Benefit Information Guide

Vantage | POS Plans

ADMINISTERED BY

SENTARA HEALTH PLANS, INC.

OptimaHealth

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Contact Us

If you are considering Optima Health or are new to the plan and do not have a member ID card, please call us toll-free at 1-877-552-7401.

Visit optimahealth.com/members or download the Optima Health mobile app to:

- view a list of Plan providers
- change your Plan primary care physician (PCP)
- update your home address, phone number, or email address
- order a new member ID card or print a temporary member ID card
- view your claims history
- view your benefits
- view your authorizations
- get important preventive care reminders
- learn about member discounts
- manage your pharmacy benefit (if administered by Optima Health)
- research drug options and pricing
- choose to receive your Explanation of Benefits (EOB) electronically
- research conditions, treatment options, and hospital quality

You must first register on optimahealth.com/members or the Optima Health mobile app to access your secure member information, as well as special tools available only to Optima Health members. Download the Optima Health mobile app from the App Store or Google Play.

Member Services
Call the number listed on the back of your member ID card.
Office hours: Mon.–Fri. 8 a.m. to 5 p.m.
After business hours, please leave a message

24/7 Nurse Advice Line
Call the number listed on the back of your member ID card

Behavioral Health Services
1-800-648-8420

Language Assistance Services
Call 1-855-687-6260 for assistance for visually impaired and non-English speaking members

TYY/TDD line for the hearing impaired
Optima Health uses the Virginia Relay Service
1-800-828-1140 or 711

Optima Health Individual & Family Plans
Customer Service for current members
1-866-514-5916

New sales inquiries and quotes
1-800-741-4825
www.optimahealth.com/individual

Email
members@optimahealth.com
Please note: Members who register and sign in to optimahealth.com or the mobile app can contact Member Services securely using the Contact Us form.

Mail
Optima Health Member Services
4417 Corporation Lane
Virginia Beach, VA 23462

OptimaHealth

Benefit Information Guide

Prepared exclusively for:

Group Name:
City of Chesapeake
POS Plan
Effective Date:
1/1/2023

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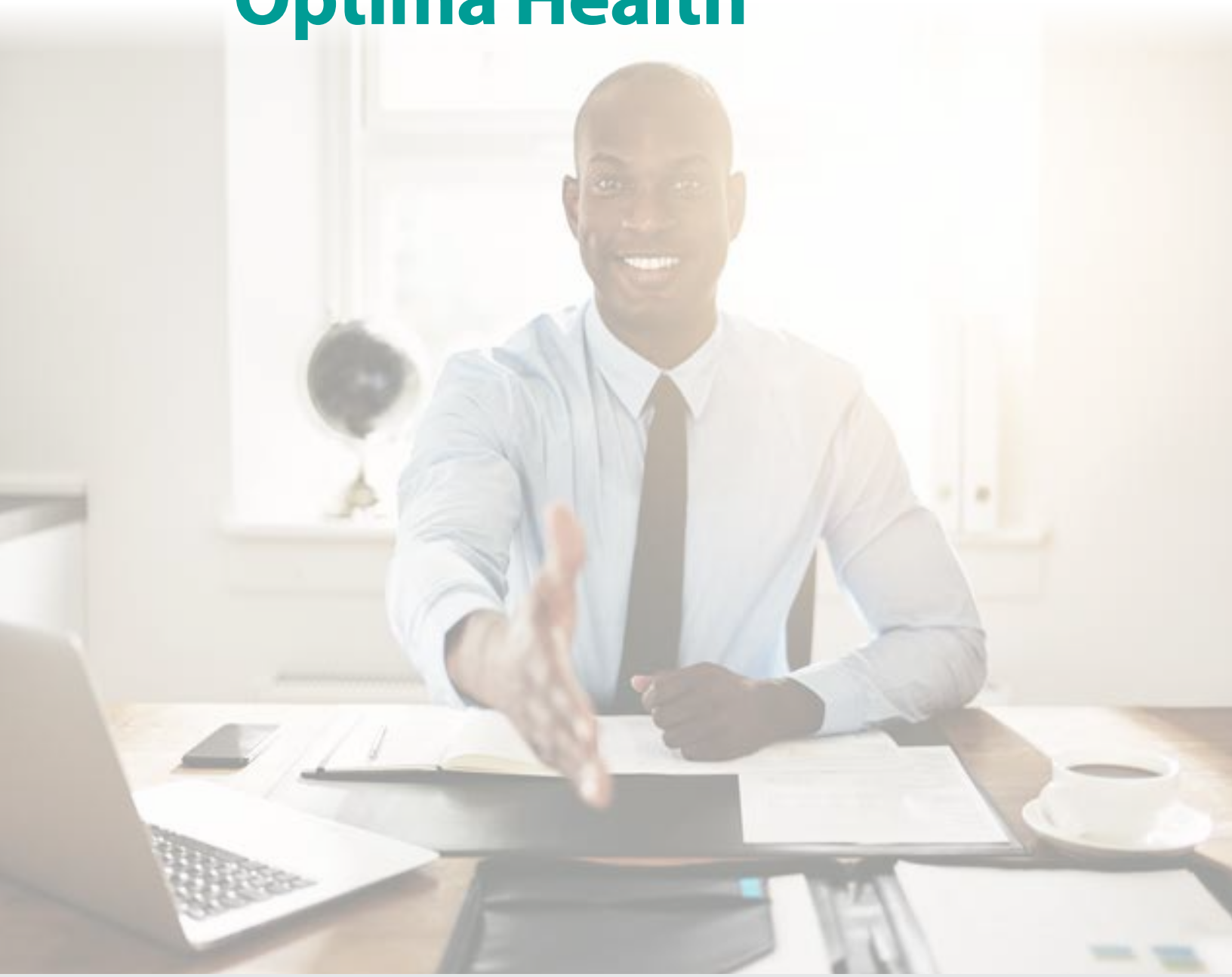
Welcome to Optima Health



Welcome to Optima Health

Within the pages of this Benefit Information Guide you will find answers to frequently asked questions about pre-authorization, emergencies, urgent care, and more. Information specific to services your plan covers, as well as plan deductibles, copayments, and other cost-share amounts can be found in the Uniform Summary of Benefits and Coverage (SBC) and the Benefit Summary in the following two sections of this Guide.

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 chosen by your employer. Refer to your Plan documents for more details.

Every individual covered by an Optima Health plan receives a member ID card, which is designed according to your specific plan. Your card includes your name, the name of your employer, group number, member ID number, the name of your plan, and important phone numbers. Depending on your plan, it will also include copayment and coinsurance amounts for prescription drugs, office visits, emergency room, and other services. Always show your member ID card whenever you receive services or get a prescription drug filled to ensure you are charged the correct amount.

You can contact us by website, mobile app, email, phone, or mail if you need additional information.

Welcome to Optima Health

Our Plans

Optima Vantage

Optima Vantage is a *referral-less* HMO plan in which you choose a Plan primary care physician (PCP) who will coordinate your healthcare needs. You are not required to obtain referrals for Plan specialist care. If you need to see a Plan specialist, your PCP may coordinate your care, or you can make your own appointment. Except for emergency services, all care must be received from Plan providers in the Optima Health networkto be covered by the Plan.

Optima Patient-Optional Point of Service

If your employer offers one of the Optima Health fully insured Vantage products, you may have the option to enroll in a Patient-Optional Point-of-Service (POSA) plan. This plan permits you and your eligible dependents to receive the full range of covered items and services from out-of-network or non-Plan providers. During your enrollment, ask your employer for information about the POSA plan available to you. Please keep in mind that if you choose to enroll in a POSA plan, your premium, copayment, and/or coinsurance for covered services may be different from the Vantage plan.

Optima Point of Service

Optima Health has a Point-of-Service (POS) plan in which you choose a PCP. Referrals are not required. The Plan features in-network and out-of-network benefit options.

Optima Design Vantage, Optima Design POS, and Optima Design POSA Plans

Optima Design Vantage is a Health Reimbursement Arrangement (HRA) coupled with a consumer-directed HMO plan. Similarly, Optima Design POS and POSA are HRA plans coupled with a high-deductible POS and POSA plan.

Benefits of Optima Design Vantage, Optima Design POS, and Optima Design POSA include:

- lower premiums - You will save money per pay period for health coverage.
- financial support - You will receive financial support in the amount determined by your employer to help offset your qualified out-of-pocket healthcare expenses.
- tax benefits - All HRA funds are tax-free and not considered part of your income.

Optima Equity Vantage, Optima Equity POS, and Optima Equity POSA Plans

Optima Equity Vantage, POS, and POSA plans are consumer-directed health plans that can be combined with a Health Savings Account (HSA). Optima Equity members electing to open an HSA are eligible to make tax-deductible contributions to the account.

Our Provider Network

Understanding your Plan's network helps you know how your care is covered by Optima Health.

In-network:

Doctors, hospitals, and other healthcare professionals who sign an agreement with Optima Health are participating, or in-network, providers. These providers have agreed to accept a set fee for services rendered to our health plan members. Except for emergent situations, Optima Vantage members must receive covered services from in-network providers in order to have their services covered by Optima Health.

Out-of-network:

Doctors, hospitals, and other healthcare professionals who do not have a signed agreement with Optima Health are considered non-Plan, or out-of-network providers. Typically, Plan members enrolled in a POSA or POS plan have out-of-network benefits. When they receive covered services from out-of-network providers, Optima Health will pay a set percentage, or an allowable charge, of the amount paid to in-network providers for the same service. The member will pay the rest. If the out-of-network provider charges more than what Optima Health pays, the provider may bill you, the member, for the difference between the two amounts.

