The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit optimahealth.com or call 1-800-741-9910. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the glossary at healthcare.gov/sbc-glossary/ or call 1-800-741-9910 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0 person / $0 family In-Network $500 person / $1,000 family Out-of-Network</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs; most services that require a copayment; and preventive care, vision, and materials are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For In-Network $2,000 person / $4,000 family. and out-of-network providers $4,500 person / $9,000 family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and healthcare this plan does not cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.optimarewards.com">www.optimarewards.com</a> or call 1-800-741-9910.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 Copayment per visit</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 Copayment per visit</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at optimaehealth.com.</td>
<td>Generic drugs (Tier 1)</td>
<td>$15 Copayment retail/$37.50 Copayment mail order</td>
<td>$15 Copayment retail/Mail Order Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>$40 Copayment retail/$100 Copayment mail order</td>
<td>$40 Copayment retail/Mail Order Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>$60 Copayment retail/$180 Copayment mail order</td>
<td>$60 Copayment retail/Mail Order Not Covered</td>
</tr>
<tr>
<td></td>
<td>Speciality drugs (Tier 4)</td>
<td>20% Coinsurance retail</td>
<td>20% Coinsurance retail</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$50 Copayment per admission then 20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/ surgeon fees</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at [https://www.optimaehealth.com/eoccoidoc/Plus_LG_PPO_201801.pdf](https://www.optimaehealth.com/eoccoidoc/Plus_LG_PPO_201801.pdf)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$200 Copayment per visit then 20% Coinsurance</td>
<td>$200 Copayment per visit then 20% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$25 Copayment per trip then 20% Coinsurance</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 Copayment per visit</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$200 Copayment per admission then 20% Coinsurance</td>
<td>30% Coinsurance</td>
<td>Pre-authorization required</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Mental Health Outpatient: 20% Coinsurance</td>
<td>Mental Health Outpatient: 30% Coinsurance</td>
<td>Pre-authorization required for intensive outpatient program, partial hospitalization services, electroconvulsive therapy, and Transcranial Magnetic Stimulation. EAV: 5 visits/presenting issue by Optima EAV providers only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EAV: No Charge</td>
<td>EAV: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$200 Copayment per admission then 20% Coinsurance</td>
<td>30% Coinsurance</td>
<td>Pre-authorization required for all inpatient services.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
<td>Pre-authorization required for prenatal services. Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$200 Copayment per admission then 20% Coinsurance</td>
<td>30% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
<td>Pre-authorization required. 100 visits/year</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Physical and Occupational Therapy: 20% Coinsurance</td>
<td>Physical and Occupational Therapy: 30% Coinsurance</td>
<td>Pre-authorization required. 30 visits/year for PT, OT. 30 visits/year for ST</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Speech Therapy: 20% Coinsurance</td>
<td>Speech Therapy: 30% Coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% Coinsurance after Inpatient Copayment</td>
<td>30% Coinsurance</td>
<td>Pre-authorization required. 90 days/year</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at [https://www.optimahealth.com/eoccidoc/Plus_LG_PPO_201801.pdf](https://www.optimahealth.com/eoccidoc/Plus_LG_PPO_201801.pdf)
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment</td>
<td><strong>In-Network Provider (You will pay the least)</strong> 30% Coinsurance</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong> 40% Coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover** (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Infertility treatment
- Long-term care
- Pediatric Dental Check-ups
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services** (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Chiropractic Care
- Non-emergency care when traveling outside the US as out-of-network benefit

### Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-800-741-9910. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, at 1-877-310-6560 or bureauofinsurance@scc.virginia.gov; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebbsa/healthreform; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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*For more information about limitations and exceptions, see the plan or policy document at [https://www.optimahealth.com/eoccidoc/Plus_LG_PPO_201801.pdf](https://www.optimahealth.com/eoccidoc/Plus_LG_PPO_201801.pdf)*
Your **Grievance** and **Appeals** Rights:

There are agencies that can help if you have a complaint against your plan. For a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Member Services at the number on the back of your member ID card. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or your state department of insurance at the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O.Box 1157, Richmond, VA, 23218, 1-877-310-6560 or bureauofinsurance@scc.virginia.gov.

**Does this Coverage Provide Minimum Essential Coverage? Yes**

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this Coverage Meet the Minimum Value Standard? Yes**

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

*For more information about limitations and exceptions, see the plan or policy document at [https://www.optimaehealth.com/eoccidoc/Plus_LG_PPO_201801.pdf](https://www.optimaehealth.com/eoccidoc/Plus_LG_PPO_201801.pdf)*
About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Event 1: Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Event 2: Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Event 3: Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan's overall deductible</strong> $0</td>
<td><strong>The plan's overall deductible</strong> $0</td>
<td><strong>The plan's overall deductible</strong> $0</td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong> 20%</td>
<td><strong>Specialist copayment</strong> $20</td>
<td><strong>Specialist copayment</strong> $20</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong> 20%</td>
<td><strong>Hospital (facility) coinsurance</strong> 20%</td>
<td><strong>Hospital (facility) coinsurance</strong> 20%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong> 20%</td>
<td><strong>Other coinsurance</strong> 20%</td>
<td><strong>Other coinsurance</strong> 20%</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
</tr>
<tr>
<td>Specialist office visits <em>(prenatal care)</em></td>
<td>Primary care physician office visits <em>(including disease education)</em></td>
<td>Emergency room care <em>(including medical supplies)</em></td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests <em>(blood work)</em></td>
<td>Diagnostic test <em>(x-ray)</em></td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment <em>(crutches)</em></td>
</tr>
<tr>
<td>Diagnostic tests <em>(ultrasounds and blood work)</em></td>
<td>Durable medical equipment <em>(glucose meter)</em></td>
<td>Rehabilitation services <em>(physical therapy)</em></td>
</tr>
<tr>
<td>Specialist visit <em>(anesthesia)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Example Cost** $12,800  
**Total Example Cost** $7,400  
**Total Example Cost** $1,900

**In this example, Peg would pay:**  
*Cost Sharing*  
Deductibles $0  
Copayments $400  
Coinsurance $700  

**In this example, Joe would pay:**  
*Cost Sharing*  
Deductibles $0  
Copayments $700  
Coinsurance $30  

**In this example, Mia would pay:**  
*Cost Sharing*  
Deductibles $0  
Copayments $400  
Coinsurance $200  

**What isn't covered**  
Limits or exclusions $0  
Total Peg would pay is $1,100  
Total Joe would pay is $730  
Total Mia would pay is $600

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-741-9910.

The plan would be responsible for the other costs of these EXAMPLE covered services.
Optima Health Alternative Language Options for Notices and other Written Information

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

Amharic:
አማርኛ እንደ ወርቅ እንደ ለማህበር ሁሉ ከመጋገር ይታወ()

Arabic:

Bengali/Bangla:
নিজ কর্মকরেন: যদি আপনি বাঙ্গালা ভাষার কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবাও পাবেন। ফোন করুন - 1-855-687-6260।

Chinese (Mandarin):
注意：如果您讲中文普通话，可以免费获得语言协助服务。请拨打电话 1-855-687-6260。

French:
ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais.Appelez le 1-855-687-6260.

German:
ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 zur Verfügung.

Gujarati:
ধান্য আপনে : জো তমে গুজরাতী বলো এই ভাষা সহায়তা সেবায় যা তামারা মাতে বিনা মূল্যে উপলব্ধ অনে। 1-855-687-6260 পর ডাল করো।

Hindi:
धाया दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 पर कॉल करें।

Hmong:

Igbo:
GEE NT Ị: ọbụntụ na ị na-asụ Igbo, ị ga-enweta enyemaka n’efu site n’aka ndi ga-enyere gi aka inweta ị ga. Kpọọ 1-855-687-6260

Japanese:
重要：日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260までお電話ください。

Korean:
주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260으로 전화해 주십시오.

Kru/Bassa:
YI LE: I bile u mpot Bassa, bot ba kobol mahop ngui nsaa wogwi wo ba ye ha l nyuu hola we. Sebel: 1-855-687-6260.

Laotian:
خاصّيّة: ทุก ๆ ภาษาที่มีการใช้, มีการบริการให้กับผู้ต้องการใช้ภาษาที่ต่างกันได้โดยไม่คิดค่า. ใน 1-855-687-6260.

Mon-Khmer, Cambodian:
Navajo:
SHOOH: Diné Bizaad bee yáníti’go doo bááh ilínígó t’áá nizaad k’ehjí níká a’doowołgo bee haz’á. Kojj’hólne’ 1-855-687-6260.

Persian/Farsi:
ترجمة:
اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 6260 487-855-1 نماس بگیرید.

Portuguese:

Russian:
ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260, и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:
ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kung kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260.

Turkish:
DIKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz 1-855-687-6260 numaralı telefonu arayın.

Urdu:
ترجمة:
اگر آپ اردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں. با شمارہ 6260 487-855-1 کال کریں.

Vietnamese:
CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260.

Yoruba:
KÉÉRÈ:
Ti o bá ń sọ èdè Yorùbá, ìsé ìrànì́̀wọ̀ èdè wà fún ọ̀ làfèè. Pe 1-855-687-6260
Welcome to Optima Health
Our Plans
Optima Health offers several different plan options to meet our customers' needs. This Benefit Information Guide outlines basic information and answers common questions about the plans we offer. Plan information such as Copayments, Coinsurance, and applicable Deductibles is referenced in your specific Plan benefit, a benefit structure that is chosen by your employer. Refer to your Plan documents for more details.

Optima Plus
Optima Plus is a preferred provider organization (PPO) designed to give members more freedom and flexibility when choosing providers for care. The plan features in-network and out-of-network benefit options:

In-network:
The in-network benefit option means you can lower your out-of-pocket costs by seeing Plan primary care physicians (PCP), specialists, therapists, and other healthcare professionals who have met all of the Optima Health credentialing requirements, and are part of the Plan network.

Out-of-network:
If you choose to use your out-of-network benefit option for covered services, it means you can select the doctor or medical facility you want for most covered services, regardless of whether or not they are Plan providers. Remember, your out-of-pocket costs will be higher when you use out-of-network benefits.

Optima Equity Plus is a consumer-directed health plan (CDHP) combined with a Health Savings Account (HSA). Employees are eligible to make tax-deductible contributions to their HSA account. Optima Equity Plus features in-network and out-of-network benefit options.

Optima Plus is a preferred provider organization (PPO) designed to give members more freedom and flexibility when choosing providers for care. The plan features in-network and out-of-network benefit options. The in-network benefit option means you can lower your out-of-pocket costs by seeing Plan primary care physicians (PCP), specialists, therapists, and other healthcare professionals who have met all of the Optima Health credentialing requirements, and are part of the Plan network. If you choose to use your out-of-network benefit option for covered services, it means you can select the doctor or medical facility you want for most covered services, regardless of whether or not they are Plan providers. Remember, your out-of-pocket costs will be higher when you use out-of-network benefits.
Member ID Cards

Your member ID card identifies you as a covered member of Optima Health and provides information about your plan. You may receive a new member ID card when you enroll or renew in a plan. You can request one online or from Member Services, or view and/or print it from our website. The following abbreviations might help you read your card.

Member ID Card Abbreviations:

- **Coins:** Coinsurance
- **OV:** Office Visit (Primary Care Physician) Copayment or Coinsurance
- **SOV:** Specialist Copayment or Coinsurance
- **UCC:** Urgent Care Center Copayment or Coinsurance
- **ED:** Emergency Department Copayment or Coinsurance
- **DX1:** Radiological and diagnostic tests performed outside the physician’s office, excluding lab work
- **DX2:** Outpatient Advanced Imaging and Testing Procedures performed in a physician’s office, a freestanding outpatient facility, or a hospital outpatient facility. Examples: MRI, MRA, PET Scans, CT Scans, CTA Scans, Sleep Studies
- **OP:** Outpatient Copayment or Coinsurance
- **IP:** Inpatient Copayment or Coinsurance
- **RxDed:** Prescription Drug Deductible
- **Rx:** Applicable Prescription Drug Copayment according to drug Tier

Note: Your card is designed according to the plan you have elected and may not contain all of the codes mentioned above.
PPO Basics

All Optima Plus plans feature in-network and out-of-network benefits. You choose the coverage you want to use each time you seek care. Below are characteristics of in-network and out-of-network coverage options:

In-Network Coverage
- In order to receive benefits at the in-network level, you must receive your care from plan providers, including, but not limited to, doctors, facilities, and laboratories.
- Generally, you pay a set copayment and/or coinsurance for services. Depending on your plan, you may have to meet a deductible before coinsurance will apply.
- Your out-of-pocket costs, or copayments/coinsurance amounts, are generally lower, and you do not need to file for reimbursement.
- Payments applied to the in-network, out-of-pocket maximum only apply toward the in-network maximum.

Any exceptions are noted on the Summary of Benefits included with your plan documents.

Out-of-Network Coverage
- You have the freedom to go out-of-network and see any provider you choose for covered services.
- Generally, an annual deductible applies. You will also pay a percentage (coinsurance) of the medical bill.*
- With out-of-network coverage, your out-of-pocket costs, including out-of-pocket maximums, are generally higher.
- If your plan has a deductible, you will need to meet your deductible before your coinsurance will apply. Copayments, coinsurance, and applicable deductibles vary or may not apply depending on your plan option. Refer to your plan documents for details.
- Before you use your out-of-network benefits, ensure that any required pre-authorization has been obtained. Without pre-authorization, your coverage may be reduced or denied, and a penalty will apply.

* You will be responsible for paying all charges in excess of the Optima Health allowable charge, in addition to any copayment and coinsurance amounts you are required to pay. Charges from nonparticipating providers will generally exceed the Optima Health allowable charge.

Before you use your in-network benefits, verify that your provider participates in the Optima Health network. Use the Find a Doctor feature or download a provider directory from optimahealth.com/members or call Member Services at the number on the back of your member ID card.
Pre-Authorization FAQs

What is pre-authorization and when is it necessary?
Pre-authorization is a clinical review of all pertinent medical information to determine medical necessity and your Plan’s benefit criteria for coverage. The provider of the service is responsible for obtaining pre-authorization. Licensed medical professionals such as LPNs, RNs, behavioral health professionals, clinicians, and medical doctors perform the process of pre-authorization by the plan.

Medical services typically requiring pre-authorization include, but are not limited to: hospitalizations, outpatient surgeries, certain diagnostic tests, advanced imaging services (MRI, CT, PET), home health services, hospice, therapies (physical therapy, occupational therapy, speech therapy), rehabilitation services, certain durable medical equipment, prosthetics, skilled nursing facilities, certain injectable drugs, and scheduled ambulance transportation.

If you are using your in-network benefits, your provider handles pre-authorization.
Please keep in mind that this is a certification of medical necessity, not a guarantee of medical payment. Benefits are always paid according to your eligibility at the time of service and the provisions of Optima Health.

When you use your out-of-network benefits, you have a responsibility for seeing that your provider has obtained any required pre-authorization.
The member should follow the plan’s pre-authorization procedures and ensure that pre-authorization is obtained for medically necessary services when required.

Your provider can obtain pre-authorization by calling Clinical Care Services at the number on the back of your member ID card and providing the following information:
• Your member ID number
• The provider’s full name, phone number, and fax number
• The diagnosis and/or procedure
• The plan of treatment
• Other pertinent information such as X-rays and lab results

What happens if certain services are not pre-authorized?
If your plan provider’s request for pre-authorization of a medical service is denied by the health plan, Optima Health will not pay for any cost associated with the requested service. If you wish to appeal the denial, you may call Member Services to initiate the appeal process. Please keep in mind that if you receive medical services that Optima Health has denied, you must pay all charges for the services.

If you believe the denial of pre-authorization will result in the loss of life, limb, or permanent injury, be sure to tell the representative at the time you request an appeal. In these situations, you may request an expedited appeal.
FAQs  Pre-Authorization

**Do I need services pre-authorized if I have primary coverage under another health plan?**
Your provider must still call the plan for pre-authorization even if you have primary coverage under another insurance plan and have Optima Health as secondary insurance. Claims that require coordination of benefits with another health plan must still receive pre-authorization to be eligible to receive maximum benefits from Optima Health.

**Do I need pre-authorization to obtain access to an OB/GYN?**
You do not need pre-authorization from Optima Health or from any other person in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining pre-authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Member Services at the number on the back of your member ID card or sign in to optimahealth.com/members.

**How far in advance should my provider obtain pre-authorization?**
Your provider should obtain elective pre-authorization at least 7-10 days, or as soon as you are aware, prior to the services being scheduled or provided.

**How do I ensure pre-authorization has been obtained?**
To ensure pre-authorization has been obtained, visit MyOptima on optimahealth.com/members, contact Member Services at the number on the back of your member ID card, or call your provider.

**What if I need to be hospitalized?**
If you need to be hospitalized for an elective procedure, your plan doctor must notify Optima Health 7-10 business days prior to your admission. If you are hospitalized due to an emergency, you or a family member should contact Optima Health within 48 hours (two business days) of admission, or as soon as medically possible.
What should I do if I get sick or hurt after business hours or during the weekend?
If you have an illness, injury, or condition that occurs during an evening or weekend, you should call your PCP or plan doctor's office, or the Optima Health After Hours Nurse Advice Line number located on the back of your member ID card.

What happens when I call the After Hours Nurse Advice Line?
When you call the After Hours Nurse Advice Line, a registered nurse will ask you to describe your medical situation in as much detail as possible. Be sure to mention any other medical conditions you have, such as diabetes or hypertension.

Depending on the situation, you may be advised about appropriate home treatments, or advised to visit your plan doctor. If necessary, the nurse may direct you to an urgent care center or emergency department.

The nurses for our After Hours Nurse Advice Line have training in emergency medicine, acute care, OB/GYN, and pediatric care. They are well prepared to answer your medical or behavioral health questions. However, since they are unable to access medical records, they cannot diagnose or medically treat conditions, order labs, write prescriptions, order home health services, or initiate hospital admissions or discharges.

Need After Hours Nurse Advice?
Call the number on the back of your member ID card.

Remember,
in an emergency always call 911, or go to the nearest emergency department.
FAQs  Emergency Care

What should I do if I have an emergency?
In any life-threatening emergency, always go to the closest emergency department or call 911.

If you received emergency care and are admitted, you or a family member should contact Optima Health within 48 hours (two business days) or as soon as medically possible. This enables Optima Health to arrange for appropriate follow-up care, if necessary. In this type of situation, care may be reviewed retrospectively to make sure it met the criteria for coverage of emergency/urgent care treatment.

How can I tell if it is an emergency?
An emergency is the sudden onset of a medical condition with such severe symptoms or pain that an average person with an average knowledge of health and medicine (prudent layperson) would seek medical care immediately because there may be serious risk to your physical or mental health, or that of your unborn child. Some examples of situations that would require the use of an emergency department include, but are not limited to:

- Heart attack/severe chest pain
- Stroke
- Loss of consciousness
- Loss of pulse or breathing
- Poisoning
- Convulsions

What conditions generally do not require emergency department treatment?
The following conditions do not ordinarily require emergency department treatment, and may be more appropriately treated in your doctor's office, or at an urgent care center:

- Sprains or strains
- Chronic conditions such as arthritis, bursitis, or backaches
- Minor injuries and puncture wounds of the skin

What is the difference between an emergency department and an urgent care center?
An emergency department is designed, staffed, and equipped to treat life-threatening conditions. An urgent care center is a more appropriate place to seek treatment for sudden acute illness and minor injuries when your plan doctor’s office is closed or not available. Copayments and coinsurance amounts for emergency department visits are generally higher than copayments for urgent care visits. If you are transferred to an emergency department from an urgent care center, you will be charged an emergency department copayment/coinsurance.

Do I need to contact Optima Health or my PCP before going to the emergency department/urgent care center?
No. If you are unsure whether to visit an emergency department or urgent care center, you can call your PCP office or the After Hours Nurse Advice Line at the number on the back your member ID card.

Are there any special emergency care policies I should know about?
Yes. Optima Health may review all emergency care retrospectively, or after the fact, to determine if a true medical emergency did exist. This retrospective review policy is designed to protect you and all other Optima Health members from the high costs associated with unnecessary use of emergency departments and urgent care centers. If you handle nonemergencies as if they are emergencies by seeking treatment at an emergency department or urgent care center when a visit to your doctor’s office would suffice, you could be responsible for paying a greater portion or all of the charges.
Emergency Care  FAQs

What if I become ill when I am outside of the Optima Health service area?
Your plan includes coverage for emergency services when you are outside the service area. If you have an unexpected illness or injury when outside of the service area, you should call the After Hours Nurse Advice Line at the number on the back of your member ID card.

In any life-threatening emergency always go to the closest emergency department or call 911.

Remember, Optima Health may review all emergency department care retrospectively, or after the fact, to determine if a medical emergency did exist. If an emergency did not exist, you could be responsible for payment for all services.

