



Benefit Information Guide

Prepared exclusively for:

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Welcome to
Optima Health

Welcome to Optima Health



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 Summary of Benefits 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



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 network.

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.

OptimaSelect® Network

As a member of an OptimaSelect® plan, you have access to a specific network of providers. The Select network utilizes local providers and facilities within key clinically integrated networks to provide high-quality and efficient care.



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 diagnoses 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 in an Optima Health plan, you can often continue your relationship with your present doctor or select a doctor with an office more convenient to your home or work addresses. You have the right to choose any PCP who participates in our network and who is available to accept you and/or your dependents. For children, you may choose a participating pediatrician as their PCP.

You can review a list of participating providers for your plan online at optimahealth.com/members. You can choose or change your PCP online by signing in, selecting Change Primary Care Physician from the left menu, and following the on screen instructions. In most cases, your PCP selection will be effective the next business day.

Please note, you do not need prior authorization from Optima Health or from any other person, including your PCP, to access obstetrical, gynecological, or other specialty care from a healthcare professional in our network. The healthcare professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or other Plan requirements.

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.



Frequently Asked Questions

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.



Frequently Asked Questions

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. 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.

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. Female 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.



Frequently Asked Questions

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.



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.



Frequently Asked Questions

Member Services, continued

When and how can I enroll my dependent up to age 26?

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

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

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 on 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.



Frequently Asked Questions

After Hours 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 After Hours Nurse Advice Line number **located on the back of your member ID card**.

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

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

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

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?

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.

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.



Frequently Asked Questions

Emergency Care, continued

Some examples of situations that would require the use of an emergency department include, but are not limited to:

- heart attack/severe chest pain
- stroke
- loss of consciousness
- loss of pulse or breathing
- poisoning
- convulsions

What conditions generally do not require emergency department treatment?

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

- sprains or strains
- chronic conditions such as arthritis, bursitis, or backaches
- minor injuries and puncture wounds of the skin

What is the difference between an Emergency Department and an Urgent Care Center?

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

Do I need to contact Optima Health or my PCP before going to the emergency department/urgent care center?

No. If you are unsure whether to visit an emergency department or urgent care center, you can call your PCP office or the After Hours Nurse Advice Line at the number on the back your member ID card.

Are there any special emergency care policies I should know about?

Yes. Optima Health may review all emergency care retrospectively, or after the fact, to determine if a true medical emergency did exist. This retrospective review policy is designed to protect you and all





Frequently Asked Questions

Emergency Care, continued

other Optima Health members from the high costs associated with unnecessary use of emergency departments and urgent care centers. If you handle nonemergencies as if they are emergencies by seeking treatment at an emergency department or urgent care center when a visit to your doctor's office would suffice, you could be responsible for paying a greater portion or all of the charges.

What if I become ill when I am outside of the Optima Health service area?

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

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

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

What if I need to be hospitalized?

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

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



Frequently Asked Questions

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. Licensed medical professionals such as RNs, LPNs, Social Workers, Patient Service Coordinators, and medical doctors perform the process of pre-authorization by the plan.

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



Frequently Asked Questions

Pre-Authorization, continued

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

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

Do I need pre-authorization to obtain access to an OB/GYN?

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

How far in advance should my provider obtain pre-authorization?

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

How do I ensure pre-authorization has been obtained?

To ensure pre-authorization has been obtained, sign in at optimahealth.com/members, contact Member Services at the number on the back of your member ID card, or call your provider.

What if I need to be hospitalized?

If you need to be hospitalized for an elective procedure, your plan doctor must notify Optima Health 7–10 business days prior to your admission. If you are hospitalized due to an emergency, you or a family member should contact Optima Health within 48 hours (two business days) of admission, or as soon as medically possible.

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



Frequently Asked Questions

Utilization Management, continued

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

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 1-800-741-9910. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the glossary at healthcare.gov/sbc-glossary/ or call 1-800-741-9910 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	No.	You will have to meet the deductible before the plan pays for any services.
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 \$2,000 person / \$4,000 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 does not 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 www.optimahealth.com or call 1-800-741-9910.	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 I 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	\$10 Copayment per visit	Not Covered	None
	Specialist visit	\$20 Copayment per visit	Not Covered	None
	Preventive care/screening /immunization	No Charge	Not Covered	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)	\$20 Copayment	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$150 Copayment	Not Covered	Pre-authorization required.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at optimahealth.com .	Generic drugs (Tier 1)	\$15 Copayment retail/\$37.50 Copayment mail order	\$15 Copayment retail/Mail Order Not Covered	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 used when a generic is available, you must pay the difference in cost plus the Copayment or Coinsurance amount. Covers up to a 31-day supply (retail); 31- to 90-day supply (mail order). Not all drugs are available through a mail order program.
	Preferred brand drugs (Tier 2)	\$40 Copayment retail/\$100 Copayment mail order	\$40 Copayment retail/Mail Order Not Covered	
	Non-preferred brand drugs (Tier 3)	\$60 Copayment retail/\$180 Copayment mail order	\$60 Copayment retail/Mail Order Not Covered	
	Specialty drugs (Tier 4)	20% Coinsurance retail	20% Coinsurance retail	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 Copayment per admission	Not Covered	Pre-authorization required.
	Physician/ surgeon fees	No Charge	Not Covered	None
If you need immediate medical	Emergency room care	\$200 Copayment per visit	\$200 Copayment per visit	None
	Emergency medical transportation	\$100 Copayment per trip	Not Covered	None

*For more information about limitations and exceptions, see the plan or policy document at https://www.optimahealth.com/eoccoidoc/Vant_LG_HMO_202001.pdf

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)	
attention	Urgent care	\$20 Copayment per visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 Copayment per admission	Not Covered	Pre-authorization required.
	Physician/surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse services	Outpatient services	Mental Health Outpatient: \$10 Copayment Per visit \$10 Copayment Other visits EAV: No Charge	Mental Health Outpatient: Not Covered EAV: Not Covered	Pre-authorization required for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy, and Transcranial Magnetic Stimulation. EAV: 5 visits/presenting issue by Optima EAV providers only
	Inpatient services	\$300 Copayment per admission	Not Covered	Pre-authorization required for all inpatient services.
If you are pregnant	Office visits	\$100 Copayment Global	Not Covered	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	No Charge	Not Covered	
	Childbirth/delivery facility services	\$300 Copayment per admission	Not Covered	
If you need help recovering or have other special health needs	Home health care	\$10 Copayment per visit	Not Covered	Pre-authorization required. 100 visits/ plan year
	Rehabilitation services	Physical and Occupational Therapy: \$25 Copayment per visit Speech Therapy: \$25 Copayment per visit	Physical and Occupational Therapy: Not Covered Speech Therapy: Not Covered	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	No Charge after Inpatient Copayment	Not Covered	Pre-authorization required. 100 days/ plan year
	Durable medical equipment	30% Coinsurance	Not Covered	Pre-authorization required for single items over \$750, all rental items, and repair and replacement.
		Hospice Care: No Charge	Hospice Care: Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at https://www.optimahealth.com/eoccoidoc/Vant_LG_HMO_202001.pdf

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)	
	Hospice services	Hospice Care: No Charge	Hospice Care: No Charge	Pre-authorization required. None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric Dental Check-ups
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic Care
- Infertility treatment

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the [plan](#) at 1-800-741-9910. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, at 1-877-310-6560 or bureauofinsurance@scc.virginia.gov; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/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.