Clinically Integrated Networks

Many of the providers within the Optima Health network participate in a clinically integrated network (CIN), which is a collection of physicians, hospitals, and specialists that join together to improve care and reduce costs. Through technology, analytics, collaboration, and in-person care, CINs are committed to high-quality care; increased access to care and overall member experience through improved wellness and disease prevention; and care coordination for members with chronic conditions.

OptimaDirect® Network

As a member of an OptimaDirect® plan, you have a tiered network of providers. This means that you have the freedom to choose from any healthcare provider in the network. You will have a lower cost share—copayments and coinsurance amounts—when you use a Tier 1 provider. With this network design, you have the option to also visit Tier 2 providers for a higher cost share than a Tier 1 provider. Please refer to your plan documents for more information about the cost savings of choosing a Tier 1 provider, specific to your plan.

You and Your Primary Care Physician

A Relationship for a Healthy Life

When you have a health concern or need medical care, do you have that one "go to" doctor you can call? A primary care physician, or PCP, is your main point of contact - your first stop - to identify an illness or condition, offer methods of care, write prescriptions, and recommend specialists or facilities if additional diagnosis and follow up are needed.

When you establish a relationship with a PCP, you develop continuity of care with someone who gets to know you and your health goals, and helps you manage your overall progress.

Benefits of a PCP

- Your PCP will provide routine and preventive care services such as annual physicals, exams, and treatment for colds and the flu.
- Your PCP can help you focus on staying healthy, in addition to treating you when you are sick or hurt.
- Through routine care, your PCP can catch problems early, before they become serious or lead to major illnesses.
- If you have a chronic condition like asthma or diabetes, your PCP will help you develop a self-management plan, monitor your progress, and refer you to specialized care if needed.

Get the most out of your time with your PCP

- **Be honest.** It's always the best policy, especially when your health could be affected.
- **Come prepared**. Write down your questions and be specific about what you intend to discuss.
- **Prioritize your concerns.** Time is limited with a provider so focus on the issues most important to you.
- **Don't be afraid to request another appointment.** If you have a long list of items, schedule another appointment, and tell the doctor you have other issues to address.
- **Bring someone with you.** A close friend or family member can help keep track of information and is a way to be sure all your questions will be answered.

You and Your Primary Care Physician, continued

- **Use an online patient portal to communicate if available.** Don't underestimate the power of communication that is not face to face.
- **Tell your doctor about over-the-counter medications, herbal supplements, and vitamins.** Some of these can interact with prescribed drugs.
- **Tell the doctor if you are stressed, depressed, or abused.** Doctors may not be therapists but they've heard it all. Don't be afraid to discuss personal issues.
- **Let your doctor know if you have reasons for not following orders.** Does your medication cause side effects? Are you unable to follow a nutrition or activity plan? Let your doctor know!
- **Tell your doctor if you can't sleep. Sleep is important to your health.** Your doctor can evaluate the problem and provide advice on how to solve it.
- **Let your doctor know if you have low energy.** Fatigue is associated with many illnesses. Let your doctor know if this is a chronic problem.

Frequently Asked Questions

How do I choose or change a plan PCP?

When you enroll, if your Plan requires the designation of a primary care provider (PCP) you have the right to designate any PCP who participates in your Plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. Your Plan may assign a PCP to you and your family until you choose a PCP. For information on how to select or change a PCP, and for a list of the participating PCPs, you can call member services. You can also find the list of participating providers on optimahealth.com.

You do not need prior authorization from your Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional within your Plan's network who specializes in obstetrics or gynecology. The healthcare 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. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact member services. You can also find the list of participating providers on optimahealth.com.

If you are new to the Optima Health community, you can often continue your relationship with your current physician, or select a new one from our extensive list of participating providers. If you have children, you may choose a participating pediatrician as their PCP. You can change your PCP or review a list of participating providers at optimahealth.com.

Primary Care Physician, continued

If you have not seen your designated PCP within the last 24 months, please contact your PCP's office or member services to ensure that the office still lists you as a patient. Having your correct PCP on file ensures that any correspondence or other outreach to your PCP is accurate.

What about my spouse and children? Do we all have to have the same PCP?

Adult members have the right to choose a general family practice or an internal medicine doctor as their PCP, and a family practice doctor or a pediatrician for their children.

What if my plan doctor leaves the Optima Health network?

If your plan doctor leaves the network, Optima Health will notify and assist you in finding a new doctor or facility. If you are in active treatment with a doctor who leaves the network, you can request to continue receiving healthcare services from the doctor for at least 90 days. If you are beyond the first trimester of pregnancy, you may be able to remain with that doctor through the provision of postpartum care directly related to the delivery. For a terminal illness, treatment may continue for the remainder of the member's life for care directly related to the terminal illness.

Specialist Care

What if I need to see a plan specialist?

You do not need a referral from your PCP for specialist care. If you and your PCP make the decision for you to see a plan specialist, your PCP will coordinate your care, and you can make your own appointment. Before you see a specialist, you should confirm that the plan specialist is in the Optima Health network. Visit optimahealth.com/members or contact member services at the number on the back of your member ID card to make sure that your specialist is in the network.

What if my plan doctor directs my care to a non-Plan provider?

It is your responsibility to ensure that you are using in-network or plan doctors and facilities. If you have an Optima Vantage (HMO) plan and your plan doctor directs you to a non-Plan provider, you will be responsible for payment of these services. If you have an Optima POS or Optima Plus (PPO) plan, you have the option of using Plan providers or non-Plan providers. Claims from non-Plan providers will be paid at a reduced benefit level and you will usually pay a higher deductible, copayment, and/or coinsurance amount. You may also be balance billed for any charges in excess of the Plan's allowable charges. Information on balance billing is located in The Fine Print section of this guide. To find a Plan provider, use the Find a Doctor or Find a Facility search feature or download a Provider Directory from optimahealth.com/members or the Optima Health mobile app. You may also contact member services at the number on the back of your member ID card.

Specialist Care, continued

Is my Plan specialist authorized to order diagnostic or X-ray tests for me?

Yes. However, some tests may require pre-authorization by the Plan.

Do I need a referral for my annual GYN exam?

No. Your Plan does not require referrals. Members may schedule an appointment for a routine annual exam with any OB/GYN in the Optima Health network.

Can an obstetrician (OB) serve as PCP while I am pregnant?

Yes. During your pregnancy, your OB can serve as your PCP. As a Plan member, you are automatically eligible for the Optima Health Partners in Pregnancy program. This program is designed to provide education and support to pregnant women. If you would like more information about the program, please call 1-866-239-0618, option 1.

Who is responsible for making sure the Plan providers I see and the services I receive are covered under my health plan?

It is up to you to know which doctors and medical facilities are Optima Health providers. To confirm Plan participation, use the Find a Doctor feature on optimahealth.com/members or the Optima Health mobile app, download a Provider Directory from optimahealth.com/members, or call member services at the number on the back of your member ID card.

Remember, while you do not need a referral to seek care, you do need to ensure that you are seeing a Plan provider. If you have an Optima Vantage plan and you seek care from a non-Plan provider, you will be responsible for payment of those services. If you have an Optima POS or Optima Plus (PPO) plan, you have the option of using Plan providers or non-Plan providers.

Member Services

When do I receive my member ID card?

You should receive your card(s) in the mail within 10 days of your plan effective date, depending on when you enroll. You can also view, download, and print a temporary card when you sign in to optimahealth.com/members and create an account, or download the Optima Health mobile app. If you do not receive your member ID card, please contact your group benefits administrator.

Frequently Asked Questions

Member Services, continued

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 at TTY 711 or 1-800-828-1140. Members who are non-English speaking can connect to a language interpretation service by calling 1-855-687- 6260. Additionally, members may request documents that contain benefit, plan, premium, and appeals information in languages other than English. If you need assistance with any accommodations in accessing healthcare, contact member services at the number on the back of your member ID card.

Who can make changes or update my membership information?

No one can make changes 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.

Member Services, continued

How can I ensure my enrollment in the health plan is processed in a timely manner?

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 incomplete or if you have failed to complete the coordination of benefits section, this may delay processing your enrollment and your effective date of coverage.

Do I have to present any additional information to have my application processed?

You may need to provide additional information if you have dependents with a last name different from your own, you may need to produce legal documentation to support your relationship (e.g. birth certificate, marriage certificate, court order, adoption papers), or if you have dependents that exceed the maximum dependent age, you will be asked to provide current documentation to support their disabled status. Contact member services to see if dependents 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 for all individuals, including children, to comply with federal law related to coordination of benefits. If you do not have a SSN 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?

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.

24/7 Nurse Advice Line

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 24/7 Nurse Advice Line number **located on the back of your member ID card.**

24/7 Nurse Advice Line, continued

When you call the 24/7 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 24/7 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.

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 resulting in severe symptoms or pain that an average person with 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

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

Emergency Care, continued

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?

If you are experiencing a life threatening emergency, you do not need to call Optima Health or your PCP, you can proceed to nearest Emergency Room. If you are unsure whether to visit an emergency department or urgent care center, you can call your PCP office or the Optima Health 24/7 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 non-emergencies 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, continued

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 24/7 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 24/7 Nurse Advice Line at the number on the back 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.

Pre-Authorization

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, when it is required. Patient service coordinators, as well as licensed medical professionals such as RNs, LPNs, social workers, and medical doctors perform the process of pre-authorization by the plan.

Pre-Authorization, continued

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, chemotherapy and radiation therapies, and scheduled ambulance transportation.

When you use 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 Medical Pre-Authorization 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.