What if I need to be hospitalized?
If you received emergency care and are admitted, you or a family member should contact Optima Health within 48 hours (two business days) or as soon as medically possible. This enables Optima Health to review your care immediately and to arrange for appropriate follow-up care. Remember, all emergency care may be reviewed retrospectively to make sure it met the criteria for coverage of emergency/urgent care treatment.

If you are admitted to a hospital outside of the Optima Health service area, call Member Services or the After Hours Nurse Advice Line at the number on the back of your member ID card.

Be prepared to give the following information:
- Member name
- Reason for treatment
- Hospital name
- City and state where treatment is occurring
- Name of treating doctor.

The doctor or hospital may also call Clinical Care Services.

What happens once I am admitted to the hospital?
As part of your Optima Health coverage, an RN case manager will follow your case from beginning to end. He or she will review your medical record, check your progress, and arrange for your continuing care needs after you leave the hospital.
FAQs Pharmacy

Optima Health pharmacy benefits will only apply if your employer group offers pharmacy that is administered by Optima Health. If you are unsure whether your pharmacy benefits are administered by Optima Health, you can refer to your plan documents, call Member Services at the number on the back of your member ID card, or ask your employer.

How will my prescription drugs be covered under Optima Health?
Optima Health uses a prescription drug formulary. The formulary is a list of drugs that are covered under your plan. Most Optima Health plans have a four (4) tier formulary. The tier your drug is placed in will determine your copayment or coinsurance amount. Drugs on tier 1 will have the lowest out-of-pocket cost to you. Drugs on higher tiers may cost you more. To view an abbreviated version of this list or calculate drug costs, sign in to optimaehealth.com/members and select Pharmacy Resources.

Some drugs require pre-authorization by Optima Health in order to be covered. Your prescribing provider is responsible for initiating pre-authorization. You should also check your plan documents to see what medications may be excluded from coverage. Optima Health may also establish monthly quantity limits for selected medications.

Specialty drugs may only be available through Proprium Pharmacy, the specialty mail order pharmacy for Optima Health. You can check the Optima Health website for a listing of specialty medications.

How does Optima Health determine my prescription drug tier?
Optima Health has a Pharmacy and Therapeutics Committee, which is composed of doctors and pharmacists. The committee reviews all drugs, including generics, for efficacy, safety, overall disease factors, and lastly, cost. Drugs are placed in tiers based on their review and recommendation. Most generic drugs usually fall into the Selected Generic Drugs tier (tier 1); more expensive generic drugs will be available in Select Brand and Other Generic Drugs tier (tier 2).

How much will I have to pay out-of-pocket for my prescription drug?
Your copayments, deductibles, or coinsurance that may apply to your pharmacy cost are outlined in your plan benefit documents. You must pay your applicable copayment/coinsurance when you pick up your drug from the retail pharmacy. If your plan includes benefits for mail order prescription drugs, you may be able to get certain maintenance drugs by your Plan’s network mail order pharmacy for lower out-of-pocket costs.

Is it possible that I would ever pay less than my Copayment/Coinsurance for a prescription?
Yes. If the pharmacy’s usual and customary cost is less than your copayment/coinsurance, you will pay the lesser amount.

Are there any restrictions on filling my prescriptions?
There are several things to keep in mind before having your prescriptions filled:

1. Registered members of optimaehealth.com can locate a participating pharmacy by signing in to optimaehealth.com/members and selecting Pharmacy Resources.

2. If you choose to have your prescription filled at a non-participating pharmacy, you will have to pay the full cost of the prescription upfront and file for reimbursement from Optima Health. You will be responsible for paying all charges in excess of the Optima Health allowable charge, in addition to any copayment, deductible, or coinsurance amounts specified in your plan documents.

3. Some drugs require pre-authorization by Optima Health in order to be covered. Your prescribing provider is responsible for initiating pre-authorization.

4. Optima Health may limit quantities of certain medications.

5. If you or your prescribing provider requests a brand medication when a generic equivalent is available; you are responsible for the difference in the cost between the generic and the brand name drug in addition to your copayment/coinsurance and/or deductible.

As a registered member of optimaehealth.com/members, you can:

- Calculate the cost for a specific drug or see which copayment applies
- See if your drug has a generic equivalent
- View the status of your pharmacy claims
- Learn about drugs that can treat your condition
- Use the Drug Information Center to learn about dosage, strength, side effects, and potential drug interactions

- View your deductibles and out-of-pocket maximums (if applicable)
- Locate and get directions to participating pharmacies
What does Optima Health do to assist members with communication disabilities?
Optima Health uses various means to facilitate healthcare services for members with physical, mental, language, and cultural barriers. For members who may be hearing impaired, Optima Health uses the Virginia Relay Service (1-800-828-1140).

Members who are non-English speaking can connect to a language interpretation service by calling the number on the back of their member ID card. Additionally, members may request documents that contain benefit, plan, premium, and appeals information in non-English versions, including Amharic, Arabic, Bengali, Chinese, French, German, Hindi, Ibo, Korean, Kru/Bassa, Navajo, Persian/Farsi, Russian, Spanish, Tagalog, Urdu, Vietnamese, and Yoruba. If you need assistance with any accommodations in accessing healthcare, contact Member Services at the number on the back of your member ID card.

How do I make changes to my membership information?
No one else can make changes to or view your information without your consent. In accordance with privacy laws, we require an Authorization of Designated Agent form whenever anyone other than the Optima Health member needs to obtain and/or change health information. This form must be signed and returned to Optima Health. Visit optimahealth.com/members to download a Designated Agent form or contact Member Services at the number on the back of your member ID card to request a form.

When and how can I add a newborn or adopted child?
You must add newborns or adopted children to the plan within 31 days of birth or placement for adoption. The application and supporting documents for these additions must be submitted directly to your employer for processing. Failure to provide information requested by Optima Health within 31 days from the birth or adoption will result in your dependent being ineligible for coverage until the next open enrollment period or qualifying event.

When and how can I enroll my dependent up to age 26?
Dependents up to age 26 can be enrolled during the month of the group’s renewal regardless of the dependent’s student status. The subscriber has 30 days to add the dependent. If the child is added within the 30-day period, coverage will begin on the plan renewal date. If the child is not added within the 30-day period, the child will have to wait until the next open enrollment or a qualifying event.

How can I ensure my enrollment in the health plan is processed in a timely manner?
To ensure your timely enrollment with Optima Health, carefully respond to each item listed on the application in its entirety. Also, pay close attention to areas requiring you to provide information about other health insurance carriers that you or your family may have. If you do not have additional health insurance, please state so in the areas indicated. If your application is not complete or if you have failed to complete the coordination of benefits section, this may delay processing your enrollment and your effective date of coverage.
FAQs  Member Services

Do I have to present any additional information to have my application processed?
You may need to provide additional information in the following circumstances:

- If you have dependents with a different last name from your own, you may need to produce legal documentation to support your relationship (e.g. birth certificate, marriage certificate, court order, adoption papers, etc.).
- If you have dependents that exceed the maximum dependent age, you will be asked to provide current documentation to support their disabled status. Be sure to contact Member Services to see if dependents exceeding the maximum dependent age are eligible for coverage.

Failure to provide information requested by Optima Health may result in your dependent being ineligible for coverage.

Why do you need social security numbers for me and my dependents?
Social security numbers (SSN) are required on all individuals, including children, to comply with federal law related to coordination of benefits. If you do not have a social security number or do not wish to provide one, a refusal form must be completed annually for each family member not providing a social security number. New enrolling members who do not provide their SSN and do not send a refusal form will not be enrolled and will be ineligible for coverage until your employer’s next open enrollment period. If you are the subscriber and do not provide the documentation, then none of your dependents will be enrolled.

Will I ever need to file a claim?
You do not need to file for reimbursement when using your in-network benefits through plan providers. If you use an out-of-network provider who does not file on your behalf, you will need to mail originals of your medical bills for reimbursement to:

MEDICAL CLAIMS
P.O. Box 5028
Troy, MI 48007-5028

The itemized bill should contain the name, address, tax ID number, and NPI number of the provider; the name of the member receiving services; the date, diagnosis, and type of services the member received, and the charge for each type of service. Your claim will be processed in accordance with out-of-network benefits.
How is utilization of healthcare services determined?
The Clinical Care Services Department at Optima Health may use any or all of the following procedures to determine your healthcare services coverage:

- Pre-Authorization (authorization for coverage from Optima Health prior to receiving services)
- Concurrent review (ongoing medical review of your care and treatment while services are being rendered) or request for an extension of previously approved services. Services include hospitalization, skilled nursing facility stays, therapies, rehabilitation, home health, and durable medical equipment.
- Retrospective review (medical review for coverage after services have been received)
- Case management (individual review and follow-up for ongoing specialized services)

Optima Health staff (nurses and doctors) make coverage decisions based on medical judgment and evidence-based criteria and policies. Our staff does not receive incentives from Optima Health based on decisions regarding coverage.

How does Optima Health pay providers?
Optima Health uses a fee-for-service payment to reimburse doctors for the care they provide. Fee-for-service payment means doctors are paid for medical care each time it is delivered, whether it is for an office visit or another form of treatment. Usually, fee-for-service payments are at a discounted rate, which has been negotiated in advance. Doctors always have the right to discuss all medical care and treatment options with their patients.

What is the Optima Health Quality Improvement Program designed to do?
The purpose of the Optima Health Quality Improvement Program is to provide a foundation for the development of programs and activities directed towards improving the health of our members. It is designed to implement, monitor, evaluate, and improve processes that are within the scope of the health plan. Several committees within the organization work on quality improvement (QI) issues. Committee membership includes Optima Health staff and plan providers, and may include representatives from other organizations. Each year, Optima Health develops a QI program and work plan that outlines our efforts to improve clinical care and service to our members. We identify areas for improving service by analyzing member complaint data and conducting an annual member satisfaction survey. If you would like a copy of the current QI program and work plan or information on other QI activities, please call 1-866-425-5257.

How does Optima Health evaluate and determine coverage for new medical technologies?
Since healthcare is constantly changing, the Optima Health team of health professionals are always researching and evaluating new medical technologies and applications of existing technologies by the following:

- Reviewing current medical literature and research studies
- Consulting with national technology firms
- Researching clinical and national state/government guidelines
- Consulting with members, local doctors, and other providers in the Optima Health network
Important Regulatory Information

How can I find out more about my covered benefits and how my Plan works?
Once you are enrolled as an Optima Health member, you are entitled to a Certificate of Insurance (COI) and a Uniform Summary of Benefits and Coverage (SBC). Your COI is an important document. Read it carefully to understand what services are covered under Optima Health. Your Copayments, Coinsurances, and Deductibles are also listed on the Face Sheet of the COI. Your SBC is a federally mandated document that contains clear, consistent, and comparable information about your health plan benefits. When you enroll, we will send you instructions on how to access your COI and SBC online at optimaehealth.com/members, or to request a paper copy.

How can I find out what doctors and hospitals are in the Optima Health Provider Network?
You are entitled to a list of providers that are in the plan’s network. You can find this list on optimaehealth.com/members or you can call Member Services at anytime to find out if your provider is in the plan’s network.

How does Optima Health use my personal information?
We understand that medical information about you and your health is personal and we are committed to protecting it. We use information about you to administer your benefits, process your claims, provide education and clinical care, coordinate your benefits with other insurance carriers, and other transactions related to providing you and your dependents healthcare coverage.

How does Optima Health protect my personal information?
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. Optima Health will not use or further disclose HIPAA protected health information (PHI) except as necessary for treatment, payment, and health plan operations, as permitted or required by law, or as authorized by you. A complete description of your rights under HIPAA can be found in the Sentara Healthcare Integrated Notice of Privacy Practices. A copy of the notice will be included in your COI when you enroll. You can also go to optimaehealth.com/members to see a copy of our privacy notice.

The Commonwealth of Virginia also has laws in place to protect the privacy of our members’ insurance information. We will not release data about you unless you have authorized it, or as permitted or required by law. Optima Health requires an Authorization of Designated Agent form whenever anyone other than the Optima Health member needs to obtain and/or change health information. You can download a copy of the form at optimaehealth.com/members under Manage My Plan, Member Forms, or by calling Member Services at the number on the back on your member ID card.

Under HIPAA and Virginia law, you have certain rights to see and copy health information about you. Under HIPAA, you have the right to request an accounting of certain disclosures of the information and under certain circumstances, amend the information. You have the right to file a complaint with Optima Health or with the Secretary of the U.S. Department of Health and Human Services, if you believe your rights under HIPAA have been violated.

What if I decide not to enroll with Optima Health at this time? Will my dependents or I be able to enroll later?
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents with Optima Health if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependents’ other coverage. However, you must request enrollment within 31 days after you or your dependents’ other coverage ends, or after the employer stops contributing toward the other coverage.

If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
Optima Health offers special enrollment for employees and dependents that lose eligibility under Medicaid or CHIP coverage.

Employees or dependents who are eligible for group coverage will be permitted to enroll late if they (1) lose eligibility for Medicaid or CHIP coverage, or (2) become eligible to participate in a premium assistance program under Medicaid or CHIP. In both cases, the employee must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, contact your employer group benefits administrator or contact Optima Health Member Services at the number located on the back of your member ID card.

What if I have coverage under more than one health plan?

If you have coverage under another health plan, that plan may have primary responsibility for the covered expenses of you or your family members. Optima Health uses order of benefit rules to determine whether it is the primary or secondary plan. Generally, the plan that covers the person as a subscriber pays first. If your dependents are covered under more than one healthcare plan, Optima Health has rules based on subscriber date of birth, length of coverage, and custody obligations that determine primary responsibility.

What are my rights under the Women’s Health and Cancer Rights Act?

Under the Women’s Health and Cancer Rights Act of 1998, and according to Virginia State Law, Optima Health provides benefits for the mastectomy-related services listed below in a manner determined in consultation with the attending doctor and the member:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis and any physical complications resulting from the mastectomy, including lymphedema.

Coverage for breast reconstruction benefits is subject to deductibles, copayments, and/or coinsurance consistent with those established for other benefits under Optima Health. Call Member Services at the number on the back of your member ID card for more information.

What rights do I have under Maternity Benefits?

Under Federal and Virginia State Law, you have certain rights and protections regarding your maternity benefits with Optima Health.

Under federal law known as the “Newborns’ and Mothers’ Health Protection Act of 1996” (Newborns’ Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Under Virginia State Law, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the “Standards for Obstetric-Gynecologic Services” prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are generally no less favorable than for physical illness.
FAQs  Important Regulatory Information

What can I do to prevent Healthcare Fraud?

Fraud increases the cost of healthcare for everyone. Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number or other personal information over the telephone or email it to people you do not know, except for your healthcare providers or Optima Health representatives.

- Do not go to a doctor who says that an item or service is not usually covered, but they know how to bill the health plan to get it paid. 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.

- Carefully review explanation of benefits (EOB) statements that you receive from the health plan. If you suspect a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, contact the provider for an explanation. There may be an error.

Optima Health provides its members a way to report situations or actions they think may be potentially illegal, unethical, or improper. If you want to report fraudulent or abusive practices, you can call the Fraud and Abuse Hotline at the number below. You can also send an email or forward your information to the address below. All referrals may remain anonymous. Please be sure to leave your name and number if you wish to be contacted for follow up. If appropriate, the necessary governmental agency (e.g., DMAS, CMS, OIG, BOI, etc.) will be notified as required by law.

Optima Health Fraud & Abuse Hotline: 1-866-826-5277
Email: compliancealert@sentara.com
Mail: Optima Health
c/o Special Investigations Unit
4417 Corporation Lane
Virginia Beach, VA 23462
Optima Health is committed to helping you reach your best health. You can do your part by:

- Eating a healthy diet
- Avoiding all tobacco products
- Maintaining a healthy weight
- Keeping your blood pressure under control
- Exercising regularly
- Maintaining healthy cholesterol levels

If you do not know your blood pressure or cholesterol levels, see your Plan doctor and get to “know your numbers.” Your heart health depends on your management of these essential indicators of health. If your numbers are higher than they should be, follow your plan doctor’s advice and take advantage of information and support offered by Optima Health.

Follow the check-up and immunization schedule below to reach your best health. The screenings listed by age and frequency help diagnose diseases in the earliest, most treatable stages. This schedule is recommended for most people. If your doctor recommends a different schedule, please follow his or her advice.

### REGULAR CHECK-UP SCHEDULE

<table>
<thead>
<tr>
<th>Adults</th>
<th>18+</th>
<th>Yearly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants and Children</td>
<td>Under 3</td>
<td>Ages 2-5 days; and 1, 2, 4, 6, 9, 12, 15, 18, and 24 months</td>
</tr>
<tr>
<td>Children and Teens</td>
<td>3-18</td>
<td>Yearly</td>
</tr>
</tbody>
</table>
## Preventive Screening Reminders

<table>
<thead>
<tr>
<th>Screening</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Immunizations</strong>*</td>
<td></td>
</tr>
<tr>
<td>Influenza (Flu Shot)</td>
<td>Annually</td>
</tr>
<tr>
<td>Tetanus, Diptheria, Pertussis (Td/Tdap)</td>
<td>First dose by age 18, then every 10 years—discuss options with your physician</td>
</tr>
<tr>
<td>Pneumonia Shot</td>
<td>Complete at age 65 or per your physician’s recommendation</td>
</tr>
<tr>
<td><strong>Colorectal Screening</strong>*</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy, or</td>
<td>Complete by age 50 and then every 10 years</td>
</tr>
<tr>
<td>Sigmoidoscopy, or</td>
<td>Complete by age 50 and then every 5 years</td>
</tr>
<tr>
<td>Fecal Occult Blood Test</td>
<td>Complete by age 50 and then yearly</td>
</tr>
<tr>
<td><strong>Early Cancer Detection - Female</strong>*</td>
<td></td>
</tr>
<tr>
<td>Pap Test</td>
<td>Start by age 21 and then retest per your physician’s recommendation</td>
</tr>
<tr>
<td>Clinical Breast Exam</td>
<td>Complete per your physician’s recommendation</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Start by age 45 and then retest per your physician’s recommendations</td>
</tr>
<tr>
<td><strong>Early Cancer Detection</strong>* - Male</td>
<td></td>
</tr>
<tr>
<td>Digital Rectal Exam</td>
<td>Start by age 50 (age 40 for those at risk), then yearly</td>
</tr>
<tr>
<td>PSA (prostate-specific antigen)</td>
<td>Complete per your physician’s recommendation</td>
</tr>
</tbody>
</table>

Visit [www.wellnessforme.com](http://www.wellnessforme.com) to request health improvement programs.

*Benefit coverage may vary by plan. Consult Member Services by calling the number on the back of your member ID card. References: OHP Clinical Guidelines 2017.*
# Children’s Immunization Schedule

Use this chart to help keep track of your child’s immunizations and ensure the best protection from disease.

<table>
<thead>
<tr>
<th>Birth</th>
<th>Optima Health Covered Immunizations</th>
<th>Recommended Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Hepatitis B</strong></td>
<td><strong>Rotavirus</strong></td>
</tr>
<tr>
<td>2 Months</td>
<td>Diphtheria/Tetanus/Pertussis</td>
<td>Rotavirus</td>
</tr>
<tr>
<td></td>
<td>Poliovirus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Haemophilus influenza type b</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumococcal conjugate</td>
<td></td>
</tr>
<tr>
<td>4 Months</td>
<td>Diphtheria/Tetanus/Pertussis</td>
<td>Rotavirus</td>
</tr>
<tr>
<td></td>
<td>Poliovirus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Haemophilus influenza type b</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumococcal conjugate</td>
<td></td>
</tr>
<tr>
<td>6 Months</td>
<td>Diphtheria/Tetanus/Pertussis</td>
<td>Rotavirus</td>
</tr>
<tr>
<td></td>
<td>Poliovirus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Haemophilus influenza type b</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumococcal conjugate</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Influenza Yearly</strong></td>
<td></td>
</tr>
<tr>
<td>12-18 Months</td>
<td>Diphtheria/Tetanus/Pertussis</td>
<td>Hepatitis A</td>
</tr>
<tr>
<td></td>
<td>Measles/Mumps/Rubella</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poliovirus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Haemophilus influenza type b</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Varicella zoster virus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumococcal conjugate</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Influenza Yearly</strong></td>
<td></td>
</tr>
<tr>
<td>4-6 Years</td>
<td>Diphtheria/Tetanus/Pertussis</td>
<td>Varicella</td>
</tr>
<tr>
<td></td>
<td>Poliovirus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles/Mumps/Rubella</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Influenza Yearly</strong></td>
<td></td>
</tr>
<tr>
<td>11-18 Years</td>
<td>Tetanus/Diphtheria</td>
<td>HPV (3 doses)</td>
</tr>
<tr>
<td></td>
<td>(Repeat every 10 years through life)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If your child was unable to receive all immunizations listed above, your doctor may complete</td>
<td></td>
</tr>
<tr>
<td></td>
<td>immunizations during this time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles/Mumps/Rubella (if child has not received second dose.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Influenza yearly</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HPV (3 doses)</td>
<td></td>
</tr>
<tr>
<td>11-12 Years</td>
<td>Meningococcal (Meningitis shot) Talk with your doctor about when this immunization is needed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HPV (3 doses)</td>
<td></td>
</tr>
</tbody>
</table>

Many of these immunizations may be combined, rather than given as individual injections. In addition, specific situations may arise for children who have not or should not receive their immunizations according to this schedule. Discuss immunizations with your physician.