Does this Coverage Provide [Minimum Essential Coverage](#)? Yes

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

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium](#) tax credit to help you pay for a [plan](#) through the [Marketplace](#).

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

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$100	■ Specialist copayment	\$20	■ Specialist copayment	\$20
■ Hospital (facility) copayment	\$300	■ Hospital (facility) copayment	\$300	■ Hospital (facility) copayment	\$200
■ Other copayment	\$20	■ Other copayment	\$20	■ Other copayment	\$25
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$900	Copayments	\$800	Copayments	\$600
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$200
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
Total Peg would pay is	\$900	Total Joe would pay is	\$800	Total Mia would pay is	\$800

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

Optima Health Alternative Language Options for Notices and other Written Information

English:

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

Amharic:

ማሳሰቢያ:

አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260።

Arabic:

تنبيه:

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

Bengali/Bangla:

লক্ষ্য করবেন: যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন- 1-855-687-6260।

Chinese (Mandarin):

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

French:

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

German:

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

Gujarati:

ધ્યાન આપો : જો તમે ગુજરાતી બોલી છો તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કોલ કરો.

Hindi:

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

Hmong:

CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260.

Igbo:

GEE NT I: ọbụrụ na i na-asụ Igbo, i ga-enweta enyemaka n’efu site n’aka ndi ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

Japanese:

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

Korean:

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

Kru/Bassa:

YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha I nyuu hola we. Sebel: 1-855- 687-6260.

Laotian:

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນຳໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

Mon-Khmer, Cambodian:

កំណត់សំគាល់: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260។

Navajo:

SHOOH: Diné Bizaad bee yáníłti'go doo bą́ąh ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'ą. Kojí' hółne' 1-855-687-6260.

Persian/Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 تماس بگیرید.

Portuguese:

ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260.

Russian:

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

Spanish:

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

Tagalog:

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

Turkish:

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

Urdu:

توجه دیں: اگر آپ اردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 کال کریں۔

Vietnamese:

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

Yoruba:**KÉÉRE:**

Ti o bá ń sọ èdè Yorùbá, isẹ̀ ìrànlọ́wọ́ èdè wà fún ọ lọfẹ́ẹ́. Pe 1-855-687-6260

NOTES

[illegible]



Benefit Information

Benefit
Information



Large Group Plans

Optima Health

Benefit Changes

The following changes apply to ODU Research Foundation renewing on July 1, 2020

Mandatory Plan Changes for Fully Insured Groups

- Infertility services has been added as a core benefit. This benefit includes the following services for members covered by the plan to diagnose and treat conditions resulting in infertility:
 - endometrial biopsies (limited to 2 per lifetime)
 - semen analysis (limited to 2 per lifetime)
 - hysterosalpingography (limited to 2 per lifetime)
 - Sims-Huhner test (smear) (limited to 4 per lifetime)
 - diagnostic laparoscopy (limited to 1 per lifetime)

Excluded treatments or services related to infertility include artificial insemination (AI), in-vitro fertilization (IVF), and all other types of artificial or surgical means of conception and drugs used in connection with these procedures.

- Chemotherapy, chemotherapy drugs, and radiation therapy will be a separate benefit from IV infusion therapy and respiratory/inhalation therapy. While cost shares will be the same, chemotherapy services, chemotherapy drugs and radiation therapy will now require pre-authorization.

Chemotherapy Radiation Therapy IV Therapy Inhalation Therapy Pre-Authorization is required for Chemotherapy and Radiation Therapy.⁵	Applicable Copayment or Coinsurance
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- The virtual consult benefit will be a separate cost share from the primary care physician (PCP) office visit benefit. For plans with a coinsurance, the virtual consult benefit will remain the same.

Virtual Consults Must be furnished by approved Optima Health providers.	You Pay \$10 Copayment
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Virtual Consults OPMH Must be furnished by approved Optima Health providers.	You Pay \$10 Copayment
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- Benefits for the treatment of Autism Spectrum Disorder will change to remove the current age limit of 2 to 10 from the Virginia Autism coverage mandate that includes treatment of Applied Behavioral Analysis (ABA) up to \$35,000 annually.
- When an Optima plan includes step therapy requirements, members and their prescribing physicians will have access to a formal process to request an exception to step therapy requirements.
- **Effective July 1, 2019** for new and renewing groups: if services are available through the provider, monitoring of clinical patient information such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload are covered by the Optima Health telemedicine services benefit.

ODU Research Foundation 2020

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Evidence of Coverage or Certificate of Insurance, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Evidence of Coverage document carefully. Except for Emergency Services You must use In-Network Plan Providers for all Services.

DEDUCTIBLE³

Your Plan Does not have a Deductible

MAXIMUM OUT OF POCKET LIMIT⁴

\$2,000 per Person Per Calendar Year

\$4,000 per Family Per Calendar Year

PHYSICIAN SERVICES

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery⁵.**

Physician Office Visits	In-Network Benefits Copayments/%Coinsurance ²
Primary Care Physician (PCP) Office Visit	You Pay \$10
Virtual Consults Must be furnished by approved Optima Health providers.	You Pay \$10
Specialist Office Visit	You Pay \$20
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of \$250 per dose. This does not include routine immunizations covered under Preventive Care.	You Pay 50%
Preventive Care ^{9,10}	In-Network Benefits Copayments/%Coinsurance ²
Routine Annual Physical Exam Well Baby Exams Annual GYN Exams and Pap Smears¹⁰ PSA Tests Colorectal Cancer Tests Routine Adult and Childhood Immunizations Screening Colonoscopy Screening Mammograms Women's Preventive Services	No Charge

OUTPATIENT THERAPY AND REHABILITATION SERVICES

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

Short Term Therapy Services ⁶	In-Network Benefits Copayments/%Coinsurance ²
Physical Therapy Occupational Therapy Pre-Authorization is required.⁵ Physical and Occupational Therapy are limited to a maximum combined benefit for all places of service of 30 visits per calendar year. ⁶	You Pay \$25