Do I need services pre-authorized if I have primary coverage under another health plan?

Your provider must still call the plan to verify pre-authorization requirements even if you have primary coverage under another insurance plan and have Optima Health as secondary insurance.

Pre-Authorization, continued

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, sign in at optimahealth.com/members or the Optima Health mobile app, 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.

Utilization Management

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
- concurrent review or request for an extension of previously approved services including: hospitalization, skilled nursing facility stays, therapies, rehabilitation, home health, and durable medical equipment
- retrospective review
- case management

Utilization Management, continued

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 Optima Health Quality Improvement Program provides 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 within the scope of the health plan. Several committees within the organization work on quality improvement (QI) issues, which 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 is 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

Uniform Summary of Benefits and Coverage (SBC)

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 1-800-229-1199. 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 1-800-229-1199 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750/Individual or $1,500/family in-network. $1,000/individual or $2,000 family out-of-network	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.
Are there services covered before you meet your deductible?	Prescription drugs; and preventive care, vision, and materials are covered before you meet your deductible.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers $4,000 individual / $8,000 family. For out-of-network providers, $6,500 individual / $13,000 family	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See optimahealth.com or call 1-800-229-1199 for a list of network providers.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment Deductible does not apply	40% coinsurance	--none--
	Specialist visit	$50 copayment Deductible does not apply	40% coinsurance	--none--
	Preventive care/screening/ immunization	No charge Deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	Pre-Authorization required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Express Scripts, phone 1-877-476-9269 or www.express-scripts.com	Generic drugs	$10 copayment retail/$25 copayment mail order	$10 copayment retail/$25 copayment mail order	Coverage is limited to FDA approved prescription drugs. For specialty drugs, the out-of-pocket amount is limited to $250 Copayment per retail prescription. If brand drugs are chosen by you when a generic is available, you must pay the difference in cost plus the copayment or coinsurance amount. One copayment covers up to a 31-day supply (retail); 31-90 day supply (mail order).
	Preferred drugs (brand or generic)	$30 copayment retail/$75 copayment mail order	$30 copayment retail/$75 copayment mail order	
	Non-Preferred drugs (brand or generic)	$50 copayment retail/ $125 copayment mail order	$50 copayment retail/ $125 copayment mail order	
	Specialty drugs	20% coinsurance retail/ mail order	20% coinsurance retail/ mail order	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	Pre-Authorization required
	Physician/surgeon fees	15% coinsurance	40% coinsurance	--none--
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	--none--
	Emergency medical transportation	Non-emergency services: $100 copayment Emergency services: $100 copayment	Non-emergency services: 40% coinsurance Emergency services: $100 copayment	Pre-authorization required for non-emergency transport.

* For more information about limitations and exceptions, see the plan or policy document at optimahealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$50 copayment Deductible does not apply	40% coinsurance	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Pre-Authorization required
	Physician/surgeon fees	15% coinsurance	40% coinsurance	--none--
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment Deductible does not apply	40% coinsurance	Pre-Authorization required for intensive outpatient program, partial hospitalization services, electroconvulsive therapy, and Transcranial Magnetic Stimulation.
	Inpatient services	15% coinsurance	40% coinsurance	Pre-Authorization required for all inpatient services.
	Emergency Services (Ambulance and ER)	15% coinsurance	15% coinsurance	--none--
If you are pregnant	Office visits	$350 global copayment	40% coinsurance	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).
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	$25 copayment Deductible does not apply	40% coinsurance	Pre-Authorization required. 100 visits/plan year
	Rehabilitation services	15% coinsurance	40% coinsurance	Pre-Authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST
	Habilitation services	Not covered	Not covered	--none--
	Skilled nursing care	15% coinsurance	40% coinsurance	Pre-Authorization required. 90 days/plan year
	Durable medical equipment	30% coinsurance	40% coinsurance	Pre-Authorization required for single items over $750, all rental items, and repair and replacement.
	Hospice services	No charge	40% coinsurance	Pre-Authorization required.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	$30 reimbursement Deductible does not apply	Coverage limited to one exam/plan year from participating VSP Vision Care providers
	Children's glasses	Not covered	Not covered	--none--
	Children's dental check-up	Not covered	Not covered	--none--

* For more information about limitations and exceptions, see the plan or policy document at optimahealth.com.

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
- Habilitation services
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Private-duty nursing
- Routine foot care unless medically necessary
- 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
- Hearing aids
- Non-emergency care when traveling outside the U.S. (under out-of-network benefit)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-800-229-1199. 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/ebsa/healthreform; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.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.

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.

Additionally, a consumer assistance program can help you file your appeal. Contact 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 plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

* For more information about limitations and exceptions, see the plan or policy document at optimahealth.com.

Does this plan meet the Minimum Value Standards? **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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-687-6260.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-687-6260.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-687-6260.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-687-6260.

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

* For more information about limitations and exceptions, see the plan or policy document at optimahealth.com.

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$750**
Specialist copayment	**$350**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,610**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,270**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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: 1-877-817-3037.

Benefit Information

4417 Corporation Lane
Virginia Beach, VA 23462

2023 City of Chesapeake Plan Changes

Vendor Changes	We changed some of the vendors we partner with including: • our vision services vendor from EyeMed to VSP Vision Care (VSP)
Benefit Changes	The **Ambulance Services** benefit has been separated into **Non-Emergent Ambulance Services** and **Emergency Ambulance Services**, which may have different cost shares depending on the plan. Non-Emergent Ambulance Services will continue to require pre-authorization. Non-emergent ambulance related to mental health diagnoses will be covered as **Other Outpatient Services** under the **Mental Health and Substance Use Disorder Services** benefit.
	Virtual Consults for mental health/behavioral health services will be covered as **Outpatient Office Visits** under the **Mental Health and Substance Use Disorder Services** benefit at a separate cost share.

Language Changes	The following updates have been made under the **Mental Health and Substance Use Disorder Services** section: • Separate rows for **Residential Treatment Services** and **Partial Hospitalization/Intensive Outpatient Program Facility Services** have been added. • **Autism Spectrum Disorder** has been moved to this section. • The separate row for Virtual Consults has been removed under this section.
	Additional language **Mental Health and Substance Use Disorder Services** updates include: • **Outpatient Office Visits** has been updated to read **Outpatient Office Visits (PCP, Specialist or Virtual Consults)**. • **Other Outpatient Visits (Facility/Freestanding Centers)** has been updated to read **Other Outpatient Services**. • **Inpatient Services** has been updated to read **Inpatient Hospital Services**.
	Language has been added to the following sections in the Benefit Summary to refer members to the updated **Mental Health and Substance Use Disorder Services** benefit. For treatment of mental health conditions or substance use disorder, cost sharing will follow the Other Outpatient Services cost sharing listed under Mental Health and Substance Use Disorder Services. These sections include: • **Physician Office Visits** • **Outpatient Therapies and Services – visit limits do not apply** • **Outpatient Lab, Diagnostic Procedures, Imaging and Testing** • **Outpatient Advanced Imaging, Testing and Scans** • **Non-Emergent Ambulance Services** • **Urgent Care Services**

Optima POS 750/25/15%
City of Chesapeake
Plan Effective Date: 01/01/2023

Sentara Health Plans, Inc.
Large Group Benefit Summary

This Benefit Summary is not a contract or health plan policy from Optima Health. If there are any differences between this document and the Optima Health coverage documents issued when You are enrolled, the provisions of the coverage documents will prevail for all benefits, conditions, cost sharing, and limitations and exclusions.

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. There are two benefit columns. One column lists cost sharing amounts You will pay for In-Network benefits from Plan Providers. The other column lists cost sharing amounts You will pay for Out-of-Network benefits from Non-Plan Providers. You or Your means the Subscriber and each family member who is a Covered Person under the Plan. Details about Covered Services are in the section "What is Covered." Details about services and treatments that are not covered are in the section "What is Not Covered."

Some benefits require Pre-Authorization before You receive them. These services are marked with an * in this document.

Some Covered Services may have visit limits. Once a visit limit is reached, no additional services are covered under the benefit. If a service is shown as covered under Out-of-Network benefits visit limits are combined with In-Network and Out-of-Network benefits unless otherwise stated.

Services or treatment You receive Out-of-Network or from Non-Plan Providers will be covered under the Plan's Out-of-Network benefits unless:

1. The Covered Service is an Emergency Service;
2. During treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

If Your Plan has a Deductible that is the dollar amount that must be paid out-of-pocket by a Member for Covered Services each year before the Plan begins to pay for benefits. Your Plan may have separate Deductibles for In-Network and Out-of-Network benefits.

Copayments and Coinsurances listed in this document are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan's Allowable Charge for Your Covered Service. You will pay a Copayment or a Coinsurance, but not both, for a Covered Service. For some benefits you may see the statement, "Cost sharing determined by the type and place of service." For these services Your cost sharing will be based on where You receive a service, for example in a physician office or inpatient setting, and/or the type of service. You may also have to pay for balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers.

Your Plan's Maximum Out-of-Pocket Amount means the total dollar amount Members pay, or that are paid on their behalf, out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the Maximum Amount. Your Plan may have separate Maximum Amounts for In-Network and Out-of-Network benefits.

Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Plan Year	$750/Individual; $1,500/Family	$1,000/Individual; $2,000/Family

The In-Network and Out-of-Network Deductibles are separate. Most amounts You pay for In-Network Covered Services will count toward meeting the In-Network Deductible. Most amounts You pay for Out-of-Network Covered Services will count toward meeting the Out-of-Network Deductible.
The Deductible applies to all Covered Services except for:

- In-Network Preventive Care Services required by law;
- Other services in this document shown as Covered without a Deductible.