Sources:
- Optima Health 2017 Clinical Guidelines
- CDC Recommended Childhood and Adolescent Immunization Schedule 2017 and CDC Recommended Adult Immunization Schedule 2017
Flu and Pneumonia Prevention

Flu Vaccine
The flu vaccine is covered for members with medical and/or pharmacy benefits administered by Optima Health. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccine for everyone six months of age and older, as the first and most important step in protecting against this serious disease. While there are many different flu viruses, the flu vaccine is designed to protect against the main flu strains that research indicates will cause the most illness during each flu season.

Optima Health members may visit the following locations to receive a flu shot:

Your doctor:
- Check with your physician to see if he or she offers the flu vaccine.
- A physician office Copayment may apply.

Your local pharmacy:
- Members should visit optimahealth.com/members to download a list of participating pharmacies.
- We recommend that you call the pharmacy in advance to check the availability of the flu vaccine.

If you need additional assistance finding a location to receive the flu vaccine, contact Optima Health Member Services at the number on the back of your member ID card.

Pneumonia Vaccine
The CDC defines pneumonia as an infection of the lungs that can cause mild to severe illness in people of all ages. Signs of pneumonia can include coughing, fever, fatigue, nausea, vomiting, rapid breathing or shortness of breath, chills, or chest pain. Certain people are more likely to become ill with pneumonia. This includes adults 65 years of age or older and children younger than five years of age. People up through 64 years of age who have underlying medical conditions (like diabetes or HIV/AIDS) and people 19 through 64 who smoke cigarettes or have asthma are also at increased risk for getting pneumonia.

The pneumococcal conjugate vaccine (PCV13 or Prevnar 13®) protects against the 13 types of pneumococcal bacteria that cause most of the severe illness in children and adults. The vaccine can also help prevent some ear infections. PCV13 is recommended for all children at 2, 4, 6, and 12 through 15 months old. PCV13 is also recommended for adults 19 years or older with certain medical conditions and in all adults 65 years or older.

The pneumococcal polysaccharide vaccine (PPSV23 or Pneumovax 23®) protects against 23 types of pneumococcal bacteria. It is recommended for all adults 65 years or older and for anyone who is 2 years or older at high risk for disease. PPSV23 is also recommended for adults 19 through 64 years old who smoke cigarettes or who have asthma.

1Optima Family Care and FAMIS members are ineligible for the Optima Health pharmacy-administered Flu Vaccination Program.

Please see your provider for information on receiving the flu or pneumonia vaccine.
Overview
Health and Preventive Services of Optima Health provides individual and group programs to improve health and prevent disease. The department offers a wide range of services including direct mail reminders, health screenings, self-learning programs, online education, flu shots, and selected classes.

Personal Health Assessment & Health Coaching
The completion of a Personal Health Assessment (PHA) includes the identification of health risks for members and targeted interventions to reduce risks and improve health. Members receive health risk information targeted at their readiness to change.

Optima Health has a powerful resource, MyLife MyPlan Connection, to help members adopt healthy behaviors, reduce health risks and lower their lifetime cost of care. MyLife MyPlan Connection offers our members flexible programs, expert guidance, and inspiration to take charge of their own health—whether they are continuing healthy behaviors, or making a change to improve their health. It all begins when the member completes a Personal Health Assessment—and creates the foundation for their Health Record and coaching program. Our health coaching partner offers a comprehensive online activities tool, known as the Digital Health Assistant (DHA). The DHA delivers a personalized, interactive, and motivational experience to help members take action and sustain healthy behaviors in a fun way.

Healthy Publications
Members can request Healthwise Handbook, a self-care manual with valuable information about health improvement, common illnesses, and preventive health care.

Patient Identification Manager Reminder System
The Patient Identification Manager Reminder System informs members of recommended immunizations and preventive health screenings that help fight communicable disease and diagnose cancer in the earliest, most treatable stages. Healthy Programs give members valuable and current information and encouragement to reduce health risks. Employees who improve their health can reduce their healthcare needs, reduce absenteeism, and reduce healthcare costs. Initiatives of this system include:

- **Mammography reminders**: Women 46 and older who have not had a mammogram in the previous 12 months receive a postcard during their birthday month. This card informs them of the recommended mammography schedule, and the importance of mammography and cervical cancer screening.
- **Cervical cancer screening reminders**: Women 22 and older who have not had a cervical cancer screening in the previous 12 months receive a postcard during their birthday month. This card informs them of Pap smear recommendations, and the importance of cervical cancer and mammography screening.
- **Healthy pregnancy mailings**: Once the health plan learns of a member’s pregnancy, she receives the following:
  1. The Planning a Healthy Pregnancy Self-Care Handbook
  2. A letter and magnet featuring the childhood immunization schedule and our wishes for a healthy delivery (sent once member is in her seventh month of pregnancy)
- **Immunization postcards and letters**: Parents receive a postcard regarding basic immunization schedule for children at 6, 12, and 18 months of age.
- **Birthday cards**: All plan members age 3 and over receive a birthday card during their birthday month from the plan. Part of this mailing includes a bookmarker that serves to remind members of the preventive health guidelines they should follow to achieve their personal best health.
- **Physician notifications**: Physicians receive monthly lists of their patients (our members) who were reminded through the PIM System and have still not completed their preventive screenings.

*To determine if you have access to telephonic Health Coaching, check with your benefits administrator or call Member Services.*
Health and Preventive Services

Based on health screening findings, members receive group, individual, and self-paced programs to reduce cardiovascular health risks and promote health.

Healthy Programs

**Eating for Life** is an award-winning educational program that helps participants develop healthy eating and exercise habits.

**Get Off Your Butt: Stay Smokeless for Life** is an educational program offering support for anyone who wants to quit tobacco use.

**Guided Meditation** is a program that invites listeners to experience a calm, peaceful retreat from everyday stressors.

**Healthy Habits Healthy You** is a program that offers helpful ways to prevent Type 2 diabetes and heart disease with healthy food choices, managing body weight, exercising, and finding ways to relax and get more sleep.

Movement Programs

**Tai Chi** is a program that helps your body to mentally and physically relax. The movements enhance your blood flow, release muscle tension, and improve your balance.

**WalkAbout with Healthy Edge** is a program that focuses on increasing regular activity. It includes a step tracking device and encourages participants to start moving and begin walking their way to better health.

**Yoga** programs include stretching and strengthening exercises to help improve flexibility, strength and cardiovascular health. Chair Yoga is also available.

Health and Preventive Services by Optima Health provides individual and group programs to improve health and prevent disease.

Members have access to direct mail reminders, health screenings, self-learning programs, Internet resources, and more.
Resolving Member Complaints and Appeals

If you have a problem or concern about Optima Health and/or the quality of care, services, and/or policies and procedures of Optima Health, call Member Services at the number on the back of your member ID card.

Optima Health has a formal process that allows your concern to be addressed with the appropriate departments/persons within Optima Health. Research into your concerns is conducted in a timely manner to accommodate any clinical urgency of the situation. Upon research and review, you will be notified of the resolution to your concern.

If your concern involves a denial of a covered service or claim, Optima Health includes a formal appeals process. You may be eligible for a routine appeal or an expedited appeal if an emergency medical condition exists. Download an appeal packet from the Manage My Plan section on optimaehealth.com/members or contact Member Services to initiate the appeals procedure.

If you are not satisfied with the decision, other resources may be available to you, depending on the type of plan that your employer has chosen. If you are unsure of the type of Plan you have, please contact Member Services at the number on the back of your member ID card.

Additional resources include:
The Managed Care Ombudsman is available through the Bureau of Insurance to help Virginia consumers who experience problems with or have questions about managed care. The Managed Care Ombudsman can assist Optima Health members in understanding and exercising their rights of appeal of adverse decisions. There are several ways to contact the Office of the Managed Care Ombudsman:

- Office of the Managed Care Ombudsman
  Bureau of Insurance
  Post Office Box 1157
  Richmond, VA 23218
  Toll-Free: 1-877-310-6560
  Richmond Metropolitan Area: 804-371-9032
  Email: ombudsman@scc.virginia.gov

- Virginia Department of Health
  Office of Licensure and Certification
  9960 Mayland Drive, Suite 401
  Henrico, VA 23233
  Toll-Free: 1-800-955-1819

- Life & Health Division
  Bureau of Insurance
  Post Office Box 1157
  Richmond, VA 23218
  804-371-9741 or In-State Toll-Free: 1-800-552-7945

An appeal is expedited if a member's life, health, or the ability to regain maximum function is in jeopardy, or if a physician believes a member would be subjected to severe pain that could not be adequately managed without the requested care or treatment.

Did you know that you could download an Appeals Packet from optimaehealth.com/members?

The local U.S. Department of Labor, Pension, and Welfare Benefits Administration can assist members in finding out what other voluntary alternative dispute resolutions are available. They may be reached toll free at 1-866-275-7922.
Member Rights and Responsibilities

As a member of Optima Health, you are entitled to all covered benefits; however, you must learn how the health plan works, follow the proper procedures, and use the proper network (i.e., Plan doctors, hospitals, mental health providers, and other Plan specialists participating with Optima Health).

**Optima Health Plan Members have the right to:**

1. Timely and Quality of Care:
   a. Access to Protected Health Information (PHI), medical records, physicians, and other healthcare professionals; and referrals to specialists when medically necessary.
   b. Continuity of care and to know in advance the time and location of an appointment, as well as the physicians and other health care professionals providing care.
   c. Receive the medical care that is necessary for the proper diagnosis and treatment of any covered illness or injury
   d. Participate with physicians and healthcare professionals in:
      i. Discussing their diagnosis, the prognosis of the condition, and instructions required for follow-up care;
      ii. Understanding the health problems and assisting to develop mutually agreed-upon goals for treatment;
      iii. Decision-making regarding their healthcare and treatment planning; and
      iv. A candid discussion of appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage.
   e. The right to affirm that all practitioners, providers, and employees who make utilization management (UM) decisions:
      i. Base decisions on appropriateness of care, services and existence of coverage;
      ii. Are not rewarded for issuing medical denials of coverage; and
      iii. Do not encourage decisions that result in underutilization through financial incentives.

2. Treatment with Dignity and Respect – Members will
   a. Be treated with respect, dignity, compassion and the right to privacy.
   b. Exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care. Expect this right by both Plan and contracting physicians.
   c. Expect protection of all oral, written, and electronic information across the Plan, and information to plan sponsors and employers.
   d. Extend their rights to any person who may have legal responsibility to make decisions on the member’s behalf regarding medical care.
   e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
   f. Be able to refuse treatment or to sign a consent form if the member feels they do not clearly understand its purpose, or crossout any part of the form they do not want applied to their care, or change their mind about any treatment for which they have previously given consent and be informed of the medical consequences of this action.

3. Receive Health Plan Information – Members will
   a. Receive information about their health plan, its services, its physicians, other health care professionals, facilities, clinical guidelines and member rights and responsibilities statements; and collection, use, and disclosure of PHI.
   b. Know by name, title, and organization the physicians, nurses or other health care professionals providing care.
   c. Receive information about medications (what they are, how to take them and possible side effects) and pharmacy benefit information (effective date of formulary change, new drugs available, or recalled medications).
Member Rights and Responsibilities

d. Receive clear information regarding benefits and exclusions of their policy, how medical treatment decisions are made/authorized by the health plan or contracted medical groups, payment structure, and the right to approve the release of information.

e. Be advised if a practitioner proposes to engage in experimentation affecting care or treatment. The member may have the right to refuse to participate in such research.

f. Be informed of policies regarding Advance Directives (living wills) as required by state and federal laws.

4. Members Solve Problems in a Timely Manner by

a. Presenting questions, concerns or complaints to a customer service specialist without discrimination and expect problems to be fairly examined and appropriately addressed.

b. Voicing concerns or complaints to Optima Health about their health plan, if the care provided was inadequate, or feel their rights have been compromised. This includes the right to appeal an action or denial and the process involved.

c. Making recommendations regarding the health plan members rights and responsibilities policies.
Member Rights and Responsibilities

**Member Responsibilities**

Optima Health Plan Members, in addition to their rights, subscribers and their enrolled dependents have the responsibility:

1. To identify themselves, and their family members as an Optima Health enrollee and present their identification card(s) when requesting healthcare services.

2. To be on time for appointments and contact the physician or other healthcare personnel at once if there is a need to cancel or if they are going to be late for an appointment. If the physician, other healthcare personnel or facility, has a policy assessing charges regarding late cancellations or “no shows”, the member will be responsible for such charges.

3. To provide information about their health to physicians and other health care professionals so they may provide appropriate medical care.

4. To actively participate and understand improving their health condition(s) by following the plans and instructions for care and treatment goals that they agreed upon with the physician or healthcare professional.

5. To act in a manner that supports the care provided to other patients and the general functioning of the office or facility.

6. To review the employee handbook and Plan documentation:
   a. To make sure the services are covered under the plan,
   b. To approve release of information and have services properly authorized before receiving medical attention,
   c. To follow proper procedures for illness before and after business hours, and
   d. For materials concerning health benefits (e.g. UM issues) and educate other covered family members.

7. To accept financial responsibility for any copayment or coinsurance associated with services received while under the care of a physician or other healthcare professional or while a patient at a facility.

8. To contact Optima Health if they have concerns, or if they feel their rights have been compromised.

For questions, concerns, or additional information, please visit www.optimahealth.com or contact Member Services at the number on the back of your member ID card. TDD/TTY services and language assistance are available.

Federal Law requires Optima Health to provide enrolled members 18 years of age or older the opportunity to make decisions concerning their right to accept or refuse medical or surgical treatment and their right to formulate written instructions called an Advance Directive.

An Advance Directive consists of three parts: a living will, designation of healthcare agent, and wishes regarding anatomical gift or organ donation. Advance Directives are recognized under State Law and Federal Law and are to provide for the wishes of individuals who are unable to make medical care decisions on their own.

The law requires that the care you receive from any Plan provider will not be affected by your making (or not making) an Advance Directive, unless your Advance Directive states that medical care should not be given to you.

In compliance with Federal Law, Optima Health is providing you with information about the Patient Self-Determination Act. The following is a summary of our policies regarding patients’ rights and Advance Directives. It means you have a chance to make important life choices. You may never need to exercise these choices, but making them ahead of any event can give peace of mind to you and your family.

You may want to take this opportunity to discuss and document your wishes with your family, attorney, and/or a close friend. It is also important to talk with your Plan doctor about your choices, so he or she is informed and understands your wishes.

We will gladly send you advance care planning guide, which tells more about Advance Directives, and information on a Virginia living will, designation of healthcare agent, and wishes regarding anatomical gift or organ donation form.

If you have an Advance Directive, take a copy of the member statement to your next Plan doctor appointment. You may download an Advance Directive from optimahhealth.com/members. If you would like more information, call Member Services at the number on the back of your member ID card.

Summary of Policies on Patient Rights and Advance Directives

Purpose
This policy is intended to enable Optima Health to comply with the Patient Self-Determination Act. The purpose of the act is to protect each adult patient’s right to participate in healthcare decision making to the maximum extent of his or her ability and to prevent discrimination based on whether the patient has executed an Advance Directive for healthcare.

Practice Statement
Optima Health supports a patient’s right to participate in healthcare decision making. Through education and inquiry about Advance Directives, this health plan will encourage patients to communicate their healthcare preferences and values to others. Such communication will guide others in healthcare decision making for the patient if the patient is incapacitated.
Advance Directives

Procedures
At enrollment, you will be provided information about your rights under Virginia law to:

- Make decisions about your medical care, including your right to accept or refuse medical and surgical treatment.
- Make an Advance Directive, such as a living will or durable power of attorney for healthcare, if you choose to do so.
- You will be asked if you have made an Advance Directive.
- If you have, you will need to give this form to your plan doctor so it will be made part of your medical record. You will need to keep an additional copy for yourself.
- If you have not, and wish to do so, you will be provided additional information upon request in order to make an Advance Directive.
- You will be encouraged to discuss your Advance Directive with your family, plan doctor, clergy, attorney, or a close friend.
- If you do not have an Advance Directive, do not want to make one, and do not want more information, you will not be asked any more questions.

You may revoke your Advance Directive at any time in writing or by oral declaration. Your making (or not making) an Advance Directive will not affect the care you receive from any plan provider, unless your Advance Directive states that medical care should not be given to you. Your Advance Directive will be followed unless it requests medical care that is inappropriate, unethical, or is of no medical benefit or harmful to you.

If your plan doctor is unwilling to comply with your Advance Directive, or with the decision of a person you designate to make decisions for you, he or she will make a reasonable effort to transfer your care to another plan doctor within 14 days. During this period, your plan doctor must continue any life-sustaining care.
Large Group Plans
Optima Health

Benefit Changes for ODU Research Foundation

The following changes will be effective July 1, 2018

All Plans

- **Contraception Virginia Mandate** - In compliance with a new Virginia state law, prescriptions for up to a 12-month supply of hormonal contraceptives are covered when dispensed or furnished at one time by an in-network provider or pharmacy. Members are responsible for the applicable Copayment or Coinsurance.

- **Statin Generic Medications** - Select Statin generic medications (used primarily to control cholesterol levels) for most adults ages 40–75 with no history of cardiovascular disease are covered at 100% under the preventive services. Medications covered include:

  - Atorvastatin 10mg
  - Atorvastatin 20mg
  - Lovastatin (all strengths)
    - Simvastatin 5mg
    - Simvastatin 10mg
    - Simvastatin 20mg
    - Simvastatin 40mg

- **3-D mammograms** – 3-D mammograms will be covered at the applicable copay/coinsurance. Screening 3D mammography is covered as a preventive service with no member cost share when received from an in-network provider. Diagnostic 3D mammography is covered at the applicable member cost share for advanced imaging.

- **Mental Health Parity** - To ensure Mental Health Parity and Addiction Equity Act requirements are met, the mental health outpatient benefit in the Vantage 10/20 and Plus 10/20% plans will change from a Copayment to a Coinsurance benefit level.

- **Standard Formulary** - This Plan uses a closed prescription drug formulary. That means Your Plan includes coverage for a specific list of drugs and medications determined by our Pharmacy and Therapeutics Committee. Drugs that are not included on the Standard formulary will not be covered under Your plan. Please use the following link to see a list of drugs on the Standard formulary: [http://public.optimahealth.com/Lists/OptimaFormsLibrary/form-doc-drug-list-standard-formulary.pdf](http://public.optimahealth.com/Lists/OptimaFormsLibrary/form-doc-drug-list-standard-formulary.pdf).
Vantage Plan

- **Out-of-Area Dependent Program** - This benefit allows out-of-area dependent children access to a national network of providers through PHCS/Multiplan. When accessing care outside of the Optima Health service area, enrolled and identified dependent children will be able to receive covered services from PHCS/Multiplan providers at the in-network benefit level.

Plus Plan

- **In-Network Maximum Out-of-Pocket** – The In-Network Maximum Out-of-Pocket will increase to $2,000 per person and $4,000 per family.

- **Out-of-Network Deductible** – The Out-of-Network Deductible will increase to $500 per person and $1,000 per family.

- **In-Network Coinsurance** – The In-Network Coinsurance will increase to 20%.

- **Out-of-Network Coinsurance** – The Out-of-Network Coinsurance will increase to After Deductible You Pay 30%.
**Optima Plus/Plus OOA 10/20%**  
**Preferred Provider Organization/Out of Area Plan Summary of Benefits**  

**ODU Research Foundation 2018**

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Evidence of Coverage or Certificate of Insurance, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. There are two benefit columns. One column lists Your Copayment or the percent Coinsurance You will pay for In Network benefits from Plan Providers. The other column lists Your Copayment or the percent Coinsurance You will pay for Out of Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Certificate of Insurance (COI) document carefully.

### Deductibles, Maximum Out-of-Pocket Limits,

<table>
<thead>
<tr>
<th>Deductibles per Calendar Year</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Plan does not have an In-Network Deductible</td>
<td>$500 per Person</td>
<td>$1,000 per Family</td>
</tr>
<tr>
<td><strong>Maximum Out-of-Pocket Limit per Calendar Year</strong></td>
<td>$2,000 per Person</td>
<td>$4,500 per Person</td>
</tr>
<tr>
<td>$4,000 per Family</td>
<td>$9,000 per Family</td>
<td></td>
</tr>
</tbody>
</table>

### Physician Services

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery**.