Speech Therapy Pre-Authorization is required.⁵ Speech Therapy is limited to a maximum benefit for all places of service of 30 visits per calendar year. ⁶	You Pay \$25
Short Term Rehabilitation Services⁶	In-Network Benefits Copayments/%Coinsurance²
Cardiac Rehabilitation Pulmonary Rehabilitation Vascular Rehabilitation Vestibular Rehabilitation Pre-Authorization is required.⁵ Services are limited to a maximum combined benefit for all places of service of 30 visits per calendar year. ⁶	You Pay \$25
Other Outpatient Therapy Services	In-Network Benefits Copayments/%Coinsurance²
IV Infusion Therapy Respiratory/Inhalation Therapy	You Pay \$10 per PCP office visit You Pay \$20 per Specialist office visit You Pay \$20 per outpatient facility visit.
Chemotherapy and Chemotherapy Drugs Radiation Therapy Pre-Authorization is required for Chemotherapy and Chemotherapy Drugs, and Radiation Therapy.⁵	You Pay \$10 per PCP office visit You Pay \$20 per Specialist office visit You Pay \$20 per outpatient facility visit.
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance. This does not include Chemotherapy Drugs.	You Pay 20%
OUTPATIENT DIALYSIS SERVICES	
	In-Network Benefits Copayments/%Coinsurance²
Dialysis Services	You Pay \$20
OUTPATIENT SURGERY	
	In-Network Benefits Copayments/%Coinsurance²
Outpatient Surgery Pre-Authorization is required.⁵ Copayment or Coinsurance applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	You Pay \$100
OUTPATIENT DIAGNOSTIC PROCEDURES	
Copayment or Coinsurance will apply when a procedure is done in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.	
Outpatient Diagnostic Procedures	In-Network Benefits Copayments/%Coinsurance²
Diagnostic Procedures	You Pay \$20
X-Ray Ultrasound Doppler Studies	You Pay \$20
Lab Work	You Pay \$20

OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES	
	In-Network Benefits Copayments/%Coinsurance ²
Magnetic Resonance Imaging (MRI) Magnetic Resonance Angiography (MRA) Positron Emission Tomography (PET Scans) Computerized Axial Tomography (CT Scans) Computerized Axial Tomography Angiogram (CTA Scans) Sleep Studies Magnetic Resonance Spectroscopy (MRS) Single Photon Emission Computed Tomography (SPECT) Nuclear Cardiology Pre-Authorization is required for all procedures except MRS, SPECT and Nuclear Cardiology.⁵ Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	You Pay \$150
MATERNITY CARE	
	In-Network Benefits Copayments/%Coinsurance ²
Maternity Care^{7, 9, 10} Pre-Authorization is required for prenatal services.⁵ Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	You Pay \$100 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services.
INPATIENT SERVICES	
Inpatient Services	In-Network Benefits Copayments/%Coinsurance ²
Inpatient Hospital Services Pre-Authorization is required.⁵ Transplants are covered at contracted facilities only.	You Pay \$300
Skilled Nursing Facilities/Services⁶ Pre-Authorization is required.⁵ Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days per calendar year that in the Plan's judgment requires Skilled Nursing Services ⁶	Covered at 100% after inpatient hospital Copayment or Coinsurance has been met.
AMBULANCE SERVICES	
	In-Network Benefits Copayments/%Coinsurance ²
Ambulance Services⁸ Pre-Authorization is required for non-emergent transportation only.⁵ Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	You Pay \$100
EMERGENCY SERVICES	
	In-Network Benefits Copayments/%Coinsurance ²
Emergency Services^{2, 8} Pre-Authorization is <u>not</u> required. Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility. Emergency care will be provided whether the provider is In-Network or Out-of-Network. If You are admitted the Copayment will be waived, and You will pay the Inpatient Hospital Services Copayment or Coinsurance.	You Pay \$200

URGENT CARE CENTER SERVICES

	In-Network Benefits Copayments/%Coinsurance ²
Urgent Care Center Services⁸ Pre-Authorization is <u>not</u> required. Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay an Emergency Services Copayment or Coinsurance.	You Pay \$20

MENTAL/BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER SERVICES

Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Pre-Authorization is required for Inpatient Services, partial hospitalization services, intensive outpatient program (IOP), electro-convulsive therapy, and Transcranial Magnetic Stimulation (TMS). ⁵	
Mental/Behavioral Health/Substance Use Disorder	In-Network Benefits Copayments/%Coinsurance ²
Inpatient Services Pre-Authorization is required⁵	You Pay \$300
Outpatient Office Visits	You Pay \$10
Virtual Consults Must be furnished by approved Optima Health providers.	You Pay \$10
Other Outpatient Visits (Includes Hospital Outpatient and Freestanding Outpatient Centers)	You Pay \$10
Employee Assistance Visits⁶ Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174.	No Charge for up to 5 visits from Optima Employee Assistance Providers per presenting issue as determined by treatment protocols. ⁶

DIABETES TREATMENT

Coverage includes benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating Eye Med Provider at the applicable office visit Copayment or Coinsurance amount.	
	In-Network Benefits Copayments/%Coinsurance ²
Insulin Pumps Pre-Authorization is required.⁵	No Charge
Pump Infusion Sets and Supplies Pre-Authorization is required.⁵	You Pay 20%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution.	Covered under the Plan's Prescription Drug Benefit.
Insulin, Needles, and Syringes	Covered under the Plan's Prescription Drug Benefit.
Outpatient Self-Management Training and Education and Nutritional Therapy	No Charge

OTHER COVERED SERVICES	
Other Services	In-Network Benefits Copayments/%Coinsurance ²
<p>Prosthetic Limbs and Components Pre-Authorization is required.⁵ Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components.</p> <p>Definitions: "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.</p> <p>"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.</p> <p>"Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.</p>	<p>You Pay 30%</p>
OTHER COVERED SERVICES	
Other Services	In-Network Benefits Copayments/%Coinsurance ²
<p>Autism Spectrum Disorder Pre-Authorization is required.⁵ Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder.</p> <p>"Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.</p> <p>"Diagnosis of Autism Spectrum Disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder.</p> <p>"Treatment for Autism Spectrum Disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) <u>Applied Behavioral Analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.</u></p> <p>"Applied Behavioral Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. <u>Coverage for Applied Behavioral Analysis under this benefit is limited to an annual maximum benefit of \$35,000.⁶</u></p>	<p>Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors.</p> <p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>

OTHER COVERED SERVICES

Other Services	In-Network Benefits Copayments/%Coinsurance ²
Chiropractic Care Rider⁶ Pre-Authorization is required by ASH for all Chiropractic services. Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit. Pre-Authorization is required by ASH for all chiropractic care services To use this benefit call ASH's Member Services at 1-800-678-9133. Representatives are available from 8 AM to 9 PM Monday-Friday. 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.	You Pay \$20
Clinical Trials Pre-Authorization is required.⁵ Coverage of routine patient costs for phase I, II and III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.
Durable Medical Equipment (DME) and Supplies Orthopedic Devices and Prosthetic Appliances Pre-Authorization is required for single items over \$750.⁵ Pre-Authorization is required for all rental items.⁵ Pre-Authorization is required for repair and replacement.⁵ Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.	You Pay 30%
Early Intervention Services Pre-Authorization is required.⁵ Covered for Dependent children from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.
Home Health Care Skilled Services⁶ Pre-Authorization is required.⁵ Services are covered up to a maximum of 100 visits per calendar year for Members who are home bound and in the Plan's judgment require Home Health Skilled Services. ⁶ You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.	You Pay \$10
Hospice Care Pre-Authorization is required.⁵	No Charge