If You are the Subscriber, and the only Member Covered under Your Plan, the Individual Deductible amount applies. If You have other Family Members on Your Plan the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one Family Member meets the Individual Deductible his or her benefits will begin. Once the total Family coverage Deductible is met benefits are available for all family Members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a Member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible.
Any amounts applied to the Plan Deductible(s) during the last three months of the Plan year can be carried forward to the next year.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Maximum Out of Pocket Plan Year	$4,000/Individual; $8,000/Family	$6,500/Individual; $13,000/Family

The In-Network and the Out-of-Network Maximum Out-of-Pocket Amounts are separate. Most amounts You pay, or that are paid on Your behalf, for In-Network Covered Services will count toward meeting the In-Network Maximum. Most amounts You pay, or that are paid on Your behalf, for Covered Services Out-of-Network will count toward meeting the Out-of-Network Maximum.

The following will not count toward any Plan Maximum Amount:

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- Except for Emergency Services, amounts You pay for Out-of-Network Services;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Other services in this document that are shown as excluded from the Maximum Amount.

If You are the Subscriber, and the only Member covered under Your Plan, the Individual Maximum applies. If You have other Family Members on Your Plan the Family Maximum applies. Under Family coverage, the Individual Maximum applies separately to each Covered Family Member. Once the total Family Coverage Maximum is met the Family Maximum Amount is satisfied. No one Member can contribute more than their Individual Maximum Amount to the Family limit.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Optima Health approved providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	You Pay $25	After Deductible You Pay 40%
Virtual Consult	No Charge	Not Covered
Specialist Visit	You Pay $50	After Deductible You Pay 40%
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.	After Deductible You Pay 50%	After Deductible You Pay 50%
Preventive Care Recommended Preventive Care Services are covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/		
Recommended exams, screenings, tests, immunizations, and other services	No Charge	After Deductible You Pay 40%
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for 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. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Speech Therapy* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Cardiac Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Vascular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network	Out-of-Network
Vestibular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
IV Infusion Therapy	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 15%	After Deductible You Pay 40%
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 15%	After Deductible You Pay 40%
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 15%	After Deductible You Pay 40%
Radiation Therapy*	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 15%	After Deductible You Pay 40%
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 15%	After Deductible You Pay 40%
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.		
Dialysis Services	After Deductible You Pay 15%	After Deductible You Pay 40%
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free standing ambulatory surgery center or Hospital outpatient surgical facility.		
Surgery Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient facility or lab or a Hospital outpatient facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Diagnostic Procedures	After Deductible You Pay 15%	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network	Out-of-Network
X-Ray Ultrasound Doppler Studies	After Deductible You Pay 15%	After Deductible You Pay 40%
Lab Work	After Deductible You Pay 15%	After Deductible You Pay 40%
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a free-standing outpatient facility or a Hospital outpatient facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Magnetic Resonance Imaging (MRI)* Magnetic Resonance Angiography (MRA)* Positron Emission Tomography (PET)* Computerized Axial Tomography (CT)* Computerized Axial Tomography Angiogram (CTA)* Magnetic Resonance Spectroscopy (MRS) Single Photon Emission Computed Tomography (SPECT) Nuclear Cardiology Sleep Studies*	After Deductible You Pay 15%	After Deductible You Pay 40%
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.		
Maternity Care *Pre-Authorization is required for prenatal services	You Pay $350 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 40%
Inpatient Services		
Inpatient Hospital Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Transplants*	After Deductible You Pay 15%	After Deductible You Pay 40%
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Non-Emergent Ambulance Services Includes Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Air, Water, Ground Services Non-Emergent Transportation *Pre-Authorization is required for non-emergency transportation.	After Deductible You Pay $100	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Emergency Services Includes Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including an independent freestanding Emergency Department, In-Network or Out-of-Network.		
Emergency Services	After Deductible You Pay 15%	After Deductible You Pay 15%
Emergency Ambulance	After Deductible You Pay $100	After Deductible You Pay $100
Urgent Care Services 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 the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	You Pay $50	After Deductible You Pay 40%
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Optima Health providers. ***Pre-Authorization is required for Inpatient Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**		
Emergency Ambulance	After Deductible You Pay 15%	After Deductible You Pay 15%
Emergency Services	After Deductible You Pay 15%	After Deductible You Pay 15%
Inpatient Hospital Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Residential Treatment Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Outpatient Office Visits (PCP, Specialist or Virtual Consults)	You Pay $25	After Deductible You Pay 40%
Partial Hospitalization / Intensive Outpatient Program Facility Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Other Outpatient Services*	You Pay $25	After Deductible You Pay 40%
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is covered from an In-Network Plan Provider or a participating Vision Services Plan (VSP) provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps*	No Charge	After Deductible You Pay 40%
Pump Infusion Sets and Supplies*	No Charge	After Deductible You Pay 40%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors, and control solution, and continuous glucose monitors, sensors, and supplies. ***Pre-Authorization is required for talking blood glucose monitors**	No Charge	After Deductible You Pay 40%
Insulin, and Needles, and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network	Out-of-Network
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	After Deductible You Pay 40%
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible You Pay 30%	After Deductible You Pay 40%
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement and rental items.**	After Deductible You Pay 30%	After Deductible You Pay 40%
Early Intervention Services For Dependent children from birth to age three.		
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices. *	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home		
Home Health Care* Limited to a maximum of 100 visits per Plan year.	You Pay $25	After Deductible You Pay 40%
Hospice Care		
Hospice Care*	After Deductible No Charge	After Deductible You Pay 40%
Vision Care Optima Health contracts with Vision Services Plan (VSP) to administer this benefit. Services must be received from VSP providers.		
Vision Exams Limited to one exam every 12 months from a VSP provider.	No Charge Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.	Members will be reimbursed up to $30 for an eye examination
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing is determined by the type and place of service.	Cost sharing is determined by the type and place of service.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network	Out-of-Network
Clinical Trials Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.		
Clinical Trial Services*	Cost sharing is determined by the type and place of service.	Cost sharing is determined by the type and place of service.
Allergy Care		
Allergy Care, Testing, and Serum	Cost sharing is determined by the type and place of service.	Cost sharing is determined by the type and place of service.
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. 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.		
Telemedicine Services	Cost sharing is determined by the type and place of service.	Cost sharing is determined by the type and place of service.
Wigs Reimbursement for wigs in conjunction with chemotherapy	After Deductible Coverage is limited to a maximum benefit of $250 once every 12 months.	

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network	Out-of-Network
Chiropractic Care Rider Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit.		
Chiropractic Care Rider ***Pre-Authorization is required by ASH for all Chiropractic services.** Maximum number of visits 20 per Calendar year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Calendar year when medically necessary.	After Deductible You Pay $20	After Deductible You Pay 40%
Hearing Aid Rider		
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $2,500 per ear: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 36 months from date of acquisition. Batteries and supplies are not covered.	After Deductible You Pay $50	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of month they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health 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.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Behavioral Health Information

Behavioral Health Information

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 your primary care physician
- 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 Summary 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 sServices at the number on the back of their member ID card or visit 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.

Other Health Insurance Information

Other Health Insurance Information

Health and Preventive Services

Overview

Optima Health department of Health and Preventive Services 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 and 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 habits, 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 Daily Habits. This online coaching program delivers a personalized, interactive, and motivational experience to help members take action and sustain healthy habits in a fun way. Optima Health also provides telephonic disease management coaching for coronary heart disease, heart failure, diabetes, respiratory conditions, and weight management.

Healthy Publications

Members can visit optimahealth.kramesonline.com/ for valuable information about health improvement, disease and condition management, and preventive healthcare. Members can also visit WebMD® Health Services to learn about specific health topics, recipes, request newsletters and other health resources. Access WebMD Health Services by completing your personal health assessment on optimahealth.com.

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. These 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 age 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.

Health and Preventive Services, continued

- Cervical cancer screening reminders: Women age 24 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 Test 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)
  3. a paid subscription to one of four parenting magazines of her choice
- Immunization postcards: 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.

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.

The MoveAbout Program is designed to assist members in their journey to become more active and stay healthy. Learn about different types of physical activity and ways to move throughout the day to achieve a goal of 150 minutes of moderate activity each week.

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

Other Health Insurance Information

Gym Network 360 Discount Program

Optima Health members have access to premier fitness, weight loss, and wellness brands at discounted pricing with Gym Network 360.

The Best Fitness Brands at the Best Prices

Gym Network 360, from Optima Health and GlobalFit, offers members great fitness brands at great prices, along with the education, resources, and tools to engage and motivate members to become more active and adopt healthier behaviors.

Exercise

Members enjoy savings of 5–20% off retail rates of over 6,000 fitness facilities and programs designed to engage at all fitness levels.

- Top brands include Anytime Fitness, Curves, Gold's Gym, LA Fitness, and more.
- Regional and specialty studio options include CrossFit, cycling, kickboxing, yoga, and more.
- Virtual fitness options include Group Fitness On Demand powered by Les Mills.

Eating

Members enjoy exclusive rates on top-ranked nutrition, weight loss, and healthy eating programs.

- Variety of meal plans include fresh prepared meals, and diet delivery options.
- Discounts on top brands such as Jenny Craig, Diet-to-Go, and Kurbo.
- Discounts on vitamins, supplements, and other healthy food products.

Education

Gym Network 360 provides wellness tools and resources to support and motivate members through their wellness journey all year long, including monthly promotions for additional savings.