#### Physician Office Visits

<table>
<thead>
<tr>
<th>Physician Office Visits</th>
<th>In-Network Benefits Copayments/Coinsurance</th>
<th>Out-of-Network Benefits Copayments/Coinsurances</th>
</tr>
</thead>
</table>
| **Primary Care Physician (PCP) Office Visit**  
Also includes Virtual Consults when furnished by approved Optima Health providers. | You Pay $10 Copayment | After Deductible You Pay 30% |
| **Specialist Office Visit** | You Pay $20 Copayment | After Deductible You Pay 30% |
| **Vaccines and Immunotherapeutic Agents**  
You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care. | You Pay 50% | After Deductible You Pay 50% |
| **Preventive Care**  
Routine Annual Physical Exams  
Well Baby Exams  
Annual GYN Exams and Pap Smears  
PSA Tests  
Colorectal Cancer Tests  
Routine Adult and Childhood Immunizations  
Screening Colonoscopy  
Screening Mammograms  
Women’s Preventive Services | Covered at 100% | After Deductible You Pay 30% |

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**UNDERWRITTEN BY OPTIMA HEALTH INSURANCE COMPANY**
## Outpatient Therapy and Rehabilitation Services

You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation services done in a Physician’s office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit.

<table>
<thead>
<tr>
<th>Short Term Therapy Services (^7)</th>
<th>In-Network Benefits Copayments/Coinsurance(^2)</th>
<th>Out-of-Network Benefits Copayments/Coinsurances(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Therapy</strong>&lt;br&gt;<strong>Occupational Therapy</strong>&lt;br&gt;<strong>Pre-Authorization is required.</strong>(^6)&lt;br&gt;Physical and Occupational Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.(^7)&lt;br&gt;Copayment or Coinsurance applies at any place of service.</td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td><strong>Speech Therapy</strong>&lt;br&gt;<strong>Pre-Authorization is required.</strong>(^6)&lt;br&gt;Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.(^7)&lt;br&gt;Copayment or Coinsurance applies at any place of service.</td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Short Term Rehabilitation Services (^7)</th>
<th>In-Network Benefits Copayments/Coinsurance(^2)</th>
<th>Out-of-Network Benefits Copayments/Coinsurances(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac Rehabilitation</strong>&lt;br&gt;<strong>Pulmonary Rehabilitation</strong>&lt;br&gt;<strong>Vascular Rehabilitation</strong>&lt;br&gt;<strong>Vestibular Rehabilitation</strong>&lt;br&gt;<strong>Pre-Authorization is required.</strong>(^6)&lt;br&gt;Services are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.(^7)&lt;br&gt;Copayment or Coinsurance applies at any place of service.</td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Outpatient Treatments</th>
<th>In-Network Benefits Copayments/Coinsurance(^2)</th>
<th>Out-of-Network Benefits Copayments/Coinsurances(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chemotherapy</strong>&lt;br&gt;<strong>Radiation Therapy</strong>&lt;br&gt;<strong>IV Therapy</strong>&lt;br&gt;<strong>Inhalation Therapy</strong>&lt;br&gt;You Pay $10 Copayment per PCP office visit&lt;br&gt;You Pay $20 Copayment per Specialist office visit&lt;br&gt;You Pay 20% per outpatient facility visit</td>
<td>After Deductible You Pay 30%</td>
<td>After Deductible You Pay 30%</td>
</tr>
</tbody>
</table>
**Pre-Authorized Injectable and Infused Medications**
Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.

<table>
<thead>
<tr>
<th></th>
<th>In-Network Benefits Copayments/Coinsurance²</th>
<th>Out-of-Network Benefits Copayments/Coinsurance²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dialysis Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment or Coinsurance applies at any place of service.</td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Authorization is required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You Pay $50 Copayment and You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outpatient Diagnostic Procedures</strong></th>
<th>In-Network Benefits Copayments/Coinsurance²</th>
<th>Out-of-Network Benefits Copayments/Coinsurance²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Procedures</strong></td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td><strong>X-Ray</strong></td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td><strong>Ultrasound</strong></td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td><strong>Doppler Studies</strong></td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td><strong>Lab Work</strong></td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
</tbody>
</table>
# Outpatient Advanced Imaging and Testing Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>In-Network Benefits Copayments/ Coinsurance(^2)</th>
<th>Out-of-Network Benefits Copayments/ Coinsurance(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td>Magnetic Resonance Angiography (MRA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positron Emission Tomography (PET Scans)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computerized Axial Tomography (CT Scans)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computerized Axial Tomography Angiogram (CTA Scans)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Authorization is required for all procedures except Sleep Studies, MRS, SPECT and Nuclear Cardiology.(^6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment or Coinsurance applies to procedures done in a Physician’s office, a free-standing outpatient facility, or a hospital outpatient facility.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Maternity Care

<table>
<thead>
<tr>
<th>Procedure</th>
<th>In-Network Benefits Copayments/ Coinsurance(^2)</th>
<th>Out-of-Network Benefits Copayments/ Coinsurance(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care(^{6,10,11})</td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td>Pre-Authorization is required for prenatal services.(^6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes prenatal, delivery, postpartum services, and home health visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Inpatient Services

<table>
<thead>
<tr>
<th>Procedure</th>
<th>In-Network Benefits Copayments/ Coinsurance(^2)</th>
<th>Out-of-Network Benefits Copayments/ Coinsurance(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services Pre-Authorization is required.(^6)</td>
<td>You Pay $200 Copayment per Admission and You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td>Transplants</td>
<td>You Pay $200 Copayment per Admission and You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td>Pre-Authorization is required.(^6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facilities/Services(^7) Pre-Authorization is required.(^6)</td>
<td>You Pay $200 Copayment per Admission and You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td>Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 90 days combined In- and Out-of-Network per calendar year that in the Plan’s judgment requires Skilled Nursing Facility Services.(^7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>In-Network Benefits</td>
<td>Out-of-Network Benefits</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Copayments/Coinsurance&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Copayments/Coinsuranc&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong>:&lt;sup&gt;8&lt;/sup&gt;</td>
<td>You Pay $25 Copayment and You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td>Pre-Authorization is required for non-emergent transportation only.&lt;sup&gt;6&lt;/sup&gt;</td>
<td>Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre- Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Emergency Services</strong></th>
<th>Copayments/Coinsurances&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Copayments/Coinsurance&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Services</strong>:&lt;sup&gt;9&lt;/sup&gt;</td>
<td>You Pay $200 Copayment and You Pay 20%</td>
<td>You Pay $200 Copayment and You Pay 20%</td>
</tr>
<tr>
<td>Pre-Authorization is not required.</td>
<td>Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Urgent Care Center Services</strong></th>
<th>Copayments/Coinsurances&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Copayments/Coinsurance&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Services</strong>:&lt;sup&gt;9&lt;/sup&gt;</td>
<td>You Pay $20 Copayment</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td>Pre-Authorization is not required.</td>
<td>Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay an Emergency Services Copayment or Coinsurance.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Mental/Behavioral Health &amp; Substance Use Disorder Services</strong></th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes inpatient and outpatient services for the treatment of mental health and substance use disorders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental/Behavioral Health/Substance Use Disorder</strong></td>
<td>Copayments/Coinsurance&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Copayments/Coinsurance&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Inpatient Services</strong>:&lt;sup&gt;6&lt;/sup&gt; Pre-Authorization is required for all Inpatient Services.</td>
<td>You Pay $200 Copayment per Admission and You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td><strong>Outpatient Office Visits</strong>:&lt;sup&gt;6&lt;/sup&gt; Pre-Authorization is required for partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.</td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td><strong>Employee Assistance Visits</strong>:&lt;sup&gt;7&lt;/sup&gt; Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174.</td>
<td>$0 Copayment for up to 5 visits from Optima Employee Assistance providers per presenting issue as determined by treatment protocols.&lt;sup&gt;6&lt;/sup&gt;</td>
<td>Services are covered only when received from Optima Health providers.</td>
</tr>
</tbody>
</table>
Diabetes Treatment
Coverage includes benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating Eye Med Provider at the applicable office visit Copayment or Coinsurance amount.

<table>
<thead>
<tr>
<th></th>
<th>In-Network Benefits Copayments/ Coinsurances&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Out-of-Network Benefits Copayments/ Coinsurances&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insulin Pumps</strong></td>
<td>Covered at 100%.</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td>Pre-Authorization is required&lt;sup&gt;6&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pump Infusion Sets and Supplies</strong></td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
</tr>
<tr>
<td>Pre-Authorization is required&lt;sup&gt;6&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Testing Supplies</strong></td>
<td>Covered under the Plan’s Prescription Drug Benefit.</td>
<td>Covered under the Plan’s Prescription Drug Benefit.</td>
</tr>
<tr>
<td>Includes test strips, lancets, lancet devices, blood glucose monitors and control solution.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Insulin, Needles, and Syringes</strong></td>
<td>Covered under the Plan’s Prescription Drug Benefit.</td>
<td>Covered under the Plan’s Prescription Drug Benefit.</td>
</tr>
<tr>
<td><strong>Outpatient Self-Management Training and Education and Nutritional Therapy</strong></td>
<td>Covered at 100%.</td>
<td>After Deductible You Pay 30%</td>
</tr>
</tbody>
</table>

Other Covered Services

<table>
<thead>
<tr>
<th></th>
<th>In-Network Benefits Copayments/ Coinsurances&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Out-of-Network Benefits Copayments/ Coinsurances&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prosthetics and Components</strong></td>
<td>You Pay 30%</td>
<td>After Deductible You Pay 40%</td>
</tr>
<tr>
<td>Pre-Authorization is required&lt;sup&gt;6&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components. Definitions: &quot;Component&quot; means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. &quot;Limb&quot; means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. &quot;Prosthetic device&quot; means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Autism Spectrum Disorder
Pre-Authorization is required. Covered Services include “diagnosis” and “treatment” of Autism Spectrum Disorder in children from age two through ten.

“Autism Spectrum Disorder” means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger’s Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

“Diagnosis of autism spectrum disorder” means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

“Treatment for autism spectrum disorder” shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.

“Applied behavioral analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Coverage for applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000.

Clinical Trials
Coverage of Routine patient costs for Phase I, II and III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.

Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.

Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors.

Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.
<table>
<thead>
<tr>
<th>Service</th>
<th>payer's responsibility</th>
<th>After Deductible payer's responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chiropractic Care</strong>&lt;sup&gt;6, 7&lt;/sup&gt;</td>
<td>You Pay 20% of ASH’s fee schedule</td>
<td>After Deductible You Pay 40% of ASH’s fee schedule</td>
</tr>
<tr>
<td>Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit.&lt;sup&gt;6&lt;/sup&gt; Pre-Authorization is required by ASH for all chiropractic care services. To receive services, contact ASH’s Member Services at 1-800-678-9133. Representatives are available from 8 AM to 9 PM Monday-Friday. Coverage is limited to a combined maximum benefit with In- and Out-of-Network benefits of 30 visits per calendar year&lt;sup&gt;7&lt;/sup&gt;. This benefit also includes coverage of Chiropractic appliances up to a combined maximum benefit with In-and Out-of-Network benefits of 1 appliance per Person per calendar year when medically necessary.&lt;sup&gt;7&lt;/sup&gt; For providers not in the ASH network the Member will be responsible for payment of all charges in excess of ASH’s allowable charge in addition to any Coinsurance amount. Allowable charge is the lesser of the provider’s actual charge or ASH’s In-Network fee schedule for the same services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME) and Supplies</strong> Orthopedic Devices and Prosthetic Appliances</td>
<td>You Pay 30%</td>
<td>After Deductible You Pay 40%</td>
</tr>
<tr>
<td>Pre-Authorization is required for single items over $750&lt;sup&gt;6&lt;/sup&gt; Pre-Authorization is required for all rental items.&lt;sup&gt;6&lt;/sup&gt; Pre-Authorization is required for repair and replacement.&lt;sup&gt;6&lt;/sup&gt; Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliodefomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Early Intervention Services</strong> Pre-Authorization is required.&lt;sup&gt;6&lt;/sup&gt; Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.</td>
<td>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.</td>
<td>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.</td>
</tr>
<tr>
<td>Service</td>
<td>You Pay 20%</td>
<td>After Deductible You Pay 30%</td>
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| **Home Health Care Skilled Services**<sup>7</sup>  
**Pre-Authorization is required.**<sup>6</sup>  
Services are covered up to a maximum combined benefit with In-Network and Out-of-Network benefits of 100 visits per calendar year for Members who are home bound, and in the Plan’s judgment require Home Health Skilled Services.<sup>7</sup>  
You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan’s annual outpatient therapy benefit limits.  
You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan’s annual outpatient rehabilitation benefit limits. | You Pay 20%                                      | After Deductible You Pay 30% |
| **Hospice Care**  
**Pre-Authorization is required.**<sup>6</sup>  | You Pay 20%                                      | After Deductible You Pay 30% |
| **Telemedicine Services**  
Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. | Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment. | Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment. |

**Notes**

All benefits are subject to the terms and conditions in the Certificate of Insurance (COI). Words that are capitalized are defined terms listed in the Definitions section of the COI.

Children are covered up to the end of the month in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your benefits. This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your COI for details about how to file a complaint or an appeal.

Under certain circumstances Your coverage can be terminated. However, Your Coverage can only be rescinded for fraud or intentional misrepresentation of material fact. Please look in Your COI in the section on When Your Coverage will end.

For Optima Health plans that require that You choose a Primary Care Provider (PCP) You have the right to choose any PCP who participates in our network and who is available to accept You or Your family members. For children, You may choose a pediatrician as the PCP.

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.
2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health’s **Allowable Charge** for the Covered Service You receive.

**Allowable Charge** is the amount Optima Health determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers Allowable Charge is the Provider’s contracted rate with Optima Health or the Provider’s actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.

Covered Services You receive from Non-Plan Providers will be administered under Your Out-of-Network benefits with the following exceptions:

- If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits.

- Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You Pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan’s Out-of-Network Deductible and Maximum Out-of-Pocket amounts.

When You use Out-of Network benefits from Non-Plan Providers Allowable Charge may be a negotiated rate; or if there is no negotiated rate Allowable Charge is Optima Health’s In-Network contracted rate for the same service performed by the same type of Provider or the Provider’s actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full. If You use a Non-Plan Provider who charges more than our allowable amount the Provider may balance bill You for the difference. You will have to pay the difference to the Provider in addition to Your Copayment or Coinsurance amount. Charges from Non-Plan Providers will be higher than the Plan’s Allowable Charge, so You will usually pay more out of pocket when You use Out-of-Network benefits.

Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at Your In-Network Copayment or Coinsurance level. Cost Sharing amounts You Pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan’s Out-of-Network Deductible and Maximum Out-of-Pocket amounts. However, You may have to pay the difference between what the Non-Plan Provider charges and the Plan’s maximum allowable amount or Allowable Charge in addition to Your Emergency Care Copayment, Coinsurance and Deductible amounts. Amounts You pay as a result of balance billing will not accumulate toward Deductible and Maximum Out-of-Pocket amounts.

The maximum allowable amount or Allowable Charge for Emergency Care from an Out-of-Network Non-Plan Provider will be the greatest of the following:

i. The amount negotiated with In-Network Providers for the Emergency service;

ii. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost sharing for the Out-of-Network cost-sharing; or

iii. The amount that would be paid under Medicare for the Emergency service.

3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. Your Plan may have separate Deductible amounts You have to meet for In-Network Covered Services and for Out-of-Network Covered Services. Amounts applied to an In-Network Deductible will apply toward the Plan’s In-Network Maximum Out of Pocket Limit. Amounts applied to an Out-of-Network Deductible will apply toward the Plan’s Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage You must satisfy the individual Member coverage Deductible before coverage begins. If You have family coverage You and Your family must satisfy the family coverage Deductible. This Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual Member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. Amounts You are required to pay for preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Preventive Care Visits and Screenings You receive from In-Network Plan Providers. Cost sharing amounts You pay for some Covered Services will not count toward any Deductible. Deductibles will not be reimbursed under the Plan. Any part of the calendar year Deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year.
Maximum Out of Pocket Limit for In-Network Benefits means the total dollar amount You and Your family pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan’s Out-of-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out of Pocket Amount Optima Health will cover most In-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Plan In-Network benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out of Pocket Amount Optima Health will cover most In-Network benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayments or Coinsurance or any other charges for the following will not count toward Your In-Network Maximum Out of Pocket Limit:

1. Amounts You pay for services or charges not covered under Your Plan;
2. Amounts You pay for services after a benefit limit has been reached;
3. Balance billing amounts from Non-Plan Providers;
4. Premium amounts;
5. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available;
6. Amounts You pay for Out-of-Network Services;
7. Cost Sharing amounts including Copayments, Coinsurance, and Deductibles for the following:
   i. Amounts You pay for Vision care unless services are considered an Essential Health Benefit (EHB) for children;
   ii. Amounts You pay for any benefits covered under a plan rider including riders for Vision Care and Materials unless services are considered an Essential Health Benefit (EHB) for children, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction unless services are considered Essential Health Benefit (EHB) for children

Maximum Out of Pocket Limit for Out-of-Network Benefits means the total dollar amount You and Your family will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan’s In-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Deductibles, Copayments, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out of Pocket Limit:

1. Amounts You pay for services or charges not covered under Your Plan;
2. Amounts You pay for services after a benefit limit has been reached;
3. Amounts You pay for In-Network Benefits;
4. Amounts You pay for Vision care;
5. Amounts You pay for any benefits covered under a plan rider including riders for Infertility Treatment, Vision Care and Materials, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction;
6. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available. Ancillary charges are not Covered Services;
7. Amounts applied to Your In-Network Deductible;
8. Balance billing amounts that exceed the Plan’s Allowable Charge for a Covered Service from a Non-Plan Provider;
9. Premium amounts;
10. Amounts You pay for transplant services from Non-Plan Providers;
6. This benefit requires Pre Authorization before You receive services. We have instructions and procedures in place for providers to obtain Pre-Authorization through Case Management/Clinical Care Services. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.

7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your Maximum Out of Pocket Maximum Limit.

8. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with duration limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical illness generally. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.

9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan’s responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the Member received care from a Plan Provider.

10. Preventive Care includes the services listed below. You may be responsible for an office visit Copayment or Coinsurance when You receive preventive care. Some services may be administered under Your prescription drug benefit under the Plan. Where no frequency or limits are indicated the Plan will use its normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Services covered under the Plan’s outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:

- **Breastfeeding support, supplies, and counseling in conjunction with each birth including**: comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
- **Contraceptive Methods and Counseling including**: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
- **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.

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- **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
- **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
- **Human Papillomavirus (HPV) DNA Test including**: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
- **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
- **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.

11. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your COI in the Utilization Management Section for more information on Pre-Authorization.
Pharmacy Benefits
This Summary of Benefits describes Your outpatient prescription drug coverage. All drugs must be United States Food and Drug Administration (FDA) approved and You must have a prescription. You will need to pay Your Copayment or Coinsurance when You fill Your prescription at the pharmacy. If Your Plan has a Deductible You must meet that amount before Your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. Your drug coverage has specific Exclusions and Limitations, so please read the next few pages carefully. Optima Health’s Pharmacy and Therapeutics Committee places covered drugs into the following Tiers. You will pay Your Copayment or Coinsurance depending on which Tier Your Drug is in.

This Plan uses a closed prescription drug formulary. That means Your Plan includes coverage for a specific list of drugs and medications determined by our Pharmacy and Therapeutics Committee. Drugs that are not included on the Standard formulary will not be covered under Your plan. Please use the following link to see a list of drugs on the Standard formulary:  http://public.optimahhealth.com/Lists/OptimaFormsLibrary/form-doc-drug-list-standard-formulary.pdf.

- **Selected Generic (Tier 1)** includes commonly prescribed generic drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.

- **Selected Brand & Other Generic (Tier 2)** includes brand-name drugs, and some generic drugs with higher costs than Tier 1 generics that are considered by the Plan to be standard therapy.

- **Non-Selected Brand (Tier 3)** includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a generic equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs or drugs determined to be no more effective than equivalent drugs on lower tiers.

- **Specialty Drugs (Tier 4)** includes those drugs classified by the Plan as Specialty Drugs. Tier 4 also includes covered compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or on-going medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional. Specialty Drugs include the following:
  - Medications that treat certain patient populations including those with rare diseases;
  - Medications that require close medical and pharmacy management and monitoring;
  - Medications that require special handling and/or storage;
  - Medications derived from biotechnology and/or blood derived drugs or small molecules; and
  - Medications that can be delivered via injection, infusion, inhalation, or oral administration.