OTHER COVERED SERVICES

Other Services	In-Network Benefits Copayments/%Coinsurance ²
Telemedicine Services Telemedicine means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.
Out of Area Dependent Program Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits listed on the Plan Face Sheet or Schedule of Benefits when Covered Services are received from Optima Health providers that participate in the Out of Area Program. The Plan will require eligible out of area Dependents to complete an annual certification form prior to being eligible for the program. All Pre-Authorization requirements apply depending on the type and place of service. Except for Emergency Services any Covered Services received outside of the service area from Out of Network Non-Plan Providers that are not included in the Out of Area Dependent Program will not be covered.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.
Infertility Services⁶ Includes the following services, for Covered Persons only, to diagnose and treat underlying medical conditions resulting in Infertility: Endometrial biopsies (Limited to 2 per lifetime) Semen analysis (Limited to 2 per lifetime) Hysterosalpingography (Limited to 2 per lifetime) Sims-Huhner test (smear) (Limited to 4 per lifetime) Diagnostic laparoscopy (Limited to 1 per lifetime) Excluded are Artificial Insemination (AI), In-Vitro Fertilization (IVF) and all other types of artificial or surgical means of conception and drugs used in connection with these procedures.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.

NOTES

All benefits are subject to the terms and conditions in the *Evidence of Coverage (EOC)*. Words that are capitalized are defined terms listed in the Definitions section of the EOC.

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

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

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

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

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.

2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

Services or treatment You receive from Out-of-Network Non-Plan Providers will not be Covered under the Plan except in the following situations:

- If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits;
- You have received advance approval from Us to use an Out-of-Network Non-Plan Provider; and We have authorized the service to be Covered under Your In-Network Benefits;
- Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket amounts.

3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. If You have individual coverage You must satisfy the individual member coverage Deductible before coverage begins. If You have family coverage You and Your family must satisfy the family coverage Deductible. This Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. Amounts You are required to pay for preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Preventive Care Visits and Screenings. Amounts applied to the Deductible will apply toward the Plan's Maximum Out of Pocket Limit. Cost sharing amounts You pay for some Covered Services will not count toward Your Deductible. Deductibles will not be reimbursed under the Plan. Any part of the calendar year Deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year.

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

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

5. This benefit requires Pre-Authorization before You receive services. We have instructions and procedures in place for providers to obtain Pre-Authorization through Medical Care Services. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.
6. Coverage for this benefit or service is limited as stated. Unless otherwise noted benefit limits are combined for all places of service. The Plan will not cover any additional services after the limits have been reached. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your Maximum Out of Pocket Maximum Limit.
7. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical illness generally. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.
8. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had You received care from a Plan Provider.
9. Recommended Preventive Care listed below will be covered with no Member cost sharing when received from In-Network Plan Providers. However, You may still have to pay Your office visit cost sharing including any Copayments, Coinsurance and Deductibles listed on the Face Sheet of Your Evidence of Coverage in certain circumstances:
 - You will pay office visit cost sharing if Your preventive care item or service is billed separately, or is tracked as individual encounter data separately from the office visit.
 - You should not pay office visit cost sharing if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit, and the primary purpose of the office visit is the delivery of the preventive item or service.
 - You will pay office visit cost sharing if an item or service is not billed separately, or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.
 - You will pay all charges for any preventive care and services and office visits You receive from Out-of-Network Non-Plan Providers.

Where no frequency or limits are indicated the Plan will use its normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Some services may be administered under Your prescription drug benefit under the Plan. Services covered under the Plan's outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. Recommended preventive care services are described below. **Please use the following link for a complete list of covered preventive care services: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>**

1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:

- **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
- **Contraceptive Methods and Counseling including:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
- **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
- **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
- **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
- **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
- **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
- **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.

10. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your EOC in the Utilization Management Section for more information on Pre-Authorization.

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Pharmacy Information



Pharmacy



Frequently Asked Questions

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

How will my prescription drugs be covered under Optima Health?

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

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

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

How does Optima Health determine my prescription drug tier?

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





Frequently Asked Questions

How much will I have to pay out-of-pocket for my prescription drug?

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

Is it possible that I would ever pay less than my copayment/coinsurance for a prescription?

Yes. If the pharmacy's usual and customary cost is less than your copayment/coinsurance, you will pay the lesser amount.

Are there any restrictions on filling my prescriptions?

There are several things to keep in mind before having your prescriptions filled:

- Registered members of optimahealth.com can locate a participating pharmacy by signing in to optimahealth.com/members and selecting Pharmacy Resources.
- If you choose to have your prescription filled at a non-participating pharmacy, you will have to pay the full cost of the prescription upfront and file for reimbursement from Optima Health. You will be responsible for paying all charges in excess of the Optima Health allowable charge, in addition to any copayment, deductible, or coinsurance amounts specified in your plan documents.
- Some drugs require pre-authorization by Optima Health in order to be covered. Your prescribing provider is responsible for initiating pre-authorization.
- Optima Health may limit quantities of certain medications.
- If you or your prescribing provider requests a brand medication when a generic equivalent is available; you may be responsible for the difference in the cost between the generic and the brand name drug in addition to your copayment/coinsurance and/or deductible.

As a registered member of optimahealth.com/members or the Optima Health mobile app, you can:

- Calculate the cost for a specific drug or see which copayment applies
- See if your drug has a generic equivalent
- View the status of your pharmacy claims
- Learn about drugs that can treat your condition
- View your deductibles and out-of-pocket maximums (if applicable)
- Locate and get directions to participating pharmacies
- Use the Drug Information Center to learn about dosage, strength, side effects, and potential drug interactions



Make the Best of Your Pharmacy Dollars

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



Examples of Savings With Generics 30-Day Supply

Drug	Quantity	What You Pay	Pharmacy \$4 Program	Sample Tier 1 Copayment
Amoxicillin 500mg capsules	30	\$2.51	\$4.00	\$15.00
Atenolol 50mg tablets	30	\$1.40	\$4.00	\$15.00
Fluoxetine 20mg capsules	30	\$2.23	\$4.00	\$15.00
Hydrochlorothiazide (HCTZ) 25mg tablets	30	\$1.30	\$4.00	\$15.00
Ibuprofen 800mg tablets	30	\$2.35	\$4.00	\$15.00
Lisinopril 20mg tablets	30	\$2.23	\$4.00	\$15.00
Metformin 500mg tablets	30	\$2.47	\$4.00	\$15.00

The drugs and prices listed above are examples only. Prices are subject to change and prices may vary between pharmacies. Optima Health offers an online tool that can help you determine what your cost will be for any of your prescription drugs. Simply sign in to optimahealth.com and select Pharmacy Resources from the MyOptima menu. Then select the Price and Save button and follow the directions to find out your cost for a specific drug.