How to Receive Services

Look for the Gym Network 360 name on the Health and Wellness Discounts page at optimahealth.com/members or the Optima Health mobile app. Members will be prompted to sign in (or first register* for their secure account) for more information. After sign in, members may choose to visit the Optima Health GlobalFit shopping platform to browse for services and activate their discount. GlobalFit Customer Service representatives are available by phone at 1-800-294-1500, Monday–Friday 8:30 a.m.–5:30 p.m. EST.

* If you have not yet registered for your secure account, visit optimahealth.com/register or download and register on the Optima Health mobile app.

Other Health Insurance Information

Complementary Alternative Medicine Discount Program (CAM)

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 healthcare provider from the Plan's website at optimahealth.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 CAM 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 1-877-327-2746 or refer to the Plan's website at optimahealth.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.

Other Health Insurance Information

Staying Healthy

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		
Adults	18+	Yearly
Infants and Children	Under 3	Ages 2-5 days; and 1, 2, 4, 6, 9, 12, 15, 18, and 24 months
Children and Teens	3-18	Yearly

Children's Immunization Schedule

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

	Optima Health Covered Immunizations	Recommended Immunizations (check your plan documents to verify coverage)
Birth	Hepatitis B	Rotavirus
2 Months	Diphtheria/Tetanus/Pertussis Poliovirus Haemophilus influenza type b Hepatitis B Pneumococcal conjugate	Rotavirus
4 Months	Diphtheria/Tetanus/Pertussis Poliovirus Haemophilus influenza type b Pneumococcal conjugate	Rotavirus
6 Months	Diphtheria/Tetanus/Pertussis Poliovirus Haemophilus influenza type b Hepatitis B Pneumococcal conjugate Influenza Yearly	Rotavirus
12–18 Months	Diphtheria/Tetanus/Pertussis Measles/Mumps/Rubella Poliovirus Haemophilus influenza type b Hepatitis B Varicella zoster virus Pneumococcal conjugate Influenza Yearly	Hepatitis A
4–6 Years	Diphtheria/Tetanus/Pertussis Poliovirus Measles/Mumps/Rubella Influenza Yearly	Varicella
11–18 Years	Tetanus/Diphtheria (Repeat every 10 years through life) If your child was unable to receive all immunizations listed above, your doctor may complete immunizations during this time. Measles/Mumps/Rubella Poliovirus (if child has not received second dose) Influenza yearly Meningococcoal (Meningitis) Talk with your doctor about when this immunization is needed HPV (2–3 doses, depending on age at initial vaccination)	

NOTE: 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 2022 Clinical Guidelines*
- *CDC Recommended Childhood and Adolescent Immunization Schedule 2021 and CDC Recommended Adult Immunization Schedule 2022*

Other Health Insurance Information

Preventive Screening Reminders

Screening	Recommendations
Adult Immunizations	
Influenza (Flu Shot)	Annually
Tetanus, Diptheria, Pertussis (Td/Tdap)	First dose by age 18, then every 10 years—discuss options with your physician
Pneumonia Shot	Complete at age 65 or per your physician's recommendation
Colorectal Screening*	
Colonoscopy, or	Complete by age 45 and then every 10 years
Sigmoidoscopy, or	Complete by age 45 and then every 5 years
Fecal Occult Blood Test	Complete by age 45 and then yearly
Early Cancer Detection - Female*	
Pap Test	Start by age 24 and then retest per your physician's recommendation
Clinical Breast Exam	Complete per your physician's recommendation
Mammogram	Start by age 45 and then retest per your physician's recommendation
Early Cancer Detection - Male*	
Digital Rectal Exam	Start by age 50 (age 40 for those at risk) then yearly
PSA (prostate-specific antigen)	Complete per your physician's recommendation

Visit wellnessforme.com for important information about 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 2022.

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 ages 50–59 with risk of cardiovascular disease
Cholesterol screening: regular screening for adults ages 45–75, selective screenings for adults ages 76-85
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 and physical activity counseling: adults with cardiovascular disease risk factors
Hepatitis B screening: adults at increased risk
Hepatitis C virus infection screening: adults ages 18–79
HIV pre-exposure prophylaxis (PrEP)
HIV screening
Hypertension screening: adults ages 18 or older without known hypertension
Immunization vaccines:
Hepatitis A
Hepatitis B
Herpes Zoster
Human Papillomavirus
Influenza
Measles, Mumps, Rubella
Meningococcal
Pneumococcal
Tetanus, Diphtheria, Pertussis
Varicella
Lung Cancer Screening: adults ages 50–80 with 20 pack-year smoking history and currently smoke or who have quit within the past 15 years
Male Condoms
Prediabetes and type 2 diabetes screening: asymptomatic adults 35-70 who are overweight or obese

Under the Affordable Care Act, certain preventive services and medications are covered at no cost to the member[1] when administered by an in-network plan physician or pharmacy.

Statin medications[2]: adults ages 40–75 with no history of cardiovascular disease who have one or more risk factors and calculated 10-year risk
STI counseling: adults at increased risk
Syphilis screening
Tobacco use counseling, generic and over-the -counter medications, and cessation interventions
Tuberculosis screening
Unhealthy drug use: adults ages 18 and older

Covered Preventive Services for Women, Including Pregnant Persons

Anemia screening: pregnant women
Asprin use: after 12 weeks of gestation in women who are at high risk for preeclampsia
Bacteriuria screening
Behavioral health counseling for healthy weight and weight gain in pregnancy
BRCA risk assessment and genetic counseling/screening
Breast cancer chemoprevention counseling
Breast cancer preventive medication[2]
Breast cancer screening: women over age 40
Breast feeding support and counseling
Cervical cancer screening
Chlamydia infection screening
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% coverage. Please visit optimahealth.com to determine member cost share for brand name oral contraceptives.

[1]An office visit copayment may be charged to health plan members for some services.
[2]Select medications only are covered at no cost to the member. Please contact member services or pharmacy services at the number on the back of your member ID card for more information.

Other Health Insurance Information

Covered Preventive Services for Women, Including Pregnant Persons (continued)

Decision making/sharing by clinicians with women at increased risk for breast cancer
Depression screening
Double electric breast pumps, parts, and milk storage supplies
Folic acid supplementation
Gestational diabetes screening: asymptomatic pregnant persons at 24 weeks of gestation or after
Gonorrhea screening
Hepatitis B screening at first prenatal visit
HIV screening: pregnant persons
HPV Test
Intimate partner violence screening and counseling
Lactation support and counseling
Osteoporosis screening: postmenopausal women younger than 65 at increased risk, and women over 65 or at high risk
Perinatal depression counseling and interventions
Preeclampsia screening and prevention
Rh incompatibility screening: first pregnancy visit and between 24 and 28 weeks gestation
Syphilis screening
Weight and nutrition counseling: women ages 40-60
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
Cardiac disease screening: at-risk children and adolescents ages 11-21
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
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: ages newborn-21
Hepatitis C virus infection screening: adolescents
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 is fluoride deficient
Oral health risk assessment
Phenylketonuria (PKU) screening: newborns
Skin cancer behavioral counseling: children, adolescents and young adults ages 10-24 years old
STI prevention counseling and screening: for all sexually active adolescents
Suicide risk screening: ages 12-21
Tobacco use interventions: school-aged children and adolescents
Tuberculin testing for children at higher risk of tuberculosis
Visual acuity screening

Other Health Insurance Information

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[1]:

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.

[1]Please see your provider for information on receiving the flu or pneumonia vaccine.

Other Health Insurance Information

Preventive Vision Care

Optima Health contracts with VSP to administer the preventive vision services benefit. Each member is eligible to receive a routine eye examination, refraction, and prescription eyeglass lenses once every 12 months from an VSP Provider.

The member is responsible for all applicable copayments, coinsurances, and any deductibles depending on the type and place of services as listed on the Plan's Benefit Summary.

Members should refer to Plan documents for Plan copayments, coinsurances, deductibles and maximum out-of-pocket amounts, in addition to coverage exclusions and limitations.

To receive covered services

- Select a participating VSP provider from the Plan's provider directory or by calling 1-800-877-7195.
- Automated location information is available 24 hours a day. VSP Customer Service representatives are available Monday through Saturday, from 9:00 a.m. to 8:00 p.m. ET.
- When you visit or call the Plan provider, have your member ID card handy. They will verify eligibility, your Plan's covered services, and any applicable copayment or coinsurance using the information on your member. Payment is due when you receive services.
- If the vision provider determines that you need additional medical care, you should contact your primary care physician or other Plan physician for treatment options.

Out-of-Network coverage

If you visit a non-Plan provider for an examination, you will be responsible for paying the provider in full at the time services are rendered. For covered services, members will be reimbursed according to the out-of-network benefit on the Benefit Summary.

For reimbursement, please call VSP Customer Service at 1-800-877-7195 to verify eligibility and request an Out-of-Network Claim Form. You will need itemized receipts that indicate patient name and date of service, services provided, and the amount charged for each service.

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 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.

Other Health Insurance Information

VSP® EMPLOYER GROUP SAVINGS PASS

The VSP Employer Group Savings Plan offers additional savings through discounts and guaranteed pricing on lenses, in addition to your Plan benefits and services.

Save up to $3,000

With Exclusive Member Extras, members can save more than $3,000 with special offers and deals from VSP and other leading industry brands.

Get up to $250 back

Members can save big with VSP exclusive mail-in rebates on eligible popular contact lens brands like Bausch + Lomb.

$1,000 savings on LASIK

Members can save up to $1,000 on LASIK at Lasik***Plus*** NVISION Eye Centers, TLC Laser Eye Centers and The LASIK Vision Institute.

