible. (Per Family Per Calendar Year)	\$500			Participating Providers Only
Prescription Drugs – Up to a 30-day supply. (Preferred Generic / Preferred Brand / Non-Preferred)	\$10 / \$25 / \$50 APD			Participating Providers Only
Prescription Drugs Mail Order – 90-day supply. (Preferred Generic / Preferred Brand / Non-Preferred)	\$30 / \$75 / \$150 APD			Participating Providers Only
MENTAL HEALTH / SUBSTANCE ABUSE				
YOU PAY				
Deductible – You must satisfy a calendar year deductible before these benefits are paid. This deductible is separate from your regular medical deductible. (Individual / Family)	\$250 / \$500			
Inpatient Services	20% AMHD			Participating Providers Only
Outpatient Services	\$25			Participating Providers Only
Out-of-Pocket Maximum – This is separate from your medical out-of-pocket maximum. Deductibles and outpatient copays do not apply. (Individual / Family)	\$3,000 / \$6,000			
ALLERGY CONDITIONS				
YOU PAY				
Testing and Treatment – After-hours copay applies if billed as an after-hours office visit.	\$15	\$25	\$35	Participating Providers Only
Serum	10%* AD	20%* AD	30%* AD	Participating Providers Only
Injections	You Pay Nothing			Participating Providers Only
OTHER BENEFITS				
YOU PAY				
Accident Related Dental Services – Dental services required as the result of an accidental injury, including, but not limited to, crowns, caps, bridges, and root canals. Limited to a combined lifetime maximum of \$1,000 per member.	50% After Level 2 Deductible			50% AD
Durable Medical Equipment (DME) – Corrective appliances, prosthetic devices. Limited to a combined benefit of \$5,000 per member, per calendar year.	20%			50%
Home Health Care – Limited to a combined benefit of 60 visits per member, per calendar year.	10%* AD	20%* AD	30%* AD	40%* AD
Home Hospice – Outpatient care for a terminally ill member. (Inpatient Hospice covered at inpatient hospital/physician services benefit level.)	10%* AD	20%* AD	30%* AD	40%* AD
Infertility Services – Authorized diagnostic procedures. Limited to a combined benefit of \$1,500 per member, per calendar year, up to a lifetime maximum of \$5,000.	50% AD	50% AD	60% AD	Participating Providers Only
Medical Supplies – Disposable medical supplies and accessories as determined medically necessary by Altius – No annual limit.	20%			50%
Neuropsychological Testing	50%* After Level 2 Deductible			Participating Providers only
Skilled Nursing Facility – Limited to a combined benefit of 60 days per member, per calendar year.	10%* AD	20%* AD	30%* AD	Participating Providers Only
Temporomandibular Joint Dysfunction (TMJ) – Testing and diagnostic services. Limited to a combined lifetime maximum of \$1,000.	50% After Level 2 Deductible			Participating Providers only

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General Information

Calendar Deductible

You must satisfy an individual or per family deductible each calendar year before certain benefits will be provided under this plan. Deductibles do not apply to benefits with "fixed" copays and deductibles do not count towards the out-of-pocket maximum.

Out-of-Pocket Maximum

Fixed dollar copays do not apply. When you or your family fulfill out-of-pocket maximums during a calendar year, then no further out-of-pocket expenses will be required for the remainder of that calendar year. This provision does not apply to any payments for benefits with fixed copayments, prescription drugs, dental services (even when necessitated by accidental injury), durable medical equipment, infertility services, TMJ services, non-covered services, or mental health services (which may have a separate out-of-pocket maximum). You are required to keep receipts of out-of-pocket expenses and furnish such proof to the Altius Claims Department when you reach your maximum.

Pre-Existing Condition Limitation

Coverage is excluded for the care and treatment of pre-existing conditions (excluding pregnancy), unless you have been continuously covered under a benefit plan with a health insurance carrier prior to your enrollment date with Altius Health Plans. This coverage may be used in satisfying all or part of the pre-existing condition waiting period requirement, except under the following circumstance: The previous health care coverage was terminated more than 63 days, prior to your enrollment date of coverage with Altius Health Plans. Your enrollment date is your first day of coverage under your plan or, if your Group has a pre-enrollment waiting period, the first day of the waiting period.

Receiving Care Through Altius

In order for a medical service to be eligible for coverage, it must be defined as a covered benefit and properly coordinated through Altius. Prior Authorization is required for many services (excluding emergency care) in order to verify that the services to be provided are medically necessary and appropriate. It is your responsibility to determine that providers and facilities have obtained Prior Authorization.