Optima Vantage \$15/40/60/20%
Outpatient Prescription Drug Summary of Benefits

This Summary of Benefits describes Your outpatient prescription drug coverage. All drugs must be United States Food, Drug Administration (FDA) approved, and you must have a prescription. You will need to pay Your Copayment or Coinsurance when you fill your prescription at the pharmacy. If Your Plan has a Deductible, You must meet that amount before your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. Your drug coverage has specific Exclusions and Limitations listed in Your coverage documents. Optima Health's Pharmacy and Therapeutics Committee places covered drugs into the following Tiers. You will pay Your Copayment or Coinsurance depending on which Tier Your Drug is in.

This Plan uses a closed prescription drug formulary. That means Your Plan includes coverage for a specific list of drugs and medications determined by our Pharmacy and Therapeutics Committee. Drugs that are not included on the Standard formulary will not be covered under Your plan. Please use the following link to see a list of drugs on the Standard formulary: <https://www.optimahealth.com>

- **Selected Generic (Tier 1)** includes commonly prescribed generic drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.
- **Selected Brand & Other Generic (Tier 2)** includes brand-name drugs, and some generic drugs with higher costs than Tier 1 generics, that are considered by the Plan to be standard therapy.
- **Non-Selected Brand (Tier 3)** includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a generic equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers.
- **Specialty Drugs (Tier 4)** includes those drugs classified by the Plan as Specialty Drugs. Tier 4 also includes covered compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or on-going medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional. Specialty Drugs include the following:
 - Medications that treat certain patient populations including those with rare diseases;
 - Medications that require close medical and pharmacy management and monitoring;
 - Medications that require special handling and/or storage;
 - Medications derived from biotechnology and/or blood derived drugs or small molecules; and
 - Medications that can be delivered via injection, infusion, inhalation, or oral administration.

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

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

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

Underwritten by Optima Health Plan

\$15/40/75/20% 4 Tier Standard Formulary

Optima Vantage \$15/40/60/20%
Outpatient Prescription Drug Summary of Benefits

Maximum Out-of-Pocket Limit	
Maximum Out-of-Pocket Limit	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Maximum Medical Out of Pocket Limit Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are not Covered, do not count toward the Plan's Maximum Out of Pocket Limit and must continue to be paid after the Maximum Out of Pocket Limit has been met.
Insulin, syringes, and needles	Covered at the cost sharing listed below for the applicable Tier.
Diabetic Testing Supplies covered including blood glucose monitors, test strips, lancets, lancet devices, and control solution	Covered at 100% Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands.
Copayments and Coinsurances.	
<p>For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge. Certain prescription drugs will be covered at a generic product level established by the Plan. If a generic product level has been established for a drug and You or Your prescribing Physician requests the brand-name drug or a higher costing generic, You must pay the difference between the cost of the dispensed drug and the generic product level in addition to the Copayment charge.</p> <p>ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider are covered with no Member cost sharing. Please use the following link for a complete list of covered preventive care services:</p> <p>https://www.healthcare.gov/what-are-my-preventive-care-benefits/</p>	
Selected Generic (Tier 1)	You Pay \$15 Copayment
Selected Brand & Other Generic (Tier 2)	You Pay \$40 Copayment
Non-Selected Brand (Tier 3)	You Pay \$60 Copayment
Specialty Drugs (Tier 4)	You Pay 20% with a maximum Copayment of \$250 per prescription per 31 day supply.
Mail Order Pharmacy Benefit Copayments and Coinsurances	
<p>Some Outpatient prescription drugs are available through the Plan's Mail Order Provider. This does not include Tier 4 Specialty Drugs. You may call OptumRx Home Delivery at 866-244-9113 to find out if a drug is available. If Your drug is available You may purchase up to a 90-day supply for 2.5 to 3 Copayments or the applicable Coinsurance amount. If available under mail order benefits Prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider are covered with no Member cost sharing.</p>	
Selected Generic (Tier 1)	You Pay \$37.50 Copayment
Selected Brand & Other Generic (Tier 2)	You Pay \$100 Copayment
Non-Selected Brand (Tier 3)	You Pay \$180 Copayment
Specialty Drugs (Tier 4)	No 90-day mail order benefits are available for Tier 4 Specialty Drugs.

LIMITATIONS AND OTHER COVERAGE TERMS.

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Optima Vantage \$15/40/60/20%
Outpatient Prescription Drug Summary of Benefits

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

1. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.
2. Copayment and Coinsurance are out-of-pocket amounts You pay directly to the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's Allowable Charge.
3. Deductible means the dollar amount You must pay out-of-pocket each year for Covered Services before the Plan begins to pay for Your benefits.
4. Prescriptions may be filled at a Plan pharmacy or at a non-participating pharmacy if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies.
5. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law.
6. Amounts You pay for any outpatient prescription drug after a benefit Limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.
7. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage. However, the Plan may approve Coverage of limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs.
8. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. You can call Member Services at the number on Your ID card to verify that your prescription drug has been pre-authorized.
9. Unless required by law, certain Prescription Drugs may not be Covered under the Plan if You could use a "clinically equivalent drug." "Clinically equivalent drug" means a drug that for most individuals will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered by the Plan please call the Member Services number on the back of Your Optima identification card. If You or Your doctor believes You need to use a different Prescription Drug, please have Your doctor contact Us. If We agree that it is Medically Necessary and appropriate we will cover the other Prescription Drug instead of the "clinically equivalent drug."
10. At its' sole discretion Optima Health's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in or if a particular drug is included on the Plan's formulary. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list or Your Plan's formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
11. Insulin, syringes, needles, blood glucose monitors, test strips, lancets, lancet devices, and control solution are covered under the Plan's prescription drug benefit. Insulin pumps, pump infusion sets and supplies, and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, are covered under the Plan's medical benefit. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under the Plan.
12. Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
13. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
14. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in

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Outpatient Prescription Drug Summary of Benefits

excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

15. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
16. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to two 90 day courses of treatment per year when prescribed by a health care provider.

PRESCRIPTION DRUG COVERAGE EXCLUSIONS.

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

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications with no approved FDA indications are excluded from Coverage.
3. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
4. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
6. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage under this rider.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage under this rider.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage under this rider.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. Therapeutic devices or appliances, including but not Limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
13. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded from Coverage
18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country
20. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage
22. Medical foods are excluded from Coverage.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following Standard reference compendia are not Covered Services:
 - a. American Hospital Formulary Service Drug Information;
 - b. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
 - c. Elsevier Gold Standard's Clinical Pharmacology.
24. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
25. Non-Sedating antihistamines are excluded from Coverage.
26. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage.
27. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.

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Outpatient Prescription Drug Summary of Benefits

28. Prescriptions written by a licensed dentist are excluded from Coverage, except for the prevention of infection or pain in conjunction with a Covered dental procedure.
29. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription
30. Sexual dysfunction drugs are excluded from Coverage
31. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
32. Infertility drugs are excluded from Coverage.
33. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
34. **This Plan uses a Closed Formulary. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are excluded from Coverage.**

Non-formulary requests. You have the right to request a non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of covered drugs (formulary), or You have been receiving a specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your physician must complete a medical necessity form and deliver it to the Optima Health pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, Optima Health will make a determination. Optima Health will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.