LEARN MORE. VISIT VSP.COM/OFFERS

Discounts through a VSP Choice Network Provider

Lenses

Lenses covered in full (after copayment) with the purchase of a complete pair of glasses

Single vision	$40	Lined trifocal	$75
Lined bifocal	$60	Lenticular	$75

Lens Enhancements

All popular lens enhancements are covered after copayment, saving our members an average of 30%

Lens Enhancement	*Single Vision*	*Multifocal*
Anti-glare coating	$41	$41
Polycarbonate – Children	No cost	No cost
Polycarbonate – Adult	$31	$35
Progressive	N/A	$55
Photochromic	$75	$75
Scratch-resistant coating	$17	$17

Prices above reflect standard lens enhancement selections; premium or custom lens enhancements may also be available at an additional cost.

Frame

- 25% off the retail frame cost with the purchase of a complete pair of glasses

Sunglasses

- **Within 12 months of exam:** 20% off unlimited additional pairs of non-prescription sunglasses from any VSP doctor

Elective Contact Lenses

- **Contact lens exam (fitting and evaluation):** Member receives 15% off contact lens exam services

VSP Laser VisionCare℠ Program

- Discounts average 15–20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, Custom LASIK, and Custom Bladeless LASIK

Discounts are only available from VSP-contracted facilities. Also custom LASIK coverage only available using wavefront technology with the microkeratome surgical device, other LASIK procedures may be performed at an additional cost to the member.

Other Information

Disclaimers and Exclusions

Based on applicable laws, benefits and savings may vary by doctor location. Promotions like special offers and rebates are continually evaluated and subject to change without notice.

The following items are not covered under this plan: two pairs of glasses instead of bifocals; replacement of lenses, frames, or contacts; medical or surgical treatment; orthoptics; vision training or supplemental testing.

The following items are not covered as contact lens benefits: insurance policies or service agreements; Refitting of contact lenses after the initial (90-day) fitting period, artistically painted or non-prescription lenses; additional lens pathology; contact lens modification, polishing or cleaning.

Please read your Schedule of Benefits for details regarding the exclusions and limitations of your coverage. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Other Health Insurance Information

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 Benefit Summary.

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 optimahealth.com or call ASH at 1-800-678-9133 Monday–Friday, 8:00 a.m.–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

Chiropractic Care, continued

- 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

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 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.

Additional Resources

Additional Resources

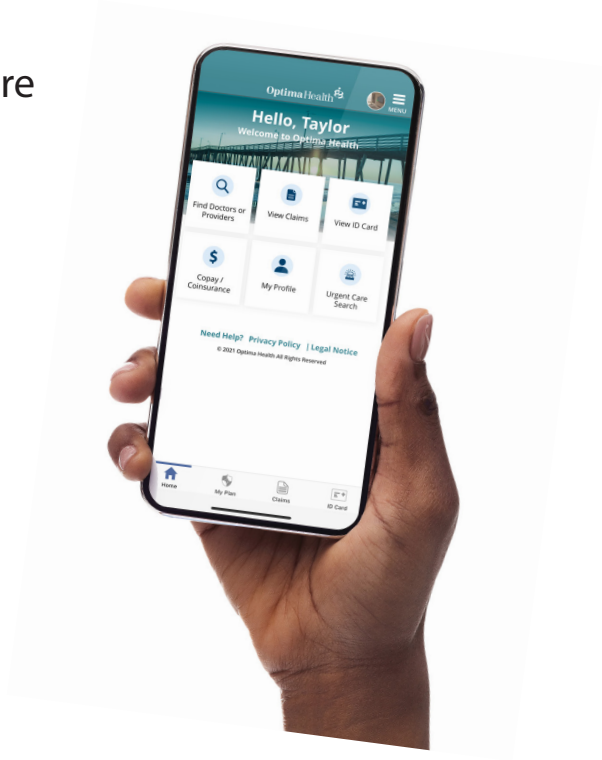
Simplicity at your Fingertips

As you read through the pages of this section, you will learn more about the various tools available to our members. Sign in and register on optimahealth.com/members or the Optima Health mobile app for 24/7/365 access to all your important plan information—when and where you need it.

With a consistent design and functionality for a seamless experience, both the mobile app and the member portal include secure access to deductible and maximum out-of-pocket balances, claims, authorizations, treatment cost estimates, member ID cards, flexible spending accounts[1], and other important health plan information. In addition, members can:

- schedule virtual consults for medical and behavioral health care
- participate in wellness activities and track health progress
- contact member services
- get important preventive care reminders
- search for nearby doctors and hospitals

and much more!



Download on the App Store

GET IT ON Google Play

At Optima Health, we empower our members to stay informed and be involved in their care, so they can get the most from their health plan.

[1] Applies to members with Equity Health Savings Account or Design Health Reimbursement Arrangement plans

Additional Resources

MY**LIFE** MY**PLAN**

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

Make checking in with your Daily Habits part of your regular routine, and you'll have what it takes to create a healthy change and stick with it. Daily Habits, powered by WebMD Health Services, uses goals and activities selected by you to create simple, weekly plans that get you from start to success. During your journey, you'll enjoy an interactive 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
- living with chronic disease
- healthy pregnancy
- back health
- better sleep

Your Daily Habit

Daily Habits are a version of online coaching that creatively engage you to improve your overall health and wellness with personal calls to action to help you form healthy habits and achieve your goals. There are 19 daily habits to choose from. Address the habit that makes sense for you in your personal health improvement journey.

Ready—Access Daily Habits

Daily Habit activities are customized to you, your health plan, and your wellness program. Access using the Optima Health website:

- sign in at optimahealth.com/member
- select Wellness Tools from the menu on the left side of the screen to navigate to your personalized WebMD wellness home page

For more information, visit
optimahealth.com/mylifemyplan

MY**LIFE** MY**PLAN, continued**

Set—Set Goals with the Daily Habit

Option One - Set a Daily Habit 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 *Daily Habits* page and choose your goal(s)

Option Two - Set a Daily Habit goal without taking the Personal Health Assesement.

- from your personalized WebMD wellness home page, select the *Daily Habits* tab at the top of the page
- land on the "To Do" tab where you can select which wellness journey you would like to start

Choose one or more of the following Daily Habits that will encourage you to eat better, move more, lose weight, sleep better, feel happier, manage chronic disease and quit tobacco.

Success—Acheive Goals with the Daily Habits

Once you have selected your Daily Habit you are ready to begin tracking your progress. Record your daily activities following these easy steps:

- sign in at optimahealth.com/mylifemyplan and select *Wellness Tools* from the menu
- from your personalized WebMD wellness home page, select the *Daily Habits* tab at the top of the

Additional Resources

Virtual Consults | Exceptional Care, Anywhere.

With virtual consults, accessible through optimahealth.com and the mobile app, you can visit with a doctor 24/7 from your home, office or on the go. Our team of board-certified doctors is available by phone or secure video to assist with non-emergency medical conditions.

Who are our doctors?

The virtual consult team has the nation's largest network of telehealth doctors. On average, our doctors have 15 years of experience practicing medicine and are licensed in the state where patients are located. Their specialties include primary care, pediatrics, emergency medicine, and family medicine. Our doctors are committed to providing convenient, quality care and are always ready to take your call.

When should I use Virtual Consults?

- for non-emergency issues that do not require a trip to the ER or an urgent care center
- during or after normal business hours, nights, weekends, and even holidays
- if your primary care doctor is not available
- if you need to request prescription refills (when appropriate)
- if you are traveling and in need of medical care

Common Conditions We Treat

- allergies
- asthma
- bronchitis
- cold and flu
- diarrhea
- ear aches
- fever
- headache
- infections
- insect bites
- joint aches
- rashes
- respiratory infections
- sinus infections
- skin infections
- sore throat
- urinary tract infections
- and more!

24/7/365 on-demand access to affordable, quality healthcare. Anytime, Anywhere.

Additional Resources

Virtual Consults, continued

How much does it cost?

You are able to take advantage of virtual appointments for the cost of a primary care physician visit or as noted in your benefit documents.

Are my children eligible?

Yes. We have pediatricians on call 24/7/365. Please note, a parent or guardian must be present during any interactions involving minors. We ask parents to establish a child record under their account. Parents must be present on each call for children 18 or younger.

Pediatric Care

- cold and flu
- constipation
- ear aches
- nausea
- pink eye
- and more!

Register now!

Call 1-866-648-3638 or sign in at optimahealth.com and select Virtual Consult.

Disclaimers: Virtual consults does not replace the primary care physician. Virtual consult is not an insurance product nor a prescription fulfillment warehouse. virtual consult operates subject to state regulation and may not be available in certain states. Virtual consult does not guarantee that a prescription will be written. virtual consult does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. virtual consult physicians reserve the right to deny care for potential misuse of services. virtual consult phone consultations are available 24/7/365, while video consultations are available during the hours of 7:00 a.m. – 9:00 p.m. EST, seven days a week or by scheduled availability.

Treatment Cost Calculator

BETTER INFORMATION — BETTER DECISIONS — BETTER HEALTH

View estimates on over 500 procedures and services in your area, based on your specific benefit plan information

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

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

Sign in at optimahealth.com or the Optima Health mobile app to calculate treatment costs

- search or browse for a procedure/service or local healthcare provider
- explore your options, view cost-saving tips, and additional guidance on technical healthcare information relevant to your search
- view out-of-pocket estimates[1] 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

1 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.

Additional Resources

Epic Hearing Healthcare

How it Works:

1. go to listenhearlivewell.com and register with your name and email address
2. complete the four 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

listenhear@epichearing.com

• • • • • •

www.listenhearlivewell.com

Additional Resources

Epic Hearing Service Plan

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 three-year product warranty and one year supply of batteries[1].