Specialty Drugs are only available through the Optima Health specialty mail order pharmacy. Proprium Pharmacy at 1-855-553-3568. Specialty Drugs will be delivered to Your home address from Our Specialty mail order pharmacy. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Member Services at the number on Your Optima Health ID Card. You can also log onto optimahhealth.com for a list of Specialty Drugs.

A compound prescription medication is used to meet the needs of a specific individual and must have at least one ingredient requiring a Physician’s authorization by State or Federal Law. Compound prescriptions can usually be filled at Your local pharmacy.

Your Copayment, Coinsurance, and Deductible amounts for each Tier are listed below. Your Maximum Out-of-Pocket Limit is also listed below. If You need help please call Member Services or log on to optimahhealth.com to find out which of the following Tiers Your drug is in.
Maximum Out-of-Pocket Limit

| Maximum Out-of-Pocket Limit | Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan’s Maximum Medical Out of Pocket Limit. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are not Covered, do not count toward the Plan’s Maximum Out of Pocket Limit and must continue to be paid after the Maximum Out of Pocket Limit has been met.

Insulin, syringes, and needles | Covered at the cost sharing listed for the applicable Tier.

Diabetic Testing Supplies covered including blood glucose monitors, test strips, lancets, lancet devices, and control solution | Covered at 100%
LifeScan products will be the sole preferred brand. Members can pick up supplies at any network pharmacy.

Copayments and Coinsurances.

For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima’s Allowable Charge. Certain prescription drugs will be covered at a generic product level established by the Plan. If a generic product level has been established for a drug and You or Your prescribing Physician requests the brand-name drug or a higher costing generic, You must pay the difference between the cost of the dispensed drug and the generic product level in addition to the Copayment charge.

Selected Generic (Tier 1) | You Pay $15 Copayment

Selected Brand & Other Generic (Tier 2) | You Pay $40 Copayment

Non-Selected Brand (Tier 3) | You Pay $60 Copayment

Specialty Drugs (Tier 4) | You Pay 20% with a maximum Copayment of $250 per prescription per 31 day supply.

Mail Order Pharmacy Benefit Copayments and Coinsurances

Some Outpatient prescription drugs are available through the Plan’s Mail Order Provider. This does not include Tier 4 Specialty Drugs. You may call OptumRx Home Delivery at 866-244-9113 to find out if a drug is available. If Your drug is available You may purchase up to a 90-day supply for 2.5 or 3 Copayments or the applicable Coinsurance amount.

Selected Generic (Tier 1) | You Pay $37.50 Copayment

Selected Brand & Other Generic (Tier 2) | You Pay $100 Copayment

Non-Selected Brand (Tier 3) | You Pay $180 Copayment

Specialty Drugs (Tier 4) | No 90 day mail order benefits are available for Tier 4 Specialty Drugs.

LIMITATIONS AND OTHER COVERAGE TERMS.

The following is a list of exclusions, Limitations and other conditions that apply to Your drug benefit.

1. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.
2. Copayment and Coinsurance are out-of-pocket amounts You pay directly to the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health’s Allowable Charge.
3. Deductible means the dollar amount You must pay out-of-pocket each year for Covered Services before the Plan begins to pay for Your benefits.
4. Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies.
5. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law.

Underwritten by Optima Health Insurance Company
$15/40/75/20% 4 Tier Standard Formulary
6. Amounts You pay for any outpatient prescription drug after a benefit Limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.
7. Over-the-counter (OTC) medications that do not require a Physician’s authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage. However, the Plan may approve Coverage of Limited quantities of an OTC drug. You must have a Physician’s prescription for the drug, and the drug must be included on the Plan’s list of covered Preferred and Standard drugs.
8. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. You can call Member Services at the number on Your ID card to verify that Your prescription drug has been pre-authorized.
9. At its sole discretion Optima Health’s Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in. The Plan’s Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
10. Insulin, syringes, needles, blood glucose monitors, test strips, lancets, lancet devices, and control solution are covered under the Plan’s prescription drug benefit. Insulin pumps, pump infusion sets and supplies, and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, are covered under the Plan’s medical benefit. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under the Plan’s prescription drug benefit or the Plan’s medical benefit.
11. Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
12. Benefits will be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
13. Benefits will be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.
14. The Plan will not exclude coverage for any prescription drug solely on the basis of the length of time since the drug obtained FDA approval.
15. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan’s medical benefits.
16. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to two 90 day courses of treatment per year when prescribed by a health care provider.

PRESCRIPTION DRUG COVERAGE EXCLUSIONS.

The following is a list of exclusions that apply to Your drug benefit.

1. Medications that do not meet the Plan’s criteria for Medical Necessity are excluded from Coverage.
2. Medications with no approved FDA indications are excluded from Coverage.
3. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
4. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician’s authorization by state or federal law are excluded from Coverage.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
6. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage under this rider.
8. Medication taken or administered to the Member in the Physician’s office is excluded from Coverage under this rider.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage under this rider.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. Therapeutic devices or appliances, including but not Limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
13. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded from Coverage.
18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage.
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country.
20. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage.
22. Medical foods are excluded from Coverage.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following Standard reference compendia are not Covered Services:
   a. American Hospital Formulary Service Drug Information;
   b. National Comprehensive Cancer Network’s Drugs & Biologics Compendium; or
24. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
25. Non-Sedating antihistamines are excluded from Coverage.
26. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage.
27. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
28. Prescriptions written by a licensed dentist are excluded from Coverage, except for the prevention of infection or pain in conjunction with a Covered dental procedure.
29. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription.
30. Sexual dysfunction drugs are excluded from Coverage.
31. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
32. Infertility drugs are excluded from Coverage.
33. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
34. This Plan uses a Closed Formulary. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan’s Prescription Drug Formulary are excluded from Coverage.
Non-formulary requests. You have the right to request a non-formulary prescription drug if you believe that you need a prescription drug that is not on the Plan's list of covered drugs (formulary), or you have been receiving a specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and your prescribing physician has determined that the formulary drug is inappropriate for your condition or that changing drug therapy presents a significant health risk to you. Your physician must complete a medical necessity form and deliver it to the Optima Health pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, Optima Health will make a determination. Optima Health will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.
Q: What is the difference between the Optima Health Standard Formulary and the formulary my employer previously used?
A: The Optima Health standard formulary is a list of prescription drugs that are covered under your employer group plan. A standard formulary is sometimes referred to as a ‘closed formulary.’ This is different from an open formulary in that some drugs not listed may be covered by the plan depending on the situation. The standard formulary includes drugs the Plan considers the best value for treating your medical condition.

Q: Where can I access the standard formulary drug list?
A: The standard formulary drug list is available at members.optimahealth.com under Member Forms and Drug Lists located under the Manage My Plan tab. For an up-to-date formulary listing, please make sure to sign into your Optima Health member account.

Q: What happens if my physician and I decide to utilize a prescription drug that is not on the standard formulary drug list?
A: If you choose to remain on a prescription not offered on the standard formulary list, the member is responsible for the total amount of the prescription.

Q: Is there a process in the case a member cannot take a particular prescription on the standard formulary?
A: Yes, there is a Pharmacy/Medical drug necessity request form that the prescribing physician can fill out if the prescribed drug is perceived not appropriate or a member has experienced an adverse reaction. The form is available here: providers.optimahealth.com/pharmacy/Pages/DrugAuthorizationForms.aspx

Q: Why is my drug no longer covered on the standard drug list?
A: There are many reasons that several brand name drugs were removed from the Optima Health Standard Formulary. The Plan uses a Pharmacy and Therapeutics Committee made up of network physicians and pharmacists to make decisions about what drugs are covered on the standard formulary list. It includes drugs that are considered the best value for treating medical conditions. The drugs included are not always the cheapest, but are those considered to result in the lowest overall healthcare costs. The drugs not covered have alternatives on the list. Using drugs on the list should save you money and essentially keeps your health care more affordable.
Q: What does it mean that a drug is equivalent to another drug not on the drug list?
A: Optima Health uses a Pharmacy and Therapeutics Committee made up of network physicians and pharmacists to make decisions about what drugs are included on the Standard Formulary. The Committee reviews the medical literature and consults with medical specialists to identify drugs that work just as well as drugs not included on the Standard Formulary.

Q: How can I request that a drug be added to the standard formulary?
A: To make a verbal request or obtain a drug formulary request form, the prescribing physician should call Optima Health Pharmacy Care Services at 1-757-552-7540 or 1-800-229-5522.

Q: What do I do if a current prescription that I am on is no longer covered on the Optima Health Standard Formulary?
A: First, you should check with your physician to discuss the alternatives. A list of the drugs that were removed and their alternatives can be found on the Optima Health website. You can print this and take it to discuss with your physician.
How it works.

1 Order up to a three-month supply of your maintenance medications — ones you take regularly — by mail, phone or online.

2 OptumRx® fills your order, mails it to you and lets you know when to expect your delivery.

3 Your medication arrives within 7 to 10 days of placing the order. OptumRx will notify you if there will be a delay in your order.

Four easy ways to enroll:

Online.
Log in to the website on the back of your member ID card.

Phone.
Call the toll-free number on the back of your member ID card.

Mail.
Complete the attached order form and mail it to OptumRx, P.O. Box 2975, Mission, KS 66201.

ePrescribe.
Or your doctor can send an electronic prescription to OptumRx.

Manage your medication home delivery on the go.
Order and track your prescriptions online or with our app.

The benefits of home delivery.

Your medication is delivered right to your mailbox, saving you a trip to the pharmacy.

Your maintenance medication could cost less.

Pay nothing for standard shipping.

Phone, text¹ and email reminders help you remember every dose and every refill.

¹ OptumRx provides this service at no additional cost. Standard message and data rates charged by your carrier may apply.
# NEW PRESCRIPTION MAIL-IN ORDER FORM

## 1. Member and physician information — please use black or blue ink. One form per member.

<table>
<thead>
<tr>
<th>Member ID Number</th>
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<tbody>
<tr>
<td>(Additional coverage, if applicable) Secondary Member ID Number</td>
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</table>

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Delivery Address</th>
<th>Apt. #</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number with Area Code</td>
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<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Gender</th>
<th>Email</th>
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<table>
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<tr>
<th>Physician Name</th>
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<tbody>
<tr>
<td>Physician Phone Number with Area Code</td>
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</tbody>
</table>

## 2. Health history

### Medication Allergies:
- Aspirin
- Cephalosporins
- NSAIDs
- Penicillin
- Quinolones
- Erythromycin
- Sulfa
- Tetracyclines
- Others:

### Health Conditions:
- Asthma
- Glaucoma
- Heart condition
- High blood pressure
- Osteoporosis
- Thyroid Disease
- Others:

### Over-the-counter/herbal medications taken regularly:

## 3. Payment and shipping information — do not send cash

Standard delivery is included at no charge. New prescriptions should arrive within about 10 business days from the date the completed order is received. Completed refill orders should arrive within about 7 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

You may log on to [optumrx.com](http://optumrx.com) to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

- **Ship overnight.** Add $12.50 to order amount (subject to change).
- **Check enclosed.** All checks must be signed and made payable to: OptumRx.
- **Charge to my credit card on file.**
- **Charge to my NEW credit card.**

**New Credit Card Number**

**Expiration Date (Month/Year)**

**Visa, MasterCard, AMEX and Discover are accepted.**

**Signature:**

**Date:**

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, I authorize OptumRx to maintain my credit card on file as payment method for any future charges. To modify payment selection, contact customer service at any time.

## 4. Mail this completed order form with your new prescription(s) to OptumRx, P.O. Box 2975, Mission, KS 66201. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

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For more information, visit [optumrx.com](http://optumrx.com) or call 1-800-777-0809.

**For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, I authorize OptumRx to maintain my credit card on file as payment method for any future charges. To modify payment selection, contact customer service at any time.**

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**54777-032016**

**ORX5633_140915**

**NRX001**
Why should I use OptumRx® for my prescriptions?
Home delivery from OptumRx is a convenient and cost-effective way for you to order up to a 90-day supply of maintenance or long-term medication for delivery to your home, office or location of your choosing. You will minimize trips to the pharmacy and save money on your prescriptions.

What is a maintenance medicine?
A maintenance medicine is taken on a regular basis for long-term conditions such as arthritis, diabetes, high blood pressure, ulcers and many others. You can save money on these medicines by filling a 90-day supply and using your OptumRx home delivery pharmacy benefit.

How do I use home delivery?
1. Have your doctor write your prescription for the number of days your plan allows for home delivery (for example, 90 days). Note: If you need your medicine right away, ask your doctor to write two prescriptions. Fill the first one at your local drug store. Mail the second one to OptumRx.
2. Fill out an order form. This form includes a confidential patient profile section for you and any family members. Write the member identification number, patient name and patient date of birth on the back of each prescription.
3. Mail the form with the prescription(s) and co-payment to: OptumRx, PO Box 2975 Shawnee Mission, KS 66201-1375
4. We will ship orders to the address entered on the form.
5. Check your order upon receipt. Make sure you review your order within 21 days of receipt. Contact us immediately to report any issues. Member service representatives and clinical pharmacists are available to discuss any questions at our toll-free number that is located on the back of your prescription ID card.

How do I refill a prescription I have already received through OptumRx?
Do one of the following:

- Visit our website: optimaehealth.com/members.
- Call OptumRx toll-free: 1-866-244-9113.
- Send in the refill slip that came with your previous order. Be sure to include your co-payment. Mail it to OptumRx.
How do I fill a new prescription?
• Fill out an order form. Write the member ID number, patient name and patient date of birth on the back of each prescription.
• Mail the form to OptumRx. Include the prescription(s) and payment information.

How can my doctor order a prescription for me?
• Doctors may call our toll-free number to prescribe your medication(s).
• Doctors may fax prescriptions to 1-888-637-5191.
• In addition to prescription information, your doctor must provide member ID number, patient name and patient date of birth.

Note: To be legally valid, the fax must originate from the physician’s office. All state laws apply.

Timing and shipping

When will I receive my order?
You should receive your order within 14 days from the time OptumRx receives your prescription. Once received, a prescription typically takes one to two days to be processed and mailed if no additional information is required. Please allow a few extra days for your first order. If you have questions or do not receive your order within 14 days, please check the website at optimahealth.com/members or contact us at 1-866-244-9113.

What situations may cause a delay in prescription processing?
Situations that may create a delay include an incomplete or unreadable prescription, manufacturer backorders and medications that require prior authorization. We will notify you if there will be a delay with your prescription shipment. Your prescriptions ship in separate packages if necessary.

Note: Orders received without payment may cause processing delays and extended delivery times.

Am I charged for shipping?
No, shipping is free. However, OptumRx also offers expedited shipping for an extra charge.

How can I check on the status of my prescription order?
Visit optimahealth.com/members or call us at 1-866-244-9113. Plan members who create an account on optimahealth.com/members will receive email notification when a prescription is shipped.

If I pay for rush shipping, when will it arrive?
Rush shipping reduces the time in transit only. The actual prescription processing time does not change and can vary due to quality checks we perform or exceptions that may arise. Possible exceptions include needing additional information from your doctor, prior authorizations or drug interactions. These steps promote the health and safety of plan members and provide the highest level of quality when processing your prescriptions.
Why am I receiving overnight shipping when I did not request it?
We ship certain medications overnight at our expense due to special handling requirements. This may apply to prescriptions for controlled substances or medications that are temperature sensitive.

What happens if I don't receive my order?
If you do not receive your order within 14 days, please contact us toll-free. We will reship your order to you as it is our priority to ensure you have the medication you need.

Prescription refills

How do I know whether I have refills remaining on my prescription?
The number of refills allowed is noted at the bottom of your medication label, on your refill form and can also be found on the optimahealth.com/members website.

How soon can I order a prescription refill?
For most prescriptions, you may reorder when you have approximately 3 weeks of your prescription left. Your medication label includes a target date for refilling the prescription.

• When ordering refills from OptumRx using the automated phone system, you will receive a message if your prescription is “too soon to refill.” You will be given the date when refills will be available.

• If you place a refill order after the expiration of your prescription, or if no refills are remaining, we will contact your physician for a new prescription. This may cause a slight delay.

I have a prescription on file at a retail pharmacy; can I order refills from OptumRx?
Yes, however a new prescription from your doctor is recommended.

Medication coverage and cost

What drugs are covered?
Your plan decides which medications are covered through OptumRx. To verify coverage please go to optimahealth.com/members, or call our toll-free number.

How much will my medicine cost me?
The easiest way to determine the cost of your prescription is to log in to optimahealth.com/members.

How can I pay for my home delivery prescriptions?
Checks, money orders or major credit cards can be used to cover your co-payments. Credit cards are preferred to allow for variations in the prices of drugs and are required when placing an order through our website. For your convenience, your credit card number will be maintained on a secured site for future orders.
Miscellaneous

How do I obtain additional order forms?
You can print order forms at optimalehealth.com/members. You also receive a reorder form, refill form and pre-addressed envelope with each prescription mailed to you.

Can I speak with a pharmacist if I use OptumRx home delivery?
Yes, pharmacists are available to answer questions regarding your medication at 1-866-244-9113.

Can I fax my prescription that I received from my doctor?
No. Legally, OptumRx is only allowed to accept faxed prescriptions from your doctor’s office.

Is my information kept private?
Yes. We ask you for some personal information and we keep this information completely private. We use this information to help make sure you get the best care possible.

Why did I receive less than a 90-day supply of my prescription?
The most common reason is that your doctor may have only written the prescription for 30 days or a prepackaged medication may not be packaged as a 30-, 60- or 90-day supply. Remember to ask your doctor to write a prescription for up to a 90-day supply, with up to three refills, if your doctor determines it’s appropriate.

What is a “controlled” medicine?
A controlled medicine, such as a narcotic, has stricter guidelines and may be handled differently than non-controlled medicines, such as a medication for diabetes. We adhere to federal and state laws in the dispensing of all medicines. State law may require a copy of a state-issued ID, such as a driver’s license, for controlled medications to be dispensed.

Call OptumRx home delivery toll-free: 1-866-244-9113
or visit: optimalehealth.com/members
What is a specialty pharmacy?
Specialty pharmacies handle high cost medications for complex health conditions. These medications often require special handling, disposal, and/or monitoring. The pharmacy’s team members help to identify and remove barriers so patients are able to take their medications and thus improve their quality of life.

What services does Proprium Pharmacy provide?
• A live answer by a team member every time you call during business hours
• Support with insurance issues and financial assistance program enrollment
• Refill reminder calls to help you refill your medications on time
• Convenient delivery of your medication to your home or physician’s office in an unmarked package
• Personalized care for every patient—We will work with you and your health care providers to develop a care plan based upon your individual health condition

What are the hours for Proprium Pharmacy and how do I contact you?
• Business Hours: Monday-Friday 8:30 AM-5:30 PM EST
• You may contact us at Phone: 757-553-3568 or Toll Free 1-855-553-3568
• A pharmacist is on-call 24 hours a day, 7 days a week for any emergency issues that may arise.

How much will my medications cost?
The cost will vary based upon medication and your insurance plan. We will tell you this amount after we have processed your prescription.

What if my insurance company doesn’t cover my medications or I cannot afford the copayment and coinsurance?
We have patient care advocates who are dedicated to working with your physician and insurance company to obtain coverage for your medications wherever possible. These patient care advocates also perform a thorough investigation and eligibility review of available patient financial assistance programs with the goal of lowering your cost as much as possible.

Call Proprium Pharmacy toll-free at 1-855-553-3568
Does Proprium Pharmacy have access to all specialty medications?

Proprium Pharmacy has access to most specialty medications. However, in the event we do not have access to your medication, we will transfer your prescription to a pharmacy that can provide the medication and we will contact you to let you know that has been done.

How do I pay for my medications?

You can pay for your medications using any major credit card or debit card. We also accept healthcare flexible spending account (FSA) cards.

How do I receive my medications?

Your medications will be shipped to your home, work, or physician’s office via a local courier or FedEx. Confidential packaging is used to ensure protection of your privacy.

What is the cost for delivery?

Nothing—the only cost for your medications is your copayment or coinsurance.

How do I refill my medication?

One of our staff members will contact you about 7 days prior to your refill due date to coordinate the delivery of your medications and needed supplies. These reminder calls are designed to serve as a reminder to refill your medications on time. If you don’t hear from us and are due for your refill, please reach out to us at the numbers listed above.

How should I dispose of unused medications?

Please contact the pharmacy for additional instructions or visit the following websites for information:


Call Proprium Pharmacy toll-free at 1-855-553-3568
Mental Health and Employee Assistance Program
Mental/Behavioral Health and Substance Use Disorder Services

Inpatient services and outpatient office visits for the treatment of mental health and substance use disorders are covered as medical benefits.