Limitations & Exclusions

The following benefits are limited under this Plan:

- Physiotherapy services (occupational, physical and speech) are limited to services that will significantly improve a member's condition, as determined by Altius.
- A \$150 copayment is required for insertion of implantable contraceptive capsules such as Norplant® and Implanon®. Limited to one implantation and removal during the maximum implantation period of the product, as determined by the product manufacturer.
- Neuropsychological evaluation and treatment is limited to those services that diagnose or treat an underlying medical condition.
- Accident-related dental services are covered only when required as a result of an accidental injury to sound, natural teeth that occurs while coverage is in force. Dental services must be received within two years following the accidental injury, and the member must be continuously covered from the date of the accidental injury through the date the dental services are provided.
- Dental anesthesia will be covered only for those members who meet all of the following criteria: member is five years old or younger; dental work involves three or more teeth; and dental procedures are restoration or extraction for rampant decay. However, any member who does not meet these criteria may still have coverage for dental anesthesia if that member has a non-dental physical condition or limitation

that makes general anesthesia for dental care medically necessary.

The following benefits are excluded from coverage under this Plan:

- Services provided outside the United States of America and its territories, except as required for an emergency or urgent condition.
- New procedures, services, supplies, and medications until they are reviewed for safety, efficacy and cost effectiveness and approved by Altius.
- Experimental or investigational treatment, procedures, tests, equipment, or facilities, or any health care service which is still undergoing evaluation and review and is not accepted as standard treatment in the medical community.
- Services, drugs, and supplies that are not medically necessary, as determined by Altius.
- Experimental medications; medications for non-approved FDA indications or non-approved indications determined by Altius Health Plans; over the counter medications and products; medications for athletic and mental performance; compounding fees; non-covered ingredients used in a compounded medication; medications for cosmetic indications; hair growth products and medications; homeopathic medications; hypodermic needles; impotence medications; medications for the treatment of infertility; skin patches for motion sickness; medications for the treatment of nail fungus; progesterone cream and suppositories; smoking cessation products, including any medications prescribed for smoking cessation; medications required exclusively for foreign travel; oral vitamins (except prescription prenatal vitamins); medications or nutritional supplements for weight loss, or for weight gain for non-medical conditions.
- The following specific medications: Aggrenox®, Potaba®, Relenza®, Sarafem®, and Tamiflu®.
- Immunizations required exclusively for foreign travel or employment.
- Infertility treatment, including, but not limited to, artificial insemination and in-vitro fertilization.
- Reversal of elective sterilization.
- Amniocentesis and ultrasonography for sex determination.
- Predictive genetic testing.
- Predictive diagnostic testing and screenings, and other preventive services performed in the absence of illness or injury, other than those procedures or tests specifically recommended by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Centers for Disease Control (CDC), and local government public health authorities. Preventive services performed more often than, or outside of the guidelines of the AAFP, AAP, CDC, and local government health authorities are excluded.
- Elective home delivery for childbirth.
- Procedures, services, drugs, and supplies related to elective 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, or to prevent the birth of a child that would be born with grave defects.
- Surgical treatment for obesity (including morbid obesity) and/or complications therefrom, including a reversal of these surgeries.
- Sex change operations or related health care services.
- Treatment, services, devices, and supplies related to sexual dysfunction.
- Surgery performed in order to prevent the possible onset of a condition or disease with which the member has not been diagnosed.
- Services, supplies, or treatment in connection with cosmetic or reconstructive procedures which alter appearance but do not restore or improve impaired physical function, or which are performed for psychological or emotional purposes. This exclusion does not apply to: (1) reconstructive surgery resulting from trauma, infection, or other diseases of the involved part; (2) circumcision for a newborn child; or (3) reconstruction of the breast(s) following a medically necessary mastectomy.
- Autopsy procedures.
- Health education services not closely related to the care and treatment of an illness or injury.
- Telephone consultations, electronic mail

communication, and communication services that do not require direct face-to-face contact between the patient and the provider.