Plan Perks

- savings on hearing exams and hearing aid devices
- access to the largest nationwide network of audiologist and ENT physicians
- pricing 30%–60% below MSRP on name brand products
- money-back trail periods
- extended warranties & batteries with purchase

Level of Hearing Aid Technology	Degree of Hearing Loss	Typical MSRP	EPIC Pricing
Basic	Mild to Moderate	$1,400-$1,600	$495
Standard	Moderate	$1,601-$2,300	$849-$1,499
Advanced	Moderate to Severe	$2,301-$3,000	$1,500-$2,099
Premium	Moderate to Severe	$3,001-$4,000	$2,100-$2,500

Contact EPIC today to start the process to better hearing

1-866-956-5400 | hear@epichearing.com | www.epichearing.com

[1]Excludes Basic Level Products

Additional Resources

Emergency Travel Assistance Provided by Assist America

No matter where you are in the world, you will always get the care you need. 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.

Services

- **Medical Consultation, Evaluation, and Referral:** Calls are evaluated by medical personnel and referred to English-speaking, Western-trained doctors and/or hospitals.
- **Hospital Admission Assistance:** Guaranteed hospital admission outside the U.S. by validating a participant's health coverage or by advancing funds to the hospital.
- **Emergency Medical Evacuation:** Whatever mode of transport, equipment, and personnel necessary is used to evacuate a participant to the nearest facility capable of providing a high standard of care, if not available locally.
- **Medical Monitoring:** Maintain regular communication with the participant's attending physician and/or hospital and relays information to the family.
- **Medical Repatriation:** If continued medical assistance is needed upon discharge from a hospital, participant will be repatriated home or to a rehabilitation facility with a medical or nonmedical escort, as necessary.

- **Prescription Assistance:** Help in filling replacement prescription(s) while traveling.
- **Compassionate Visit:** Economy, round-trip, common carrier transportation to the place of hospitalization for a designated family member or friend for participants hospitalized for more than seven days.
- **Care of Minor Children:** Arrangement of the care of children left unattended due to medical emergency and payment for any transportation costs involved in such arrangements.
- **Return of Mortal Remains:** Arrangement and payment 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 Operations Center

1-800-872-1414 (inside USA) | **+1-609-986-1234** (outside USA) | Reference Number: **01-AA-OPT-10113**

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.

The Fine Print

Frequently Asked Questions

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 Summary Plan Description (SPD), and a Uniform Summary of Benefits and Coverage (SBC). Your SPD is an important document. Read it carefully to understand what services are covered under your employer's health plan. Your copayments, coinsurances, and deductibles are also listed on the SPD. 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 SPD and SBC online at optimahealth.com/members or 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 optimahealth.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 SPD when you enroll. You can also go to optimahealth.com/members to see a copy of our privacy notice.

Frequently Asked Questions

Regulatory Information, continued

We will not release data about you unless you have authorized it, or as permitted or required by law. Optima Health requires a Designated Representative Authorization 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 optimahealth. com/members/manage-plans/forms, or by calling member services at the number on the back on your member ID card.

Under HIPAA, you have certain rights to see and copy health information about you. 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 decline 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 your 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.

Does Optima Health offer 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.

Frequently Asked Questions

Regulatory Information, continued

What happens if I lose my coverage but still need health insurance?

You may be able to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under Your Plan as a result of a qualifying event. You, your spouse, or your dependents may have to pay for such coverage. Please check with your employer for information on your rights under COBRA, or other available options if you lose coverage under your group's Plan.

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, 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 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).

Frequently Asked Questions

Regulatory Information, continued

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 that does not exceed 48 hours following a vaginal delivery, or 96 hours following a cesarean section.

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 your 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. CMS, OIG) 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

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 (e.g. Plan doctors, hospitals, mental health providers, and other specialists participating with Optima Health).

Optima Health Plan members have the right to:

Timely and Quality Care:

- access to Protected Health Information (PHI), medical records, physicians, and other healthcare professionals; and referrals to specialists when medically necessary
- 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
- receive the medical care that is necessary for the proper diagnosis and treatment of any covered illness or injury
- participate with physicians and healthcare professionals in:
    - discussing their diagnosis, the prognosis of the condition, and instructions required for follow-up care
    - understanding the health problems and assisting to develop mutually agreed-upon goals for treatment
    - decision-making regarding their healthcare and treatment planning
    - a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage
- the right to affirm that all practitioners, providers, and employees who make utilization management (UM) decisions:
    - base decisions on appropriateness of care, services and existence of coverage
    - are not rewarded for issuing medical denials of coverage
    - do not encourage decisions that result in underutilization through financial incentives

Treatment with Dignity and Respect—Members will

- be treated with respect, dignity, compassion and the right to privacy
- 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
- expect protection of all oral, written, and electronic information across the Plan, and information to plan sponsors and employers
- extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding medical care
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

Member Rights and Responsibilities, continued

- 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

Receive Health Plan Information—Members will

- 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
- know by name, title, and organization the physicians, nurses or other health care professionals providing care
- 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)
- 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
- 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
- be informed of policies regarding Advance Directives (living wills) as required by state and federal laws

Members Solve Problems in a Timely Manner by

- presenting questions, concerns or complaints to a customer service specialist without discrimination and expect problems to be fairly examined and appropriately addressed
- 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
- making recommendations regarding the health plan members rights and responsibilities policies

Member Rights and Responsibilities, continued

Member Responsibilities

In addition to their rights, Optima Health plan subscribers and their enrolled dependents have the responsibility:

- to identify themselves, and their family members as an Optima Health enrollee and present their identification card(s) when requesting healthcare services.
- 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.
- to provide information about their health to physicians and other health care professionals so they may provide appropriate medical care.
- 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.
- to act in a manner that supports the care provided to other patients and the general functioning of the office or facility.
- to review the employee handbook and Plan documentation:
    - to make sure the services are covered under the plan,
    - to approve release of information and have services properly authorized before receiving medical attention,
    - to follow proper procedures for illness before and after business hours, and
    - for materials concerning health benefits (e.g. UM issues) and educate other covered family members.
- 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.
- 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.

Code of Federal Regulations. Revised as of July 2020. 482.13, 482.58, 45 C.F.R. § 164.520, 42 C.F.R. §489.102, 422.128, and 438.6(i)(1). Retrieved from gpo.gov/.
National Committee for Quality Assurance (NCQA) (2019). Standards and Guidelines for the Accreditation of Health Plans. 2020 HP Standards and Guidelines. Washington, DC

Advance Directives

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 an 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 optimahealth.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 , continued

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.

Code of Federal Regulations. Revised as of July 2020. 42 C.F.R. §§ 489.102, 422.128, and 438.6(i)(1). Retrieved from https://www.gpo.gov/.

Your Rights and Protections Against Surprise Medical Bills

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

Your Rights and Protections Against Surprise Medical Bills, continued

- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may use the following contact information for help at the federal level:

Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the DOL's website (www.dol.gov/ebsa). In addition, information from HHS on private health insurance coverage and coverage provided by nonfederal governmental group health plans can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/cciio), and information on health care reform can be found at www.HealthCare.gov.

Resolving Member Complaints and Appeals of Adverse Benefit Determinations

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.

> *Internal and External appeals may be 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.*

Optima Health has formal complaint and appeal processes that allows your concerns to be addressed with the appropriate department or persons within Optima Health. You can file a complaint anytime within 180 days from the date of your concern with your care or services. We will review your complaint as quickly as possible and notify you of how it will be resolved. You may have someone else, such as a doctor or family member, file a complaint for You. We may ask that You sign a form authorizing the other person to act for you.

If your concern involves an adverse benefit determination, such as a denial of pre-authorization, denial of a covered service or denial of a claim, Optima Health has a formal internal appeals process. You may choose to have another individual or your doctor file an appeal on your behalf. You can download an appeal packet from the Manage My Plan section on optimahealth.com/members or contact member services to initiate an internal appeal.

We will notify you of the decision on your appeal in writing. If you are not satisfied with the internal appeal decision, an external appeal may be available. Check your plan documents or Summary Plan Description for instructions on how to file an external appeal. You can also call Member Services at the number on the back of your member ID card for help.

Additional Resources

The U.S. Department of Labor, Pension, and Welfare Benefits Administration can assist members in finding out what other voluntary alternative dispute resolutions are available.

U.S. Department of Labor
Toll Free: 1-866-4-USA-DOL (1-866-487-2365) or 1-866-275-7922

For questions about your appeal rights or for assistance, contact:
Employee Benefits Security Administration
1-866- 444-EBSA (1-866-444-3272)

You can download an Appeals Packet at optimahealth.com/members.

Section 6 What is Not Covered (Exclusions and Limitations)

This chapter lists services that are not covered. Services mean both medical and behavioral health (mental health) services and supplies unless otherwise specifically stated. The Plan does not cover any services that are not listed in this section unless required to be covered under state or federal laws and regulations. The Plan does not cover services unless they are Medically Necessary. In this section examples may be given of specific services that are covered. However, that does not mean that other similar services are covered. Some services are covered only if they have been authorized by the Plan.

A

Abortion is a Covered Service in the first 12 weeks of pregnancy. After 12 weeks abortion is a Covered Service 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 a Covered Service.

Adaptations to Your Home, Vehicle or Office are not Covered Services. Handrails, ramps, escalators, elevators, or any other changes because of a medical condition or disability are not Covered Services.

Ambulance Service for non-emergency transportation is not a Covered Service unless authorized by the Plan.

Non-medical **Ancillary Services** You are referred to are not Covered Services. Vocational rehabilitation services, employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education, or other non-medical services are not Covered Services.