**Pre-Authorization is required for inpatient services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**

**How to receive services**
- Call Optima Behavioral Health at 1-800-648-8420 to be directed to a participating behavioral health provider. It is not necessary to go through the Primary Care Physician; or
- contact a participating behavioral health provider directly to arrange for an initial authorization.

If hospitalization is required, the behavioral health provider will arrange for admission to the appropriate facility.

**Emergency services**
If currently in treatment, contact the attending behavioral health provider.
If not currently receiving care, call Optima Behavioral Health at 1-800-648-8420, and arrangements will be made for the member to be seen by a behavioral health professional. In order to ensure a prompt response to any clinical emergency, a 24-hour crisis hotline is available after normal business hours, on weekends, and on holidays.

If any member is engaged in behaviors that pose an immediate danger to themselves or to the life of another, please call 911 or go directly to an Emergency Department facility.

**Exclusions**
Non-medical ancillary services are not covered. These may include, but are not limited to: vocational rehabilitation services, employment counseling, health education, expressive therapies, or other non-medical services. Residential or sub-acute level of care or treatment is not covered by the Plan.

The member is responsible for all applicable Copayments, Coinsurances, and any Deductibles depending on the type and place of service as listed on the Plan’s Face Sheet or Schedule of Benefits.

Members should refer to Plan documents for Plan Copayments, Coinsurances, Deductibles, and Maximum Out-of-Pocket amounts, in addition to coverage exclusions and limitations.

**Additional Information**
Current members with questions regarding benefits may call Member Services at the number on the back of their member ID card or visit optimahhealth.com to view Plan documents and find network physicians.
If you are considering enrolling for the first time and have questions, please contact the group’s Benefits Administrator.

A telecommunications device for the hearing impaired can be accessed by dialing 1-800-828-1140 or 711.
Optima Employee Assistance Program

The Optima Employee Assistance Program (EAP) is designed to offer brief, solution-focused counseling by licensed and/or certified behavioral health professionals. Services include short-term problem assessment through counseling sessions and referrals. Members may seek counseling for life issues including, but not limited to:

- work-place related stress,
- marital or family difficulties (or concerns with any significant relationship),
- parenting issues,
- depression or other mental health issues,
- substance use or dependency, and
- stress-related problems.

**Benefit**
This benefit provides up to three (5) sessions per presenting issue for each member.

After an initial meeting with a counselor to assess short-term and long-term needs, the counselor will work with members to develop an appropriate course of action.

Members should refer to Plan documents for additional coverage exclusions and limitations.

**How to receive services**
Call 1-800-899-8174 Monday – Thursday between 8:30 a.m. and 7:00 p.m. ET, and 8:30 a.m. to 5:00 p.m. ET on Friday to schedule an appointment. Optima EAP offers day and evening appointments and can assist in locating a counselor. Services are covered only when received from Optima Health providers.

Members’ confidentiality is assured. Discussions with counselors are confidential and protected.

**Virtual Counseling**
Members and their household can request the option and convenience of a virtual counseling session instead of a face-to-face visit. Virtual counseling sessions can be accessed using a smart phone, tablet, or video-capable computer.

**Emergency Services**
Optima EAP maintains a 24-hour crisis hotline. Please call 1-800-899-8174 for assistance after hours and on weekends or holidays.

If any person is engaged in behaviors that pose an immediate danger to his/her life or the life of another, please call 911 or go directly to an Emergency Department.
What is Optima EAP?
Optima EAP (Employee Assistance Program) is a helpful resource that can be used to address life’s challenges, solve personal problems, or tackle work related issues. Optima EAP’s confidential, short-term, and solution-focused services are provided by a group of skilled, professional, and caring counselors. Best of all, Optima EAP is available to you at no cost.

When should I use Optima EAP?
Whether you are trying to improve your relationship, provide direction for a child, better manage stress, deal with a difficult coworker, care for an elderly family member, or make changes in your life, Optima EAP is here to help. You can confidentially turn to us - even before an issue or concern severely impacts your home life or work performance.

Give us a call and we will be happy to assist you with topics such as:
- Stress
- Work-Related Concerns
- Relationships
- Children / Adolescents
- Grief / Loss
- Anger Management
- Domestic Violence
- Eldercare
- Difficult Behavior
- Substance Abuse / Dependency
- Depression
- Personal Development

How can I get in touch with an Optima EAP counselor?
When you call Optima EAP, one of our representatives will locate a counselor near your home or work and help you schedule an appointment. Contact us at 757-363-6777 or 1-800-899-8174. Or you can send a confidential email from OptimaEAP.com.

What if I need additional help?
If additional services are required, Optima EAP will assist you with referrals. We will help you utilize your mental health benefits or provide recommendations for reputable community-based resources. We will stay active in this process until you can access the services you need.

Do I have the right to privacy?
Yes. Confidentiality is an important component of Optima EAP. Discussions with an EAP counselor are protected by strict guidelines and regulations. In fact, no information about you or a family member will be shared with your employer unless you consent in writing or the law requires it. Optima EAP falls under the guidelines of Protected Health Information. Because we are dedicated to confidentiality, you can feel comfortable and confident using Optima EAP when you need assistance.

Will there be any cost or Copayment to use Optima EAP?
Optima EAP is an employer-sponsored benefit, meaning there is no cost to you and your family members to use this service.

Are there other services besides counseling provided by Optima EAP?
Yes. In the privacy of your own home, visit OptimaEAP.com for details about classes, tools, and other services. You will also find information, articles, and features on a wide variety of topics, including emotional concerns, mental health treatment, workplace issues, frequently asked questions, and inspirational pieces.

If your home life is affecting your work, or if your work life is affecting your home, Optima EAP can help.

For more information about Optima EAP, please call 757-363-6777 or 1-800-899-8174 or visit OptimaEAP.com.

Optima Health is a trademark of Optima Health Insurance Company.
Virtual Counseling
Frequently Asked Questions

What is the Virtual Counseling option?
The Optima EAP recognizes that it is not always possible or convenient for an employee to get to a face-to-face counseling appointment. The Virtual Counseling program makes use of a HIPAA-compliant platform that allows for the counseling to be done using a smart phone, tablet, or desktop computer.

How many counseling sessions do I get if I use the Virtual Counseling option?
The Virtual Counseling option provides the same number of sessions as you would receive if you were seeing a counselor in his or her office.

Will there be any co-payments or costs to me?
The Optima EAP is paid by your employer and there is no cost to access EAP services.

My manager has told me I must attend EAP counseling sessions; can I use the Virtual Counseling option?
The Virtual Counseling option is only available to individuals who are accessing EAP services on a voluntary basis. Formal or mandatory EAP referrals require additional services not available through the Virtual Counseling option.

How do I schedule a Virtual Counseling appointment?
Appointments are made by calling Optima EAP at 1-800-899-8174. The Intake Coordinator can confirm that your company allows the use of the Virtual Counseling program, schedule your appointment, and request your email address to communicate appointment details. Encrypted emails will be sent to you with instructions on how to complete your pre-appointment paperwork and how to access your counseling session.

Where should I be located when using my Virtual Counseling appointment?
The regulations of the Commonwealth of Virginia require that you must be physically present in Virginia to receive Virtual Counseling. You need to arrange a location that is free from distractions and ensures your personal privacy.

What if after my first session I decide that I do not want to continue with Virtual Counseling?
If either you or your counselor determines that you would be better served by another form of therapeutic services, you will then be referred to a licensed mental health provider in your area. The number of EAP counseling sessions available will be determined by a review of your case records.

What happens if my Virtual Counseling session is interrupted due to a technical failure?
If a session is cut short by technical issues, a determination as to whether the session will count against the allotted number of sessions will be based upon the duration of the session.

Is my Virtual Counseling session confidential?
The Virtual Counseling platform is encrypted and meets HIPAA regulations for the protection of your Personal Health Information (PHI). Your counselor will maintain the same level of confidentiality as if he or she were seeing you in person. It is your responsibility to make sure that the location you choose to conduct your Virtual Counseling session is private. If the counselor perceives that you are in an inappropriate location, they will ask you to reschedule your session and will work with you to determine an appropriate location.

Optima Employee Assistance Program
1-800-899-8174 or 757-363-6777
OptimaEAP.com
Chiropractic Care

Optima Health contracts with American Specialty Health (ASH) to administer this benefit.

**Pre-Authorization is required by ASH for all chiropractic care services.**

Covered services include examination, re-examination, manipulation, conjunctive therapy, radiology, chiropractic appliances (up to a maximum benefit of one (1) appliance per person per year), and laboratory tests related to the delivery of chiropractic services when medically necessary. Coverage is limited to a maximum benefit of 30 visits per year.

The member is responsible for all applicable Copayments, Coinsurances, and any Deductibles depending on the type and place of service as listed on the Plan’s Face Sheet or Schedule of Benefits.

Members should refer to Plan documents for Plan Copayments, Coinsurances, Deductibles, and Maximum Out-of-Pocket amounts, in addition to coverage exclusions and limitations.

**How to receive covered services**
To select an ASH participating provider, you can visit optimalehealth.com or call ASH at 1-800-678-9133 Monday-Friday, 8:00 a.m. to 9:00 p.m. ET. Contact the participating chiropractic provider of choice to schedule an appointment. No physician referral is required. The ASH chiropractic provider is responsible for obtaining authorization from ASH prior to providing care (except for an initial examination and Emergency Services).

**The following are excluded from coverage:**
- Any services or treatments not authorized by ASH, except for initial examination and Emergency Services.
- Any services or treatments not delivered by participating chiropractors for the delivery of chiropractic care to Members, except for Emergency Services.
- Services for examinations and/or treatments for conditions other than those related to neuromusculoskeletal disorders from participating chiropractors.
- Hypnotherapy, behavior training, sleep therapy, and weight programs.
- Thermograph.
- Services, lab tests, X-rays and other treatments not documented as clinically necessary as appropriate or classified as experimental or investigational and/or as being in the research stage.
- Services and/or treatments that are not documented as Medically Necessary services.
- Magnetic resonance imaging, CAT scans, bone scans, and nuclear radiology and any diagnostic radiology other than covered plain film studies.
- Transportation costs including local ambulance charges.
• Education programs, non-medical self-care or self-help or any self-help physical exercise training or any related diagnostic testing.

• Services or treatments for pre-employment physicals or vocational rehabilitation.

• Any services or treatments for pre-employment physicals or vocational rehabilitation.

• Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment, except as described as covered.

• Drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

• Services provided by a chiropractor practicing outside the Service Area, except for Emergency Services.

• Hospitalization, anesthesia, manipulation under anesthesia and other related services.

• All auxiliary aids and services, including but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

• Adjunctive therapy not associated with spinal, muscle or joint manipulation.

• Vitamins, minerals, or other similar products.

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**Additional Information**

Current members with questions regarding benefits may call Member Services at the number on the back of their member ID card or visit [optimahealth.com](http://optimahealth.com) to view Plan documents and find network physicians.

If you are considering enrolling for the first time and have questions, please contact the group’s Benefits Administrator.

A telecommunications device for the hearing impaired can be accessed by dialing 1-800-828-1140 or 711.
Diabetes Treatment - Traditional Plans

*(not Equity or HSA-eligible)*

Pre-Authorization is required for insulin pumps and pump infusion sets and supplies.

Coverage includes benefits for FDA-approved equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items.

- Insulin pumps, pump infusion sets and supplies, outpatient self-management training and education, and nutritional therapy are covered under the Plan's medical benefits.

- Insulin, needles, and syringes as well as testing supplies (test strips, lancets, lancet devices, blood glucose monitors, and control solution) are covered under the Plan's pharmacy benefits. Diabetes testing supplies will be limited to LifeScan products, except in the case of members using an insulin pump associated with a specific, non-LifeScan product.

- For members who may not be using a LifeScan meter currently, there are two ways to obtain a free LifeScan meter:
  1. Order online at [www.OneTouch.orderpoints.com](http://www.OneTouch.orderpoints.com) and input the Optima Health order code 741OPT016;
  2. Call the toll-free number: 1-855-776-4464 and provide the order code 741OPT016; or
  3. Visit a participating pharmacy and present the attached pharmacy voucher:

- An annual diabetic eye exam is covered when received from an Optima Health Plan Provider or a participating EyeMed Provider.

Optima Health also covers in-person outpatient self-management training and education—including medical nutrition therapy. Training must be provided by a certified, registered, or licensed healthcare professional. Members may call 1-800-SENTARA for information on training and educational classes.

The member is responsible for all applicable Copayments, Coinsurances, and any Deductibles depending on the type and place of service as listed on the Plan’s Face Sheet or Schedule of Benefits.

Members should refer to Plan documents for Plan Copayments, Coinsurances, Deductibles, and Maximum Out-of-Pocket amounts, in addition to coverage exclusions and limitations.

Prior to receiving an ID card, any member with questions may call Member Services at 1-877-552-7401. Members with ID cards may call the toll-free number on the ID card.

Optima Health is the trade name of Optima Health Plan, Optima Health Insurance Company, Optima Health Group, Inc. and Sentara Health Plans, Inc. Optima Vantage HMO plans are underwritten by Optima Health Plan. Optima Preferred Provider Organization products are underwritten by Optima Health Insurance Company. Self-funded employer benefit plans are administered by Sentara Health Plans, Inc. All Optima Health plans have benefit exclusions and limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of coverage please call your broker or Optima Health at 1-800-741-4825 or visit optimahhealth.com.
Complementary Alternative Medicine Discount Program

Each covered individual is offered a discount on acupuncture, chiropractic, therapeutic massage services, physical therapy, occupational therapy, and podiatry through the ChooseHealthy® Program. Participating providers extend a 25% discount off their usual and customary charges.

**How to receive services**
Select a participating complementary healthcare provider from the Plan’s website at optimaehealth.com.

Schedule an appointment with a participating provider. A physician referral is not necessary. The participating provider will develop, if necessary, a treatment plan for the member. There are no visit limitations. Changing your participating provider is permitted at any time.

In order to receive the complementary discount, present your member ID card at the time of service. The member is responsible for payment of services at each visit. There are no claim forms to file.

If chiropractic care is covered under the Plan’s medical benefit, the member may find it beneficial to use this discount program after the annual Plan limit has been met, or for services not covered under that benefit.

**Additional Information**
For more information regarding this discount program, or to nominate a provider not yet in the network, please call ChooseHealthy Member Services at 1-877-335-2746 or refer to the Plan’s website at www.optimaehealth.com. ASH's Member Service representatives are available from 8 a.m. to 9 p.m. ET, Monday-Friday.

Current members with questions regarding benefits should call Member Services at the number on the ID card. If you are considering enrolling for the first time and have questions, please consult with your group’s Benefit Administrator.

A telecommunications device for the hearing impaired can be accessed by dialing 1-800-828-1140 or 711.

The ChooseHealthy Program is administered by ChooseHealthy, Inc., a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

Please note that this program is not insurance. You should check any insurance benefits you have before using this discount program, as those benefits may result in lower costs to you than using this discount program. The discount program provides for discount specialty health care services from participating practitioners. You are obligated to pay for all health care services, but will receive a discount from those health care practitioners who have contracted with the discount program. The discount program has no liability for providing or guaranteeing services, and assumes no liability for the quality of services rendered.
Exclusions and Limitations
EXCLUSIONS AND LIMITATIONS

*Plus Products*

The following is a list of Exclusions and Limitations that generally apply to all Optima Health plans. Once you are an enrolled member please refer to your Plan documents for the Exclusions and Limitations specific to your plan.
The following is a list of services that are not covered under Optima Health Insurance Company Plans. Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Please call Member Services if You have questions.

A
Abortion is covered in the first 12 weeks of pregnancy. After 12 weeks abortion is covered if the mother’s life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.
Acupuncture is not covered.
Adaptations to Your Home, Vehicle or Office are not covered. Handrails, ramps, escalators, elevators, or any other changes because of a medical condition or disability are not covered.
Ambulance Service for non-emergency transportation is not covered unless We authorize the service.
Non-medical Ancillary Services You are referred to are not covered. Vocational rehabilitation services, employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education, or other non-medical services are not covered.
General Anesthesia in a Physician’s office is not covered.
Aromatherapy is not covered.
Autopsies are not covered.

B
Batteries are not covered except for motorized wheelchairs, left ventricular assist device (LVAD) and cochlear implants when authorized.
Blood and Blood Products are not covered except for expenses incurred in connection with hemophilia and congenital bleeding disorders. We do not cover any costs for finding blood donors. We do not cover the cost of transportation and storage of blood in or outside the Plan’s Service Area.
Bone Densitometry Studies more than once every two years are not covered unless We authorize them.
Bone or Joint treatment of the head, neck, face or jaw. We do not exclude coverage or impose limits on bone or joint treatments of the head, neck, face, or jaw that are more restrictive than limits on treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone, and is deemed Medically Necessary to attain functional capacity of the affected part. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone.
Botox injections are not covered unless We have approved them.
Breast Augmentation or Mastopexy is not covered unless We have authorized them.
Cosmetic procedures or surgery for breast enlargement or reduction are not covered.
Procedures for correction of cosmetic physical imperfections are not covered. Breast implants are not covered. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.
Breast Ductal Lavage is not covered.
Breast Milk from a donor is not covered.

C
Chelation Therapy is not covered except for arsenic, copper, iron, gold, mercury or lead poisoning.
Contact Lenses are not covered. Fitting of lenses or eyeglasses is not covered. We will cover the first pair of lenses following cataract surgery including contact lens, or placement of intraocular lens or eyeglass lens only.
Cosmetic Surgery and Cosmetic Procedures are not covered. We do not cover medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary.
We will not cover any of the following:
- Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Non-medically necessary treatment or services resulting from complications due to cosmetic experimental procedures;
- Breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following mastectomy;
- Tattoo removal;
- Keloid treatment as a result of the piercing of any body part;
- Consultations or office visits for obtaining cosmetic or experimental procedures;
- Penile implants;
- Vitiligo or other cosmetic skin condition treatments by laser, light or other methods.
Costs of Services paid for by Another Payor are not covered. We do not cover the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers’ liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of covered services in those cases where You received services in accordance with the Plan’s referral procedures. We will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.
Court Ordered Examinations or Treatments are not covered unless they are determined to be medically necessary and are a Covered Service under the plan.
Custodial Care is not covered. We will not cover any of the following:
- residential care;
- rest cures;
- care from institutions or facilities licensed solely as residential treatment centers, intermediate care facilities, or other non-skilled sub-acute inpatient settings;
- examination or care ordered by a court of law not authorized by the Plan to be provided at a Plan Provider.

D
Dentistry/Oral Surgery/Dental Care
Dentistry
- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are not covered.
We will cover Medically Necessary dental services from an accidental injury. It does not matter when the injury occurred. For injuries occurring on or after Your effective date of coverage treatment must be sought within 60 days of the accident.

We will cover Medically Necessary dental services performed during an emergency department visit immediately after a traumatic injury and in conjunction with the initial stabilization of the traumatic injury subject to utilization review for Medical Necessity.

- Cosmetic services to restore appearance are not covered.
- Dental implants or dentures and any preparation work for them are not covered.
- Dental services performed in a hospital or any outpatient facility are not covered. This does not include covered services listed under "Hospitalization and Anesthesia for Dental procedures."

**Oral Surgery**

- Oral surgery which is part of an orthodontic treatment program is not covered.
- Orthodontic treatment prior to orthognathic surgery is not covered.
- Dental implants or dentures and any preparation work for them are not covered.
- Extraction of wisdom teeth is not covered unless Your plan includes a rider.

**Dental Care**

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are not covered.
- Dental implants or dentures and any preparation work for them are not covered.

**Diagnostic Tests or Surgical Procedures** are not covered where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.

**Disposable Medical Supplies** are not covered unless ordered as part of wound care and authorized by the Plan. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide and other disposable supplies are not covered.

**Driver Training** is not covered.

**Durable Medical Equipment (DME)** is covered up to the limits stated on Your Plan’s Schedule of Benefits. We will only cover an amount, supply or type of DME that We determine will safely and adequately treat Your condition. **We will not cover any of the following:**

- More than one item of DME for the same or similar purpose;
- DME and appliances not uniquely relevant to the treatment of disease;
- Disposable medical supplies and medical equipment;
- Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide;
- DME for use in altering air quality or temperature;
- DME for exercise or training;
- DME mainly for comfort, convenience, well-being or education;
- Batteries for repair or replacement except for motorized wheelchairs or cochlear implants;
- Blood pressure monitors unless authorized by the plan.

**Drugs** for certain clinical trials are not covered. This includes drugs paid for directly by the clinical trial or another payor.

**E**

**Electron Beam Computer Tomography (EBCT)** is not covered. We do not cover any other diagnostic imaging test where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.

Services, treatment, or testing required to complete **Educational Programs**, degree requirements, or residency requirements are not covered.