Synchronization of Medication. For prescription drugs Covered under the Plan We will permit and apply a prorated daily cost sharing rate to prescriptions that are dispensed by an In-Network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the Member, and the Member requests or agrees to a partial supply for the purpose of synchronizing the Member's medications. Proration will not occur more frequently than annually.

The Plan will not deny Coverage for the dispensing of a medication by an In-Network pharmacy on the basis that the dispensing is for a partial supply if the prescribing provider or the pharmacist determines the fill or refill is in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the Member's medications.

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Fill your prescriptions with home delivery

How it works.

1. Order up to a three-month supply of your maintenance medications — ones you take regularly — by mail, phone or online.
2. OptumRx® fills your order, mails it to you and lets you know when to expect your delivery.
3. Your medication arrives within 7 to 10 days of placing the order. OptumRx will notify you if there will be a delay in your order.

Four easy ways to enroll:

Online.

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

Phone.

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

Mail.

Complete the attached order form and mail it to

OptumRx, P.O. Box 2975, Mission, KS 66201.

ePrescribe.

Or your doctor can send an electronic prescription to OptumRx.

Manage your medication home delivery on the go.

Order and track your prescriptions online or with our app.

The benefits of home delivery.



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



Your maintenance medication could cost less.



Pay nothing for standard shipping.



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

¹ OptumRx provides this service at no additional cost. Standard message and data rates charged by your carrier may apply.

Frequently Asked Questions

Why should I use OptumRx® for my prescriptions?

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

What is a maintenance medicine?

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

How do I use home delivery?

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

How do I refill a prescription I have already received through OptumRx?

Do one of the following:



Visit our website: optimahealth.com/members.



Call OptumRx toll-free: 1-866-244-9113.



Send in the refill slip that came with your previous order. Be sure to include your co-payment. Mail it to OptumRx.

Frequently Asked Questions

How do I fill a new prescription?

- Fill out an order form. Write the member ID number, patient name and patient date of birth on the back of each prescription.
- Mail the form to OptumRx. Include the prescription(s) and payment information.

How can my doctor order a prescription for me?

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

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

Timing and shipping

When will I receive my order?

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

What situations may cause a delay in prescription processing?

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

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

Am I charged for shipping?

No, shipping is free. However, OptumRx also offers expedited shipping for an extra charge.

How can I check on the status of my prescription order?

Visit **optimahealth.com/members** or call us at **1-866-244-9113**. Plan members who create an account on **optimahealth.com/members** will receive email notification when a prescription is shipped.

Frequently Asked Questions

If I pay for rush shipping, when will it arrive?

Rush shipping reduces the time in transit only. The actual prescription processing time does not change and can vary due to quality checks we perform or exceptions that may arise. Possible exceptions include needing additional information from your doctor, prior authorizations or drug interactions. These steps promote the health and safety of plan members and provide the highest level of quality when processing your prescriptions.

Why am I receiving overnight shipping when I did not request it?

We ship certain medications overnight at our expense due to special handling requirements. This may apply to prescriptions for controlled substances or medications that are temperature sensitive.

What happens if I don't receive my order?

If you do not receive your order within 14 days, please contact us toll-free. We will reship your order to you as it is our priority to ensure you have the medication you need.

Prescription refills

How do I know whether I have refills remaining on my prescription?

The number of refills allowed is noted at the bottom of your medication label, on your refill form and can also be found on the optimahealth.com/members website.

How soon can I order a prescription refill?

For most prescriptions, you may reorder when you have approximately 3 weeks of your prescription left. Your medication label includes a target date for refilling the prescription.

- When ordering refills from OptumRx using the automated phone system, you will receive a message if your prescription is "too soon to refill." You will be given the date when refills will be available.
- If you place a refill order after the expiration of your prescription, or if no refills are remaining, we will contact your physician for a new prescription. This may cause a slight delay.

I have a prescription on file at a retail pharmacy; can I order refills from OptumRx?

Yes, however a new prescription from your doctor is recommended.

Medication coverage and cost

What drugs are covered?

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

Frequently Asked Questions

How much will my medicine cost me?

The easiest way to determine the cost of your prescription is to log in to optimahealth.com/members.

How can I pay for my home delivery prescriptions?

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

Miscellaneous

How do I obtain additional order forms?

You can print order forms at optimahealth.com/members. You also receive a reorder form, refill form and pre-addressed envelope with each prescription mailed to you.

Can I speak with a pharmacist if I use OptumRx home delivery?

Yes, pharmacists are available to answer questions regarding your medication at **1-866-244-9113**.

Can I fax my prescription that I received from my doctor?

No. Legally, OptumRx is only allowed to accept faxed prescriptions from your doctor's office.

Is my information kept private?

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

Why did I receive less than a 90-day supply of my prescription?

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

What is a "controlled" medicine?

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



Call OptumRx home delivery toll-free: **1-866-244-9113**



or visit: **optimahealth.com/members**

OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum® company — a leading provider of integrated health services. Learn more at optum.com.

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Frequently Asked Questions

Proprium PHARMACY

What is a specialty pharmacy?

Specialty pharmacies handle high cost medications for complex health conditions. These medications often require special handling, disposal, and/or monitoring. The pharmacy's team members help to identify and remove barriers so patients are able to take their medications and thus improve their quality of life.

What services does Proprium Pharmacy provide?

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

What are the hours for Proprium Pharmacy and how do I contact you?

- Business Hours: Monday-Friday 8:30 AM-5:30 PM EST
- You may contact us at Phone: 757-553-3568 or Toll Free 1- 855-553-3568
- A pharmacist is on-call 24 hours a day, 7 days a week for any emergency issues that may arise.

How much will my medications cost?

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

What if my insurance company doesn't cover my medications or I cannot afford the copayment and coinsurance?

We have patient care advocates who are dedicated to working with your physician and insurance company to obtain coverage for your medications wherever possible. These patient care advocates also perform a thorough investigation and eligibility review of available patient financial assistance programs with the goal of lowering your cost as much as possible.

Frequently Asked Questions

Proprium P H A R M A C Y

Does Proprium Pharmacy have access to all specialty medications?

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

How do I pay for my medications?

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

How do I receive my medications?

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

What is the cost for delivery?

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

How do I refill my medication?

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

How should I dispose of unused medications?

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

www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm

www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/default.htm



Behavioral Health Information

Behavioral
Health





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 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.

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



Optima Employee Assistance Program (EAP)

Optima EAP (Employee Assistance Program) provides short-term, solution-focused counseling services through professional, caring counselors. You can confidentially turn to Optima EAP even before an issue or concern severely impacts your home life or work performance.



Simply call 1-800-899-8174 or visit OptimaEAP.com to get started.