- Charges for failure to keep a scheduled appointment.
- Interest or finance charges, except as specifically required by law.
- Prolotherapy (the use of injections to strengthen tendons and ligaments).
- Services for crossmatching and/or harvesting organs when the organ recipient is not a Plan member.
- Routine foot care, unless directly related to a systemic disease.
- Treatment of weak, strained or imbalanced feet, including foot orthotics, wedges or shoe inserts, unless herein provided.
- Corrective appliances, prostheses, artificial aids and durable medical equipment, including supplies and accessories, are excluded when determined to be primarily for convenience, comfort, non-therapeutic purposes, or in the absence of illness or injury.
- Routine periodic servicing, such as cleaning and regulating, of durable medical equipment, corrective appliances, and prostheses is not covered. Replacement is not covered unless the existing device has become inoperable through normal wear and tear and cannot be repaired, or replacement is prescribed by a physician because of a change in the member's physical condition.
- All shipping, handling, or postage charges, except as incidentally provided without a separate charge.
- Any devices used to aid hearing, including, but not limited to, hearing aids and cochlear implants, including the fitting of such devices and related hearing examinations.
- Eyeglasses, contact lenses, examination for contact lenses and visual training aids, unless required due to surgical removal, surgical replacement, or congenital absence of an organic lens.
- Eye surgeries performed primarily to correct refractive errors. Examples include, but are not limited to: PRK (photorefractive keratectomy), LASIK (laser-assisted in-situ keratomileusis), RL (refractive lensectomy), ICRS (intraocular ring segments) and phakic intraocular lenses (unless related to post-cataract surgery).
- Non-emergency follow-up care provided in an emergency room.
- Charges for transportation, including ambulance, unless determined medically necessary by Altius.
- Travel expenses, including hotel, motel and other non-medical room and board.
- Private hospital rooms, unless medically necessary.
- Hospital take-home drugs and personal, comfort, or convenience items.
- Private duty nursing.
- Custodial care, domiciliary care, rest cures, and independent living training.
- Home health services requested for the convenience of the patient or family that do not require the training and technical skills of a nurse.
- Hospice services that are not reasonable and necessary for palliation or management of a terminal illness.
- Vocational testing and treatment.
- Speech therapy services for psychosocial speech delay.
- Psychiatric treatments or services performed in the absence of a psychiatric diagnosis.
- Treatment for mental disorders that are irreversible or for which there is little or no reasonable expectation for improvement.
- Evaluation, testing, and treatment provided by public or private schools.
- Charges in connection with a work-related injury or sickness for which coverage is provided or would be provided under any state or federal worker's compensation, employer's liability, or occupational disease law. When the employer is required by law to have such coverage, this exclusion applies whether or not such coverage is in effect.
- Services, supplies, or treatment for which coverage is provided under any motor vehicle no-fault plan. When the member is required by law to have no-fault insurance, this exclusion applies to charges up to the minimum coverage required by law whether or not such coverage is in effect.
- Care for military service connected disability to which a member is legally entitled, and for

which facilities are reasonably available to the member.

- Care or treatment of an illness or injury caused by war or any act of war (whether declared or undeclared), or voluntary participation in hostilities, riot, or civil insurrection.
- Care for conditions which state or local law requires to be treated in a public facility.
- Services and treatments provided in connection with, or to comply with, involuntary admissions, police detentions, and similar arrangements.
- Examinations and services obtained for administrative purposes, such as treatment, care, reports or appearances obtained for, or pursuant to, legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, travel, or military services.
- Oral surgery, including but not limited to orthognathic surgery, and any services related to the treatment of Temporomandibular Joint Syndrome (TMJ), unless determined medically necessary by Altius for direct treatment of an invasive tumor or acute traumatic injury. This exclusion does not apply to diagnosis and evaluation of TMJ dysfunction.
- Services related to the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth, including dental splints and dental prostheses, unless herein provided or necessitated by accidental injury that occurs while coverage is in force.
- Acupuncture or cupressure.
- Holistic and homeopathic treatments.
- Alternative medicine programs such as hypnosis, massage therapy and biofeedback.
- Injury or illness sustained when in the act of an illegal activity.
- Services provided by a member of the person's immediate family or household.
- Expenses related to non-covered services, including pre- and post-operative evaluation and/or diagnostic testing.
- Treatment or care for complications resulting from non-covered services, supplies, and/or medications.
- Pre-existing conditions during the pre-existing condition waiting period, when applicable.
- Benefits and services not specified as covered in the Group Service Agreement.
- Mental health behavioral services including: psychotherapy, counseling or other services in connection with marital or family problems; social, occupational, religious, or other social maladjustments; conduct disorders; chronic adjustment disorders; psychosexual disorders; chronic organic brain syndromes; personality disorders; developmental disorders; learning disabilities; or mental retardation. This exclusion does not apply to the initial assessment for diagnosis of the condition, nor to the medical management of an underlying medical illness which may be contributing to the disability.
- Electro-sleep or electronarcosis therapy, rapid detoxification programs, methadone clinics and treatment, residential treatment programs, and milieu therapy.

Altius Health Plans

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