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Educational Testing, Evaluation, Screening, or tutorial services are not covered. Any other service related to school or classroom performance is not covered. This does not include services that qualify as Early Intervention Services under the Plan’s benefit; or if Your plan includes coverage for Autism Spectrum Disorder those services covered under Autism Spectrum Disorder benefits.

Enteral or Parenteral Feeding supplements are not covered unless they are used as the sole or major source of nutrition. We do not cover over the counter infant formulas or medical foods.

Examinations, testing or treatment required for employment, insurance, or judicial or administrative proceedings are not covered.

Exercise Equipment is not covered. We do not cover bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment. We do not cover pool, gym, or health club membership fees.

Experimental or Investigative drugs, devices, treatments, or services are not covered.

Experimental or Investigative means any of the following situations:

- the majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- the use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable value as reported by current scientific literature and/or regulatory agencies; or
- the research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
- the drug or device is not approved for marketing by the United States Food and Drug Administration (FDA); or
- the drug, device, medical treatment or procedure is currently under study in a Non-FDA approved Phase I or Phase II clinical trial, an experimental study/investigational arm of a Phase III clinical study, or otherwise under study to determine safety and efficacy or to compare its safety and efficacy to current standards of care; or
- The drug device or medical services is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment.

Eye Examinations required for work are not covered. Corrective or protective eyewear required for work is not covered.

Eye Glasses and contact lenses are not covered. Fitting of lenses or eyeglasses is not covered. We will cover the first pair of lenses following cataract surgery including contact lenses, or placement of intraocular lenses or eyeglass lenses only.

Eye Movement Desensitization and Reprocessing Therapy are not covered.

Eye Corrective Surgery such as Radial Keratotomy, PRK, LASIK, or any other eye corrective surgery is not covered.

F

We do not cover any of the following Foot Care Services except for Members with Diabetes or severe vascular problems:

- Removal of corns or calluses;
- Nail trimming;
- Treatment and services for or from flat-feet, fallen arches, weak feet, or chronic foot strain;
- Foot Orthotics of any kind;
- Customized or non-customized shoes, boots, and inserts.

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G
Genetic Testing and Counseling is not covered unless we have authorized the services. Counseling is covered only as part of the approved genetic test unless considered preventive care.
GIFT programs (Gamete Intrafallopian Transfer) are not covered.
Growth Hormones are only covered under the Plan’s Outpatient Prescription Drug Rider. Growth hormones for the treatment of idiopathic short stature are not covered.

H
Hearing Aids are not covered unless your plan has a rider. Fittings, molds, batteries or other supplies are not covered unless your plan has a rider.
Home Births are not covered.
Home Health Care Skilled Services are not covered unless you are homebound, physically unable to seek care on an outpatient basis or service is provided in lieu of inpatient hospitalization. Services are limited as stated on your Plan’s Schedule of Benefits. We do not cover any services after you have reached your Plan’s limit. We only cover services or supplies listed in your home health care plan. We do not cover custodial care. We do not cover transportation.
Hypnotherapy is not covered.

I
Immunizations required for foreign travel or for employment are not covered.
Implants for cosmetic breast enlargement are not covered. We do not cover cosmetic procedures or cosmetic surgery for breast enlargement or reduction. We do not cover procedures for correction of cosmetic physical imperfections. This does not apply to procedures required by state or federal law for breast reconstruction and symmetry following mastectomy.
Incarceration - We do not cover services and treatments done during incarceration in a local, state, federal or community correctional facility or prison.
Infertility Services are not covered unless your plan includes a rider. **We will not cover any of the following:**

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility;
- Services, tests, medications, and treatments for the enhancement of conception;
- Services, tests, medications, and treatments that aid in or diagnose potential problems with conception;
- In-vitro fertilization programs;
- Artificial insemination or any other types of artificial or surgical means of conception;
- Drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- Reproductive material storage;
- Treatment related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage;
- Sperm washing;
- Services to reverse voluntary sterilization;
- Infertility Treatment or services from reversal of sterilization;
- Semen analysis;
- Sims-Huhner test (smear);
- Drugs used to treat infertility.

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K

Keloids from body piercing or pierced ears are not covered.

L

Laboratory Services from Non-Plan providers or laboratories are covered under Out-of-Network benefits only. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

M

Massage Therapy is not covered unless provided as part of an approved medical therapy program.

Matristem Extracellular Wound Care System is not covered.

Maximum Benefit Amounts are stated on Your Plan’s Face Sheet or Schedule of Benefits. We do not cover any additional benefits after a benefit limit has been reached.

Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not covered unless Pre-Authorized by the Plan.

Medically Necessary Treatments - Any services, supplies, treatments, or procedures not specifically listed as a Covered Service, and any other services, supplies, or treatments or procedures determined not to be Medically Necessary are not covered unless required to be covered under state or federal laws and regulations.

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not covered. **We do not cover any of the following:**

- Exercise equipment;
- Air conditioners, purifiers, humidifiers and dehumidifiers,
- Whirlpool baths,
- Hypoallergenic pillows or bed linens,
- Telephones,
- Handrails, ramps, elevators and stair glides;
- Orthotics not approved by Us;
- Changes made to vehicles, residences or places of business;
- Adaptive feeding devices, adaptive bed devices;
- Water filters or purification devices;
- Disposable Medical Supplies such as medical dressings, disposable diapers;
- Over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

Medical Nutritional Therapy and nutrition counseling are not covered except when provided as part of preventive care, diabetes education or when received as part of covered wellness services or screening visits. Nutritional formulas and dietary supplements that are available over the counter and/or without a written prescription are not covered.

Membership Fees to pools, gyms, health clubs, or athletic clubs are not covered.

Mobile Cardiac Outpatient Telemetry (MCOT) is not covered.

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not covered unless Your plan includes a rider, and services have been **authorized by the Plan for Members who meet established criteria.**

Motorized or Power Operated Vehicles or chair lifts are not covered unless authorized by the Plan.
N
Neuro-cognitive therapy is not covered.
Newborns or other Children of a Covered Dependent Child are not covered.

O
Obstetrical Care Home births are not covered.
Oral Surgery services listed below are not covered:
  ➢ Oral surgery which is part of an orthodontic treatment program;
  ➢ Orthodontic treatment prior to orthognathic surgery;
  ➢ Dental implants or dentures and any preparation work for them;
  ➢ Extraction of wisdom teeth unless Your plan includes a rider.
Orthoptics or vision or visual training and any associated supplemental testing are not covered.
Out-of-Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers, whether referred or directed by a Plan Provider, are covered under Out-of-Network Benefits only. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

P
PARS System (Physical Activity Reward System) is not covered.
Pass Devices (Patient Activated Serial Stretch) are not covered.
Paternity Testing is not covered.
Penile implants are not covered.
Personal comfort items such as, but not limited to, telephones, televisions, extra meal trays, personal hygiene items, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs and any other similar items for personal comfort are not covered.
Physician Examinations are limited as follows:
  ➢ Physicals for employment, insurance or recreational activities are not covered.
  ➢ Executive physicals are not covered.
  ➢ School physicals are not covered except when You have not had a health assessment with a physician during the calendar year.
  ➢ A second opinion from a Non-Plan Provider is covered under Out-of-Network benefits only.
  ➢ Services or supplies ordered or done by a provider not licensed to do so are not covered.
Physician's Clerical Charges are not covered. Charges for broken appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records or correspondence to other parties, and any other clerical services are not covered.
Outpatient Prescription Drugs are not covered unless Your plan includes a rider.
Private Duty Nursing is not covered.
Pulsed Irrigation Evacuation System is not covered

Q

R
Reconstructive surgery is not covered unless services follow trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. If the trauma occurred before the Member’s effective date of

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Coverage, the reconstructive surgery is covered subject to the Plan's Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is covered.

**Remedial Education and Programs are not covered.** Services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities or for mental are not covered.

**Residential or Sub-Acute Level of Care** or treatment is not covered.

**S**

**Second Opinions** from Plan Providers do not require authorization. A second opinion from a Non-Plan Provider is covered under Out-of-Network Benefits only.

**Services -We do not cover any of the following:**
- Services for which a charge is not normally made;
- Services or supplies prescribed, performed or directed by a provider not licensed to do so;
- Services provided before Your plan effective date;
- Services provided after Your coverage ends;
- Virtual Consults except when provided by Optima Health approved providers;
- Charges for missed appointments;
- Charges for completing forms
- Charges for copying medical records.
- Services not listed as a covered service under this plan.
- Any service or supply that is a direct result of a non-covered service.

**Spinal Manipulation** is not covered unless covered under Chiropractic Care benefits.

**Sterilization**
- Reversal of voluntary sterilizations is not covered.
- Any infertility services required because of a reversal are not covered.

**T**

Non-interactive **Telemedicine Services** such as fax, telephone only conversations, email or online questionnaire are not covered Telemedicine Services.

**Therapies** - Physical, Speech, and Occupational **Therapies** are limited as stated on Your Schedule of Benefits. Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. **We do not cover any of the following except for those services that are covered through Early Intervention Services, or if Your plan includes coverage for Autism Spectrum Disorder those services covered under Autism Spectrum disorder benefits:**
- Therapies for developmental delay or abnormal speech pathology;
- Therapies which are primarily educational in nature;
- Special education services;
- Treatment of learning disabilities;
- Lessons for sign language;
- Therapies to correct an impairment resulting from a functional nervous disorder, i.e. stuttering, stammering;
- Therapies to maintain current status or level of care;
- Restorative therapies to maintain chronic level of care;
- Therapies available in a school program;
- Therapies available through state and local funding;
- Recreational or nature therapies;
- Art, craft, dance, or music therapies;

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Exercise or equine therapies;
Sleep therapies;
Driver evaluations as part of occupational therapy;
Driver training;
Functional capacity testing needed to return to work;
Work hardening programs;
Gambling therapies;
Remedial education and programs.

**Total Body Photography** is not covered.

**Transplant Services - We do not cover any of the following:**
- Organ and tissue transplant services not listed as covered;
- Organ and tissue transplants not medically necessary;
- Organ and tissue transplants considered experimental or investigative;
- Services from non-contracted providers unless pre-authorized by the plan;
- Services and supplies for organ donor screenings, searches and registries;
- Out-of-Network services are excluded from the Out-of-Network Maximum Out of Pocket Amount;
- Services related to donor complications following a transplant.

**Travel and Transportation** expenses are not covered. Medically Necessary transport is covered only when approved by the Plan. **Elective or non-emergent** ambulance services are only covered when approved and authorized by Us. Treatment and services received outside of the United States of America are covered under Out-of-Network benefits only.

**V**

**Video Recording or Video Taping** of any service or procedure is not covered.
Treatment of **Varicose Veins** or **telangiectatic dermal veins** (spider veins) for cosmetic purpose are not covered.

**Virtual Consults - We do not cover any of the following:**
- Electronic mail message;
- Facsimile transmission;
- Online questionnaires.

**Vision Materials** not listed under Covered Services are not covered.

**W**

**Wigs** or cranial prostheses for hair loss for any reason are not covered.
**Wisdom Teeth** extraction is not covered unless under a rider.
**Work-related** injuries or diseases when the employer must provide benefits or when that person has been paid by the employer are not covered.

**X**

**Y**

**Z**
Each year the flu virus may be different, so it is important to get a flu shot every year.

Members with medical and/or pharmacy benefits administered by Optima Health will be covered for the 2017-2018 influenza season. According to the Centers for Disease Control and Prevention (CDC), 2017-2018 flu vaccine coverage will include both Trivalent and Quadrivalent.

Optima Health members may visit the following locations to receive a flu shot:

Your physician’s office:
Check with your physician to see if he or she offers the flu vaccine. A physician office Copayment may apply if you receive the flu vaccine during a scheduled office visit.

Your local pharmacy:
Members will pay no Copayment when receiving a flu vaccine from a participating pharmacy. Please contact your local pharmacy to verify participation.

High Dose Influenza Vaccines and Adjuvant Influenza Vaccines for adults are NOT covered.

Optima Health members (excluding FAMIS), age 18 and younger, MUST obtain influenza vaccinations through the Vaccines for Children (VFC) program. Please see your doctor or physician for information on receiving the flu vaccine.
Optima Health Emergency Travel Assistance
provided by Assist America

Peace of Mind! No matter where you are in the world, you will always get the care you need.

Employers have a responsibility to safeguard their employees when they travel. You also want some peace of mind whenever you travel for fun. Your enrollment with Optima Health includes a FREE Emergency Travel Assistance program that can handle and resolve your medical and travel emergencies. You, and any dependents on your Optima Health medical plan, are covered whenever traveling 100 miles or more away from your permanent residence, or in another country.

Emergency Travel Assistance Services Include:

- **Medical Consultation, Evaluation, and Referral**
  Calls to Assist America’s Operations Center are evaluated by medical personnel and referred to English-speaking, Western-trained doctors and/or hospitals.

- **Hospital Admission Assistance**
  Assist America will guarantee hospital admission outside the United States by validating a participant’s health coverage or by advancing funds to the hospital.

- **Emergency Medical Evacuation**
  If adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment, and personnel necessary to evacuate a participant to the nearest facility capable of providing a high standard of care.

- **Medical Monitoring**
  Assist America will maintain regular communication with the participant’s attending physician and/or hospital and relay information to the family.

- **Medical Repatriation**
  If a participant still requires medical assistance upon being discharged from a hospital, Assist America will repatriate them home or to a rehabilitation facility with a medical or non-medical escort, as necessary.

- **Prescription Assistance**
  If a participant needs a replacement prescription while traveling, Assist America will help in filling that prescription.

- **Compassionate Visit**
  If a participant is traveling alone and will be hospitalized for more than seven days, Assist America will provide economy, round-trip, common carrier transportation to the place of hospitalization for a designated family member or friend.

- **Care of Minor Children**
  Assist America will arrange for the care of children left unattended as the result of a medical emergency and pay for any transportation costs involved in such arrangements.

- **Return of Mortal Remains**
  Assist America will arrange and pay for the return of mortal remains in the event of a participant’s death.

- **Emergency Trauma Counseling**
  Telephone-based counseling and referrals to qualified counselors.

- **Lost Luggage or Document Assistance**
  Help locating lost luggage, documents, or personal belongings.

- **Interpreter and Legal Referrals**
  Referrals to interpreters and/or legal personnel.

- **Pre-trip Information**
  Web-based country profiles that include visa requirements, immunization and inoculation recommendations, as well as security advisories for any travel destination.

For more information, visit optimahealth.com.

Assist America is not insurance, it is a provider of global emergency services. Assist America’s services do not replace medical insurance during emergencies away from home. All medical costs incurred should be submitted to Optima Health and are subject to the policy limits of your health coverage.
Dear Member,

Thank you for choosing Optima Health!

To help ensure that you are paying the lowest possible price for your medicines, make sure you show your member ID card EVERYTIME you fill a prescription!

WE WANT TO HELP YOU MAKE THE BEST OF YOUR PHARMACY DOLLARS

In order to maximize your pharmacy benefit, be sure to present your Optima Health member ID card whenever you have a prescription filled. This is important whether the prescription is for a brand or a generic drug because the cost of many drugs can be less than your Copayment. Some pharmacies advertise a $4 drug list; however that may not be the lowest price for you. For some drugs the actual cost of the drug with your Optima Health member ID card may be less than the advertised $4 generic program.

Here are a few examples where your cost may be less than $4:

Examples of Savings with Generics
30-day supply

<table>
<thead>
<tr>
<th>Drug</th>
<th>Quantity</th>
<th>What You Pay</th>
<th>Pharmacy $4 Program</th>
<th>Sample Tier 1 Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin 500mg capsules</td>
<td>30</td>
<td>$2.51</td>
<td>$4.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Atenolol 50mg tablets</td>
<td>30</td>
<td>$1.40</td>
<td>$4.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Fluoxetine 20mg capsules</td>
<td>30</td>
<td>$2.23</td>
<td>$4.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Hydrochlorothiazide (HCTZ) 25 mg tablets</td>
<td>30</td>
<td>$1.30</td>
<td>$4.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Ibuprofen 800 mg tablets</td>
<td>30</td>
<td>$2.35</td>
<td>$4.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Lisinopril 20 mg tablets</td>
<td>30</td>
<td>$2.23</td>
<td>$4.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Metformin 500 mg tablets</td>
<td>60</td>
<td>$2.47</td>
<td>$4.00</td>
<td>$15.00</td>
</tr>
</tbody>
</table>

The drugs and prices listed above are examples only. Prices are subject to change and prices may vary between pharmacies.

Optima Health offers an online tool that can help you determine what your cost will be for any of your prescription drugs. Simply sign in to optimah.ealth.com and select Pharmacy Resources from the MyOptima menu. Then select the Price and Save button and follow the directions to find out your cost for a specific drug.

5/2017
As a registered user of optimahealth.com, you can:

- Update your contact information
- Change your primary care physician
- Print and order a new member ID card
- View the status of your healthcare claims
- View Authorizations
- View your medical benefits
- View your pharmacy benefits
  (if administered by Optima Health)
- View a list of Plan providers
- View Newsletters
- View your Evidence of Coverage or Certificate of Insurance Documents
- Download member forms
- Learn about preventive health programs
- Receive documents electronically, such as your Explanation of Benefits (EOB) statements
- Complete a Personal Health Assessment

Do you need to find:
- Doctors,
- Pharmacies, or
- Hospitals?

Then optimahealth.com is the tool for you! Utilize our homepage to find doctors, hospitals and facilities, behavioral health providers, pharmacies, urgent care centers, or out-of-network providers via our PHCS partners. The links are located on the bottom of the page. Click these links to gain access to a specialized search form that will help you meet your healthcare needs.
Get Started with a Personal Health Assessment (PHA)! Improving your health can be fun when you know where to start. By taking an online PHA, you can take stock of your current health status and proactively plan for your future. The PHA takes minutes to complete. When you’re done, you’ll instantly receive a report, health score, and suggestions for improvement.

Getting started is easy. Sign in to MyOptima on optimaehealth.com/members, click on “Personal Health Assessment” in the left menu bar and follow the prompts.

Once you have completed your PHA, the My Health Assistant (your online “coach”) helps you set up a health routine specific to your needs and goals.

Download the Optima Health mobile app, MyOptima. MyOptima is available in the iTunes store for iPhone users, and in Google Play for Android™ users. You can use it to update contact information; view claims, benefit information, and your member ID card; search for doctors and hospitals; shop plan options and more—anywhere, anytime, anyplacc.

Scan the QR code with your phone to go directly to the app:
Optima Health

TREATMENT

COST CALCULATOR

Better Information
View estimates on over 350 procedures and services in your area, based on your specific benefit plan information.

Better Decisions
Shop and compare out-of-pocket costs for a specific procedure at a specific doctor or medical facility.

Better Health
Compare your options, plan for future expenses, and make the best decisions for both your health and your wallet.

MyOptima
Sign in at optimahealth.com/members, then select Treatment Cost Calculator from your MyOptima menu on the left side of the screen.

SEARCH

Did you know ...

Your Out of Pocket Estimate is: $45

View out-of-pocket estimates* based on real-time balances of your health plan’s Deductibles and Out-of-Pocket Maximums.

View maps, get directions, call for appointments, and print or email estimates.

*Please Note: estimates provided within the Treatment Cost Calculator are not quotes. While every effort is made to provide members with the most accurate information, in some instances the actual charges from your healthcare provider may be different than the average estimate provided.
My Health Assistant: Keeping you on track, online.

Your 24/7 resource to help you keep your eyes on the prize.

Make checking in with My Health Assistant part of your regular routine, and you’ll have what it takes to start a good health routine and stick with it.

My Health Assistant uses the goals and activities you select to create simple weekly plans that get you from start to success.

During your journey, you’ll enjoy an interactive online experience that’s motivational, fun, and invigorating.

Focus on one or more of the following areas:
- Nutrition
- Exercise
- Weight loss
- Stress management
- Emotional health
- Tobacco cessation

Let My Health Assistant inspire you today at:

optimahealth.com/members

Optima Health MyLife MyPlan Connection powered by WebMD Health Services
My Health Assistant: Your Digital Health Assistant (DHA)

The DHA is an online coach that creatively engages you to improve your overall health and wellness with specific, personal calls to action to help you form healthy habits and achieve your goals.

Accessing the Digital Health Assistant

DHA activities are customized to you, your health plan, and your wellness program. You can access this tool from the Optima Health website:

- Sign in at optimahealth.com/members.
- Select Wellness Tools from your MyOptima menu on the left side of the screen to navigate to your personalized WebMD wellness home page.

Setting Goals with the Digital Health Assistant

Option One - Set a DHA goal based on your Personal Health Assessment (PHA) score.
- Complete the PHA questionnaire.
- From your PHA results screen, click the green Let’s Go! button to navigate to the My Health Assistant page and choose your goal(s).