Our services are sponsored by your employer, meaning there is no cost to you or your household members.

Whether you're trying to support a family member, improve a relationship, find tools to manage stress, handle conflict with a coworker or an employee, or make other positive changes in your life, **Optima EAP is here to help**. With our resources, you can learn how to:

- Manage stress or anger
- Improve family dynamics
- Address substance abuse/dependency
- Deal with grief or a loss
- Build resilience
- Balance work and life obligations like working and taking care of a sick loved one

Counseling Services

Call 1-800-899-8174 to schedule an in-person or virtual counseling appointment with a counselor near you. Confidentiality is an important component of our program. Discussions with our counselors are protected by strict Protected Health Information (PHI) privacy laws. Optima EAP will not share any PHI, either in written or verbal form, unless required by law or if you give prior consent.

Online Resources

Visit OptimaEAP.com for inspirational posts, web-based training, self-tests, and questionnaires. We also have fast facts and informational articles on topics such as child development and parenting, financial issues, depression, and much more.

You and your household members can receive up to five (5) in-person or virtual counseling sessions per presenting issue.



Frequently Asked Questions

What can I expect when I call Optima EAP?

Our friendly and helpful Intake Coordinators will ask for basic information, such as your name and the name of your employer. They will then assist you with scheduling a counseling appointment.

How much do Optima EAP services cost?

Optima EAP services are paid for by your employer and are available at no cost to you or your household members.

Will it really help to talk with someone about my problems?

It's often helpful to speak with a trained professional who can offer objectivity. A counselor may have a different perspective on the problem and offer suggestions or interventions that you haven't considered. Our focus is on helping you to find a solution.

What happens at a counseling session?

When you first arrive, you will be asked to complete some basic paperwork and a health questionnaire. You will then meet with a counselor who will assess your situation and work with you to develop solutions. Counseling sessions typically last about 45 minutes.

What is Virtual Counseling?

Optima EAP recognizes that it is not always possible or convenient to have a face-to-face counseling appointment. Our Virtual Counseling option uses a HIPAA-compliant platform to allow you to speak with a counselor using a smartphone, tablet, or desktop computer.

How do I schedule a Virtual Counseling appointment?

You can make an appointment by calling Optima EAP at 1-800-899-8174 Monday to Thursday from 8 a.m. – 7 p.m. and Friday 8 a.m. – 5 p.m. We will confirm that you are eligible to use Virtual Counseling, schedule your appointment, and ask for your email address. We will then send you an encrypted email with instructions on how to complete your pre-appointment paperwork and how to access your counseling session.





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 Digital Health Assistant (DHA). The DHA delivers a personalized, interactive, and motivational experience to help members take action and sustain healthy habits in a fun way.

Healthy Publications

Members can visit optimahealth.kramesonline.com/ for valuable information about health improvement, disease and condition management, and preventive healthcare.

Patient Identification Manager Reminder System

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

- Mammography reminders: Women 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.
- Cervical cancer screening reminders: Women age 22 and older who have not had a cervical cancer screening in the previous 12 months receive a postcard during their birthday month. This card informs them of Pap Test recommendations, and the importance of cervical cancer and mammography screening.



Health and Preventive Services, continued

- **Healthy pregnancy mailings:** Once the health plan learns of a member's pregnancy, she receives the following:
 1. the Planning a Healthy Pregnancy Self-Care Handbook
 2. a letter and magnet featuring the childhood immunization schedule and our wishes for a healthy delivery (sent once member is in her seventh month of pregnancy)
- **Immunization postcards:** 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 bookmark 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.

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

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



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 9,500 fitness facilities and programs designed to engage at all fitness levels.

- Top brands include 24 Hour Fitness, 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, and exercise videos from Zumba.

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 Nutrisystem, 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. Members will be prompted to sign in (or first register* for their free, secure online 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. – 6 p.m. EST.

* If you have not yet registered for your free online account, visit optimahealth.com/register. The information you provide must match the information on your Optima Health member ID card.

These discounts apply for all Optima Health members and do not, in any way, affect your premium, nor are they covered benefits under your health plan. These discounts cannot be used in conjunction with any other discount, rider, or benefit, and you will be responsible for applicable taxes. Optima Health is the trade name of Optima Health Plan, Optima Health Insurance Company, and Sentara Health Plans, Inc. Optima Vantage HMO products and Point-of-Service products are underwritten by Optima Health Plan. Optima Plus PPO products and Optima Individual Plans are underwritten by Optima Health Insurance Company. Sentara Health Plans, Inc. provides administrative and TPA services for self-insured group health plans. The services listed on this page are value-added benefits available to Optima Health plan members, and not covered benefits under any Optima Health Plan.



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 1-877-335-2746 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.



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 Meningococcal (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 2019 Clinical Guidelines
- CDC Recommended Childhood and Adolescent Immunization Schedule 2019 and CDC Recommended Adult Immunization Schedule 2019



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 50 and then every 10 years
Sigmoidoscopy, or	Complete by age 50 and then every 5 years
Fecal Occult Blood Test	Complete by age 50 and then yearly
Early Cancer Detection - Female*	
Pap Test	Start by age 21 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 recommendations
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 2019.



Preventive Services Covered Under Health Care Reform

Covered Preventive Services for Adults

Abdominal aortic aneurysm screening: men

Alcohol misuse: screening and counseling

Aspirin use: adults aged 50–59 with risk of cardiovascular disease

Blood pressure screening

Cholesterol screening for adults of certain ages

Colorectal cancer screening and generic and over-the-counter prep medications: adults age 50–75

Consultation for screening colonoscopy

Depression screening

Diabetes screening: adults with high blood pressure

Falls prevention: adults 65 years or older—Vitamin D and exercise or physical therapy

Healthy Diet Counseling

Hepatitis B screening

Hepatitis C virus infection screening: adults born between 1945 and 1965

HIV pre-exposure prophylaxis (PrEP)

HIV screening

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 55–80 with history of smoking

***Statin medications:** adults ages 40–75 with no history of cardiovascular disease who have one or more risk factors and calculated 10-year risk

STI counseling

Syphilis screening

Tobacco use counseling, generic and over-the-counter medications, and cessation interventions

Tuberculosis screening

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

Covered Preventive Services for Women, Including Pregnant Women

Anemia screening: pregnant women

Bacteriuria screening

BRCA risk assessment and genetic counseling/ screening

Breast cancer chemoprevention counseling

***Breast cancer preventive medication**

Breast cancer screening: women over age 40

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.