General **Anesthesia** in a Physician's office is not a Covered Service.

Aromatherapy is not a Covered Service.

Autopsies are not Covered Services.

B

Batteries are not covered except for motorized wheelchairs, Left Ventricular Assist Device (LVAD), and cochlear implants when authorized.

Blood Donors. 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 authorize by the Plan.

Bone or Joint treatment of the head, neck, face or jaw. The Plan does not exclude 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 Accident/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 Accident/Injury that prevents normal function of the joint or bone.

Botox injections are not Covered Services unless the Plan has approved them.

Breast Augmentation or Mastopexy is not a Covered Service unless the Plan has authorized them. Cosmetic procedures or surgery for breast enlargement or reduction are not Covered Services for correction of cosmetic physical imperfections. Breast implants are not a Covered Service. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Breast Ductal Lavage is not a Covered Service.

Breast Milk from a donor is not a Covered Service.

C

Chelation Therapy is not a Covered Service except for arsenic, copper, iron, gold, mercury or lead poisoning.

Contact Lenses are not a Covered Service. Fitting of lenses or eyeglasses is not a Covered Service. Covered Services include 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 Services. Medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures are not Covered Services. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **The following are not Covered Services:**

- 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;
- Treatment or services resulting from complications due to cosmetic or 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 unless Medically Necessary and approved by the Plan.

Costs of Services paid for by Another Payor are not Covered Services. Covered Services do not include 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. Covered Services will not include 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 Services unless they are determined to be Medically Necessary and are listed as a Covered Service under the Plan

Custodial Care is not a Covered Service. The following are not Covered Services:

- 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 Services.
- Covered Services include Medically Necessary dental services from an Accident/Injury. It does not matter when the Accident/Injury occurred. For Accident/Injury occurring on or after Your effective date of Coverage treatment must be sought within 60 days of the Accident/Injury.
- Covered Services include 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 Services.
- Dental implants or dentures and any preparation work for them are not Covered Services.
- Dental services performed in a hospital or any outpatient facility are not Covered Services. 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 a Covered Service.
- Orthodontic treatment prior to orthognathic surgery is not a Covered Service.
- Dental implants or dentures and any preparation work for them are not Covered Services.
- Extraction of wisdom teeth is not a Covered Service.

Dental Care

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are not Covered Services.

- Dental implants or dentures and any preparation work for them are not Covered Services.

Diagnostic tests, or Diagnostic Imaging, or Surgical Procedures are not Covered Services where there is insufficient scientific evidence of the safety or efficacy of the test or procedure in improving clinical outcomes.

Disposable Medical Supplies are not Covered Services 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 Services.

Driver Training is not a Covered Service.

Durable Medical Equipment (DME) is a Covered Service only up to the limits stated on Your Plan's Schedule of Benefits. DME is limited to an amount, supply or type of DME that will safely and adequately treat Your condition. Covered Services will not include 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 Services. This includes drugs paid for directly by the clinical trial or another payor.

E

Electron Beam Computer Tomography (EBCT) is not a Covered Service. Other diagnostic imaging tests are not Covered Services 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 Services.

Educational Testing, Evaluation, Screening, or tutorial services are not Covered Services. Any other service related to school or classroom performance is not a Covered Service. This does not include services that qualify as Early Intervention Services under the Plan's benefit or those services covered under Autism spectrum disorder benefits.

Enteral or Parenteral Feeding supplements are not Covered Services unless covered under the Plan's benefit for Medically Necessary And Enteral Nutrition Products. Over the counter

supplements, over the counter infant formulas, or over the counter medical foods are not Covered Services.

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

Exercise Equipment is not a Covered Service. Bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment are not Covered Services. Pool, gym, or health club membership fees are not Covered Services.

Experimental or Investigative drugs, devices, treatments, or services are not Covered Services. 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 Services. Corrective or protective eyewear required for work is not a Covered Service.

Eye Glasses and contact lenses are not Covered Services. Fitting of lenses or eyeglasses is not a Covered Service. Covered Services are limited to 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 is not a Covered Service.

Eye Corrective Surgery such as Radial Keratotomy, PRK, LASIK, or any other eye corrective surgery is a Covered Service.

F

The following **Foot Care Services** are not Covered Services unless authorized by the Plan.

- Operations which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions;
- Treatment and services related to plantar warts.

The following **Foot Care Services** are not Covered 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.

G

Genetic Testing and Counseling are not Covered Services unless authorized by the Plan. Counseling is a Covered Service only when part of the approved genetic test unless considered preventive care.

GIFT programs (Gamete Intrafallopian Transfer) are not Covered Services.

Growth Hormones are Covered Services only under the Plan's Outpatient Prescription Drug Benefits. Growth hormones for the treatment of idiopathic short stature are not Covered Services.

H

Home Births are not Covered Services.

Home Health Care Skilled Services are not Covered Services unless You are homebound, physically unable to seek care on an outpatient basis or the service is provided in lieu of inpatient hospitalization. Services are limited as stated on Your Plan's Schedule of Benefits. Covered Services do not include any services after You have reached Your Plan's limit. Covered Services are limited to services or supplies listed in Your home health care plan. Custodial care is not a Covered Service. Transportation is not a Covered Service.

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not a Covered Service.

Implants for cosmetic breast enlargement are not a Covered Service. Cosmetic procedures or cosmetic surgery for breast enlargement or reduction are not Covered Services. Procedures for correction of cosmetic physical imperfections are not Covered Services. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Incarceration –Services and treatments done during incarceration in a Local, State, Federal or Community Correctional Facility or prison are not Covered Services.

Infertility Treatment or Services listed below are not Covered Services:

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as a Covered Service in this SPD;
- Services, tests, medications, and treatments for the enhancement of conception;
- Services, tests, medications, and treatments that aid in or diagnose potential problems with conception not listed as a Covered Service in this SPD;
- 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;
- Surrogate pregnancy services;
- Drugs used to treat infertility.

J

K

Treatment of **Keloids** from body piercing or pierced ears are not Covered Services.

L

Laboratory Services from Non-Plan Providers or laboratories are Covered Services under the Plan's Out-of-Network benefits only. This exclusion does not apply to Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility.

M

Massage Therapy is not a Covered Service unless provided as part of an approved therapy program.

Matristem Extracellular Wound Care System is not a Covered Service.

Maximum Benefit Amounts are stated on Your Plan's Schedule of Benefits. Additional benefits after a benefit limit has been reached are not Covered Services.

Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not a Covered Service.

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 Services 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 Services. **The following are not Covered Services:**

- 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 Services except when provided as part of preventive care, diabetes education or when received as part of preventive 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 Services.

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

Mobile Cardiac Outpatient Telemetry - (MCOT) is not a Covered Service.

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not Covered Services.

Motorized or Power Operated Vehicles or chair lifts are not Covered Services unless authorized by the Plan.

N

Neuro-cognitive therapy is not a Covered Service.

Newborns or other children of a Covered Dependent Child are not eligible for Covered Services.

O

Obstetrical Care Home births are not Covered Services.

Oral Surgery services listed below are not Covered Services:

- 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.

Orthoptics or vision or visual training and any associated supplemental testing are not covered services except when medically necessary for treatment of convergence and insufficiency. Pre-authorization is required.

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 Services under the Plan's Out-of-Network benefits only. This exclusion does not apply to Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility.

P

PARS System (Physical Activity Reward System) is not a Covered Service.

Pass Devices (Patient Activated Serial Stretch) are not Covered Services.

Paternity Testing is not a Covered Service.

Penile implants are not a Covered Service.

Personal comfort items are not Covered Services. 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 Services.

Physician Examinations are limited as follows:

- Physicals for employment, insurance or recreational activities are not Covered Services.
- Executive physicals are not Covered Services.
- A second opinion from a Non-Plan Provider is a Covered Service only under the Plan's Out-of-Network benefits. A second opinion by a Plan Provider does not require authorization by the Plan.
- Services or supplies ordered or done by a provider not licensed to do so are not Covered Services.

Physician's Clerical Charges are not Covered Services. 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 Services.

Private Duty Nursing is not a Covered Service.

Pulsed Irrigation Evacuation System is not a Covered Service.

Q

R

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

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

Residential or Sub-Acute Level of Care or treatment is not a Covered Service unless authorized by the Plan. Services that are merely custodial, residential, or domiciliary in nature are not Covered Services.

S

Second Opinions from Plan providers do not require authorization. A second opinion from a Non-Plan provider is a Covered Service only under the Plan's Out-of-Network benefits.

Services. The following are not Covered Services:

- 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.

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Sterilization

- Reversal of voluntary sterilizations is not a Covered Service.
- Any infertility services required because of a reversal are not Covered Services.

T

Non-interactive **Telemedicine Services** such as Fax, telephone only conversations, or email are not Covered Services.

Physical, Speech, and Occupational **Therapies** are limited as stated on Your Schedule of Benefits. Therapies will be Covered Services only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. Covered Services do not include any of the following except for those services that are covered through Early Intervention Services or 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;
- 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 a Covered Service.

Transplant Services. Covered Services do not include 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;
- Services related to donor complications following a transplant.

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

U

V

Video Recording or Video Taping of procedures or treatment is not a Covered Service.

Treatment of **Varicose Veins or telangiectatic dermal veins** (spider veins) for cosmetic purposed is not a Covered Service.

Vision Exams and Materials not listed as a Covered Services are not covered.

W

Wisdom Teeth extraction is not a Covered Service.

Work-related injuries or diseases when the employer must provide benefits or when that person has been paid by the employer are not Covered Services.

X, Y, Z

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