Option Two - Set a DHA goal without taking the Personal Health Assessment.
- From your personalized WebMD wellness home page, select the Healthy Living tab at the top of the page.
- Select My Health Assistant.
- Choose which goal(s) you would like to work towards by clicking Set this goal from the corresponding DHA.

Choose one or more of the following DHA goals: Eat Better, Enjoy Exercise, Lose Weight, Conquer Stress, Feel Happier, Quit Tobacco.

Reaching Goals with the Digital Health Assistant

Once you have selected your DHA goal(s), you are ready to begin tracking your progress. Record your daily activities following these easy steps:

- Sign in at optimahealth.com/members and select Wellness Tools from your MyOptima menu.
- From your personalized WebMD wellness home page, select the Healthy Living tab at the top of the page and choose My Health Assistant.
- Click on the icon that best represents your daily activities towards each goal.
- Sign in daily or weekly to record your activities. Weeks begin on Sunday and end on Saturday; you may only back-track and record past activities completed since Sunday of the current week.

<table>
<thead>
<tr>
<th>DHA</th>
<th>How to Record Your Daily Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eat Better</td>
<td>click On Track, A Little Off, or Off Track</td>
</tr>
<tr>
<td>Enjoy Exercise</td>
<td>click More than 20 Minutes, 20 Minutes, or Less than 20 Minutes</td>
</tr>
<tr>
<td>Lose Weight</td>
<td>enter your current weight</td>
</tr>
<tr>
<td>Conquer Stress</td>
<td>enter your current stress level on a scale from low to high</td>
</tr>
<tr>
<td>Feel Happier</td>
<td>click Happy, Okay, Down, or Sad</td>
</tr>
<tr>
<td>Quit Tobacco</td>
<td>enter how many times you use tobacco daily</td>
</tr>
</tbody>
</table>
Welcome
to the *Listen Hear, Live Well*
Hearing Health Wellness Program

Here’s How it Works:

1. Members go to www.listenhearlivewell.com and register with your name and email address.

2. Complete the 4 fun, educational hearing health activities.

3. Receive your reward coupon for additional savings off of your purchase.

*Listen Hear, Live Well* reward coupon savings are applied per each hearing device that is purchased—maximizing your value! Plus, these reward savings are applied on top of the 30% - 60% savings off of MSRP that is already available on an open selection of major brand hearing aids through the EPIC Hearing Service Plans. Simply complete the online wellness program on your desktop or mobile device and contact the EPIC Hearing Service Plan toll free at 1 866.956.5400 to redeem your reward, and start the process to better hearing!

Save

- Premium Devices: $200 off
- Advanced Devices: $100 off
- Standard Devices: $50 off

LISTENHEARLIVEWELL.COM | LISTENHEAR@EPICHEARING.COM
The EPIC Hearing Service Plan (HSP) gives you access to the largest hearing care provider network in the country and substantial savings on top tier manufacturer brand devices and related professional services.

<table>
<thead>
<tr>
<th>LEVEL OF HEARING AID TECHNOLOGY</th>
<th>DEGREE OF HEARING LOSS</th>
<th>TYPICAL MSRP</th>
<th>EPIC PRICING</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASIC</td>
<td>Mild to Moderate</td>
<td>$1,400-$1,600</td>
<td>$495</td>
</tr>
<tr>
<td>STANDARD</td>
<td>Moderate</td>
<td>$1,601-$2,300</td>
<td>$849-$1,499</td>
</tr>
<tr>
<td>ADVANCED</td>
<td>Moderate to Severe</td>
<td>$2,301-$3,000</td>
<td>$1,500-$2,099</td>
</tr>
<tr>
<td>PREMIUM</td>
<td>Moderate to Severe</td>
<td>$3,001-$4,000</td>
<td>$2,100-$2,500</td>
</tr>
</tbody>
</table>

- Savings on hearing exams and hearing aid devices
- Access to the largest nationwide network of Audiologists and ENT physicians
- Pricing 30% - 60% below MSRP on name brand products
- Money-back Trial Periods
- Extended warranties & batteries with purchase

Welcome
The EPIC Hearing Service Plan is the nation’s first specialty care plan devoted to the vital sense of hearing. EPIC is dedicated to delivering the highest quality of care at the best value to our members.

Provider Network
The EPIC network is comprised of professional Audiologists and ENT physicians and represents the largest accredited network of its kind in the nation, with provider locations in all 50 states.

Hearing Aids
The EPIC Hearing Service Plan gives you access to all name brand hearing aid technology by the top tier hearing aid manufacturers at reduced prices, 30%-60% below MSRP; maximizing your value and savings. Note: the following top tier manufacturer brands are available through EPIC: Phonak, Unitron, Lyric, GN Resound, Starkey, Siemens, Oticon, and Widex.

How it Works
Contact an EPIC hearing counselor today. The hearing counselor can answer any questions you may have about the plan and coordinate your referral to a nearby participating provider. If the provider recommends you obtain hearing aids, an EPIC counselor will contact you to coordinate your coverage and payment. You will receive a 45 day trial period with a complimentary extended 3 year product warranty and one year supply of batteries*.

*Excludes Basic Level Products

Call EPIC today to start the process to better hearing.

1 866.956.5400
hear@epichearing.com

www.epichearing.com
Preventive Services Covered under Health Care Reform

Covered Preventive Services for Adults

Abdominal aortic aneurysm screening: men
Alcohol misuse: screening and counseling
Aspirin use: adults aged 50–59 with risk of cardiovascular disease
Blood pressure screening
Cholesterol screening for adults of certain ages
Colorectal cancer screening and generic and over-the-counter prep medications: adults age 50–75
Consultation for screening colonoscopy
Depression screening
Diabetes screening: adults with high blood pressure
Falls prevention: adults 65 years or older—Vitamin D and exercise or physical therapy
Healthy Diet Counseling
Hepatitis B screening
Hepatitis C virus infection screening: adults born between 1945 and 1965
HIV screening
Immunization vaccine: Herpes Zoster
Immunization vaccines:
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
Lung cancer screening
Pathology Exam for biopsy following screening colonoscopy
Obesity screening and counseling
Sexually Transmitted Infection (STI) prevention counseling
*Statin medications: adults ages 40–75 with no history of cardiovascular disease who have one or more risk factors and calculated 10-year risk
Syphilis screening
Tobacco use counseling, generic and over-the-counter medications, and cessation interventions
Tuberculosis screening

Covered Preventive Services for Women, Including Pregnant Women

Anemia screening: pregnant women
Bacteriuria screening
BRCA risk assessment and genetic counseling/screening
Breast cancer chemoprevention counseling
*Breast cancer preventive medication
Breast cancer screening: women over age 40
Breastfeeding support and counseling
Cervical cancer screening
Chlamydia infection screening

Continued on next page
Covered Preventive Services for Women, cont.

Contraception: All Food and Drug
Administration-approved contraceptive methods and intrauterine devices (IUD); sterilization procedures including tubal ligations and Essure; and patient education and counseling; not including abort/facient drugs. Generic oral contraceptives are eligible for 100 percent coverage. Please visit optimhealth.com to determine member cost share for brand name oral contraceptives.

Decision making/sharing by clinicians with women at increased risk for breast cancer
Depression screening
Folic acid supplementation
Gestational diabetes mellitus screening

Gestational diabetes screening: women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
Gonorrhea screening
Hepatitis B screening at first prenatal visit
HIV screening: pregnant women
HPV Test
Intimate partner violence screening and counseling
Lactation support and counseling
Osteoporosis screening: women over 65 or at high risk
Preeclampsia screening and prevention
Rh incompatibility screening: first pregnancy visit and between 24 and 28 weeks gestation
STI counseling
Syphilis screening
Well-woman visits
Tobacco counseling and intervention

Covered Preventive Services for Children

Alcohol and drug use assessments
Autism screening: children at age 18 and 24 months
Behavioral assessments
Blood pressure screening
Cervical dysplasia screening: sexually active females
Congenital hypothyroidism screening: newborns
Dental cavities prevention: infants and children up to age five years
Depression screening: adolescents
Developmental screening: children under age three, and surveillance throughout childhood
Dyslipidemia screening: children at high risk of lipid disorders
Fluoride chemoprevention supplements for children without fluoride in their water source
Gonorrhea prophylactic medication: newborns
Hearing loss screening: newborns
Height, weight, and body mass index measurements
Hematocrit or Hemoglobin screening
Hemoglobinopathies screening: newborns
Hepatitis B screening: non-pregnant adolescents and adults
HIV screening

Immunization vaccines:
Diphtheria, Tetanus, Pertussis
Haemophilus influenzae type b
Hepatitis A
Hepatitis B
Human Papillomavirus
Inactivated Poliovirus
Influenza
Measles, Mumps, Rubella
Meningococcal
Pneumococcal
Rotavirus
Varicella
Iron supplementation
Lead screening for children at risk of exposure
Medical history
Obesity screening: children and adolescents
Oral fluoride supplementation starting at age six months for children whose water supply is fluoride deficient
Oral health risk assessment
Phenylketonuria (PKU) screening: newborns
Skin cancer behavioral counseling: children, adolescents and young adults age 10 to 24 years old
STI prevention counseling and screening for adolescents at high risk
Tobacco use interventions: children and adolescents
Tuberculin testing for children at higher risk of tuberculosis
Visual acuity screening
TIPS FOR COMPLETING YOUR ENROLLMENT APPLICATION

If you are enrolling your spouse or your children, read this first!

The following situations require that you provide additional information or documentation so that your spouse, or your children up to age 26 can be enrolled in your health plan. Without this information your enrollment and I.D. cards may be delayed.

Coordination of Benefits

Complete Coordination of Benefits Information Page only if you or any of your enrolling family members will have medical coverage in addition to the Optima Health plan (check "Yes" for Section 8 - Additional Coverage).

Continuation of Coverage for Children with an Intellectual Disability or Physical Handicap:

Children over age 26 with an intellectual disability or physical handicap may continue to be eligible for coverage. You will need to include a statement from the child’s physician with this application. Please use/follow instructions on the Disabled Dependent Certification form located on our website: http://members.optimahealth.com/manageplans/Pages/Downloadable-Forms-and-Documents.aspx

Or you may contact Member Services for this form or for additional information.

Check your application carefully to be sure all birthdays and Social Security numbers are correct.

Please make sure to include birth dates and Social Security numbers for each person who will be covered under the Plan.
**Coordination of Benefits Information Page**  
*Please retain a copy of this coordination of benefits page for your records.*

**Applicant’s Name:** ________________________________ **Soc. Sec. #:** ________________________________

**Date of Birth:** ________________________________  
**NOTE:** Complete section 1 and section 3 if you have additional commercial insurance. Complete section 2 and section 3 if you have Medicare.

### SECTION 1 (Commercial Insurance)

**Name of other Insurance Company:** __________________________________________________________

**Address:** __________________________________________________________

**Phone Number:** __________________________________________________________

**Policy Number:** ___________ **Effective Date:** ________________________________

**Employer:** __________________________________________________________

**Group Number:** __________________________________________________________

**Policyholder’s Name:** __________________________________________________________

**Birthdate:** __________________________________________________________

List family members covered by this insurance: __________________________________________________

### SECTION 2 (Medicare Information)

**Applicant:** ________________________________ **Claim#:** ________________________________

**Hospital Insurance (Part A) Effective Date:** ____________________________________________

**Hospital Insurance (Part B) Effective Date:** ____________________________________________

**Are you retired:** Yes ☐ No ☐ **Retirement date:** ________________________________

**Spouse:** __________________________________________________________ **Claim#:** ________________________________

**Hospital Insurance (Part A) Effective Date:** ____________________________________________

**Hospital Insurance (Part B) Effective Date:** ____________________________________________

**Are you retired:** Yes ☐ No ☐ **Retirement date:** ________________________________

### SECTION 3

I hereby certify that except as reported above, no service or payments are provided or are recoverable through any other group insurance or service plan.

**Signature of Applicant:** ________________________________ **Date:** ________________________________
Optima Health Plan and Optima Health Insurance Company
Large Group (Combined) Enrollment Application

IMPORTANT: Incomplete information will delay enrollment. Please use a ball point pen, press firmly and print clearly.

Section 4
To be completed by employer

Group No. __________________ Sub Group No. __________________

**Required**

- NEW
- Open Enrollment
- Continuation of Coverage
- C.O.B.R.A.
- PCP or Address Change

- Cancel All
- Add Dependent/Spouse
- Cancel Dependent/Spouse
- Reinstatement

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Effective/Termination Date</th>
<th>Employee’s Social Security No.</th>
<th>Hire Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 5

Optima Health Plan Selection:
HMO/POS Products Underwritten by Optima Health Plan

- Vantage (HMO)
- Equity Vantage (HMO)
- Design Vantage (HMO)
- Vantage POSA
- Equity POSA
- Design POSA

Optima Health Insurance Company Plan Selection:
PPO Products Underwritten by Optima Health Insurance Company

- Plus (PPO)
- Equity Plus (PPO)
- Design Plus (PPO)

Section 6
TO BE COMPLETED BY EMPLOYEE- (PLEASE PRINT LEGAL NAME)

Last Name: ___________________ First Name: ___________________ Middle Init. ___________________

Address: ____________________ Primary Language: __________________

City/State/Zip: __________________

Primary Phone: ( ) __________ Secondary Phone: ( ) __________

Section 7
NOTE: Complete this section only if you have selected an Equity plan in Section 5

Health Savings Account (HSA) Administration- If you have chosen the Equity HSA eligible high deductible plan offered through your employer, you are eligible to establish a Health Savings Account (HSA). HealthEquity is Optima Health’s preferred vendor for HSA account administration.

Do you want to establish a HSA account?
- Yes, please do establish a health savings account for me with HealthEquity.
- No, please do not establish a health savings account for me with HealthEquity.

Section 8
Additional Coverage-

REQUIRED INFORMATION TO BE COMPLETED BY EMPLOYEE FOR ALL PERSONS LISTED BELOW.

Will any of the persons listed below have any other medical health insurance in addition to Optima Health Plan when this coverage takes effect? ___________________

- Yes
- No

If Yes, please complete Sections 1, 2, and 3 on the Coordination of Benefits form attached. If you have other health coverage and have elected a Health Savings Account (HSA), consult your tax advisor on your eligibility for contributing to an HSA.
Section 9  Communication-
Please select the method in which you would prefer to receive communications from Optima Health.

<table>
<thead>
<tr>
<th>EOBs: Explanation of Benefits</th>
<th>Print</th>
<th>Electronic</th>
<th>Email Address: (Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBC: Summary of Benefits &amp; Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Communications: Newsletters etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 10 Please list below all persons to be covered by the enrollment application

<table>
<thead>
<tr>
<th>Social Security No.</th>
<th>Last Name</th>
<th>First Name, MI</th>
<th>Date of Birth MO/DAY/YR</th>
<th>M/F</th>
<th>Primary Care Physician &amp; ID #</th>
<th>Current Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DR.</td>
<td>YES / NO</td>
</tr>
<tr>
<td>SPOUSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DR.</td>
<td>YES / NO</td>
</tr>
<tr>
<td>CHILD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DR.</td>
<td>YES / NO</td>
</tr>
<tr>
<td>CHILD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DR.</td>
<td>YES / NO</td>
</tr>
<tr>
<td>CHILD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DR.</td>
<td>YES / NO</td>
</tr>
<tr>
<td>CHILD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DR.</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>

IF ADDING TO POLICY, DATE OF QUALIFYING EVENT (BIRTH, MARRIAGE, ETC.) ____________________

Section 11  AUTHORIZATION

I am applying for Optima Health coverage for myself and the family members listed, and agree that once enrolled I and my family members will abide by the provisions of coverage in the Group Policy and Certificate of Insurance or Group Agreement and Evidence of Coverage under which we will be enrolled. Optima Health is the trade name for several different companies including Optima Health Plan and Optima Health Insurance Company.

I understand that misrepresentation in answering questions on this application or non-payment of premiums may result in loss of coverage under the Group Health Plan.

I authorize any physician, hospital, pharmacy, or other provider of health services or supplies, to disclose to Optima Health medical and other information related to eligibility for coverage or a claim for benefits relating to the individuals specified on this application. I also give Optima Health the right to receive from, and release information to, other insurance companies needed to administer coordination of benefits (COB) provisions under the Group Policy or Group Agreement.

I understand that Optima Health upon receiving information may use it to evaluate eligibility for coverage, a claim for benefits, a request for change in policy benefits, or administer COB. This Authorization shall not extend to the disclosure of a provider’s notes taken during psychotherapy sessions that are maintained separately from the rest of the provider’s medical record.

Any information received by Optima Health pursuant to this application is subject to restrictions on disclosure to others as set forth under state and Federal laws. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I understand and agree that no benefits shall take effect until this application is received and processed by Optima Health and an Optima Health ID card with an effective date of coverage has been provided.

I understand that it is my responsibility to report and verify to Optima Health any change in the eligibility of myself or my covered family members. If requested, I agree to supply acceptable documentation. I also understand that I am obligated to pay applicable copayments, coinsurance or deductibles at the time services are rendered.

I certify that I have maintained a copy of this completed application for my records. I understand that this application shall become a part of the Group Policy or Group Agreement. I further understand that I or my authorized representative may receive a copy of this application upon request. I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that, for the purpose of collecting information in connection with this application, this authorization is valid for 30 months from the date of my signature, and for the purpose of collecting information in connection with a claim for benefits this authorization is valid for the term of coverage of the policy.

Signature of Applicant ________________________ Date __________________

Benefit Administrator ________________________ Date __________________

OHPOHIC_LG_APPLICATION_18
Optima Health Alternative Language Options for Notices and other Written Information

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

Amharic:
አማርኛ: ከማርኛ ማስታወወ በወርቅ ከማርኛ ማስታወቂያ በወርቅ ከማርኛ ማስታወቂያ ገራ ስለ ከስተወቹ 1-855-687-6260:

Arabic:

تنبيه:
إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجاناً، اتصل بالرقم 6260-687-855-1.

Bengali/Bangla:
লক্ষ্য করলেনে: যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবার প্রয়োজন। ফোন করুন-1-855-687-6260।

Chinese (Mandarin):
注意：如果您讲中文普通话，可以免费获得语言协助服务。请拨打电话 1-855-687-6260。

French:
ATTENTION : Si vous parlez français, les services d’assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260.

German:
ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfdienste kostenlos unter der Rufnummer 1-855-687-6260 zur Verfügung.

Gujarati:
ধান আপনে: তুই গুজরাটী বলো তো ভাষা সহায়তা সেবাও তামার মাটী বিনামূল্যে উপলব্ধ ছ. 1-855-687-6260 পর কোল করো.

Hindi:
धान दे: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 पर कॉल करें।

Hmong:

Igbo:
GE: oburu na i na-asụ Igbo, i ga-enweta enyemaka n’efu site n’aka ndj ga-enyere gi aka inweta ya. Kpọ 1-855-687-6260

Japanese:
重要：日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260までお電話ください。

Korean:
주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260번으로 전화해 주십시오.
Kru/Bassa:
YI LE: I bale u mpot Bassa, bot ba kobol mahop nguï nsaa wogui wo ba ye ha l nyuu hola we. Sebel: 1-855-687-6260.

Laotian:
ເດີເດີລາວ: ບໍ່ຄູນ້າທາງ, ຊຸດເວທດຮ້ອຍທີ່ທ້ານເທົ່າທ້ານໄດ້ຕັ້ງຕິດຕາມເພີ່ມຂຶ້ນໄດ້ເປັນເວທດຮ້ອຍທີ່ທ້ານ. ຄຣ 1-855-687-6260.

Mon-Khmer, Cambodian:
អូក្រក្រវែង: អំពីអក្សរស៊ីនីការពារ, ជី័នការសិក្សាពីរៀងរាល់ភាសាចិន្ទឹមសម្រាប់ការបង្កើតអំណាចសម្រាប់អ្នក។ សមតែង 1-855-687-6260។

Navajo:
SHOOH: Diné Bizaad bee yáníîti’go doo bááh ílinígóó t’áá nizaad k’éhjí niká a’doowolgo bee ha’át. Kojj’ hólíné’ 1-855-687-6260.

Persian/Farsi:
توجه: 
اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 6260-687-685-1855 نماس بگیرید.

Portuguese:

Russian:
ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260, и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:
ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260.

Turkish:

Urdu:
توجه دین: 
اگر آپ اردو زبان ہوئے ہیں تو، زبان کی معاونتی خدمات، بہتر کسی خرچ کے، آپ کے لئے دستیاب ہیں 6260-687-685-1855 کال کریں.

Vietnamese:
CHỦ Y: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260.

Yoruba:
KÉÉÈÈ:
Ti o bá ní só èdè Yorúbá, iṣẹ irànólówò èdè wà fún o lọfè. Pe 1-855-687-6260