* 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 Women (continued)

Decision making/sharing by clinicians with women at increased risk for breast cancer

Depression screening

Folic acid supplementation

Gestational diabetes screening: women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes

Gonorrhea screening

Hepatitis B screening at first prenatal visit

HIV screening: pregnant women

HPV Test

Intimate partner violence screening and counseling

Lactation support and counseling

Osteoporosis screening: 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

Well-woman visits

Tobacco counseling and intervention

Covered Preventive Services for Children

Alcohol and drug use assessments

Autism screening: children at age 18 and 24 months

Behavioral assessments

Blood pressure screening

Cervical dysplasia screening: sexually active females

Congenital hypothyroidism screening: newborns

Dental cavities prevention: infants and children up to age five years

Depression screening: adolescents

Developmental screening: children under age three, and surveillance throughout childhood

Dyslipidemia screening: children at high risk of lipid disorders

Fluoride chemoprevention supplements for children without fluoride in their water source

Gonorrhea prophylactic medication: newborns

Hearing loss screening: newborns

Height, weight, and body mass index measurements

Hematocrit or Hemoglobin screening

Hemoglobinopathies screening: newborns

Hepatitis B screening: non-pregnant adolescents and adults

HIV screening

Immunization vaccines:

Diphtheria, Tetanus, Pertussis

Haemophilus influenzae type b

Hepatitis A

Hepatitis B

Human Papillomavirus

Inactivated Poliovirus

Influenza

Measles, Mumps, Rubella

Meningococcal

Pneumococcal

Rotavirus

Varicella

Iron supplementation

Lead screening for children at risk of exposure

Medical history

Obesity screening: children and adolescents

Oral fluoride supplementation starting at age six months for children whose water supply is fluoride deficient

Oral health risk assessment

Phenylketonuria (PKU) screening: newborns

Skin cancer behavioral counseling: children, adolescents and young adults age 10 to 24 years old

STI prevention counseling and screening for adolescents at high risk

Tobacco use interventions: children and adolescents

Tuberculin testing for children at higher risk of tuberculosis

Visual acuity screening



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 shot¹:

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.

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



Chiropractic Care

For covered services under this benefit, Optima Health contracts with American Specialty Health (ASH) to provide chiropractic services in the Plan's service area.

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

How to receive covered services

- Call an ASH participating provider and schedule an appointment. You do not need a referral.
- The ASH chiropractic provider is responsible for getting authorization from ASH before you receive care except for initial examination and Emergency Services.
- If you have questions about what is covered or how to find an ASH provider, please call ASH toll-free at 1-800-678-9133, Monday through Friday 5 a.m. to 6 p.m. ET.

Covered services include examination, re-examination, manipulation, conjunctive therapy, radiology, chiropractic appliances, and laboratory tests related to the delivery of chiropractic services subject to the following:

- An initial exam is performed by the participating provider to determine the nature of the member's problem and, if covered services are needed, a treatment plan is prepared. One initial exam is provided for each new patient. A copayment is required when services are rendered.
- A re-examination may be performed by the participating provider to assess the need to continue, extend, or change a treatment plan approved by ASH. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment is required.
- Subsequent office visits may involve an adjustment, a brief re-examination, and other services. A copayment is required for each visit to the office.
- Adjunctive therapy may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.
- X-rays and clinical laboratory tests are payable in full when referred by a participating chiropractor and authorized by ASH. Radiological consultations are a covered benefit when authorized by ASH as Medically Necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH to provide those services.
- Chiropractic appliances are covered up to a maximum benefit of one (1) appliance per year when prescribed by a participating chiropractor and authorized by ASH.

The following are excluded from coverage:

- any services or treatments not authorized by ASH, except for initial exam 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 exams and/or treatments for conditions other than those related to neuromusculoskeletal disorders from participating chiropractors
- hypnotherapy, behavior training, sleep therapy, and weight programs



Chiropractic Care, continued

- 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 (MRI), CT scans, bone scans, nuclear radiology and any diagnostic radiology other than covered plain film studies
- transportation costs including local ambulance charges
- education programs, non-medical self-care or self-help or any self-help physical exercise training or any related diagnostic testing
- 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 in this document
- 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.

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



Diabetes Treatment—Traditional Plans

Does not apply to Equity or HSA-eligible plans

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

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

- Insulin pumps, pump infusion sets and supplies, outpatient self-management training and education, and nutritional therapy are covered under the Plan's medical benefits.
- Insulin, needles, and syringes as well as testing supplies (test strips, lancets, lancet devices, blood glucose monitors, and control solution) are covered under the Plan's pharmacy benefits. Diabetes testing supplies will be limited to LifeScan products, except in the case of members using an insulin pump associated with a specific, non-LifeScan meter.
- For members who may not be using a LifeScan meter currently, there are two ways to obtain a free LifeScan meter:
 - Order online at OneTouch.orderpoints.com or call the toll-free number: 1-855-776-4464 and input the Optima Health order code 741OPT016
 - Visit a participating pharmacy and present the attached pharmacy voucher
- An annual diabetic eye exam is covered when received from an Optima Health Plan Provider or a participating EyeMed Provider.

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

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

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

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OUT OF AREA DEPENDENT CHILD NOTIFICATION

For use with Out of Area Dependent Program

This form is required for dependent children living outside of the Optima Health service area.

TO ENSURE ACCURATE CLAIMS PAYMENT, THIS FORM MUST BE COMPLETED AND RETURNED TO YOUR HUMAN RESOURCES DEPARTMENT.

Group No. _____ **Group Name:**_____ **Member No.** _____

Eff. Date of Coverage: _____ PRODUCT: _____

YOUR COMPLETE NAME

SOCIAL SECURITY NUMBER

Last Name	First	MI
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Enter the names(s) and address(es) of your eligible dependents out-of-area:

Dependent 1	Name	_____
	SSN	_____
	DOB	_____
	Address	_____
	City, State, Zip	_____
	Telephone	_____

Dependent 2 Name _____
 SSN _____
 DOB _____
 Address _____
 City, State, Zip _____
 Telephone _____

Dependent 3	Name	_____
	SSN	_____
	DOB	_____
	Address	_____
	City, State, Zip	_____
	Telephone	_____

Protect Yourself, Protect Others. Get your Flu Shot.



OPTIMA HEALTH MEMBERS MAY VISIT THE FOLLOWING LOCATIONS TO RECEIVE A FLU SHOT

YOUR PHYSICIAN'S OFFICE

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

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

YOUR LOCAL PHARMACY

There is no Copayment, Coinsurance, or Deductible for members that receive a covered flu vaccine from a participating pharmacy (age restrictions may apply). Please contact your local pharmacy to verify participation.

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

2019–2020 INFLUENZA SEASON

Optima Health covers the flu vaccine for members with medical and/or pharmacy benefits. We will cover the flu vaccine under your preventive care benefit at 100% for the 2019–2020 influenza season.

For the 2019–2020 influenza season, Optima Health will cover Trivalent and Quadrivalent Influenza Vaccines. Adjuvant Influenza Vaccine is covered for members age 65 and older.

High-Dose and Flu Mist Influenza Vaccines are NOT covered for all ages. Adjuvant Influenza Vaccines are NOT covered for members age 64 and younger. Optima Family Care and Optima Health Community Care members (excluding FAMIS) age 18 and younger MUST obtain influenza vaccinations through the Vaccines for Children (VFC) program. Please see your doctor, physician, or pharmacy for information on receiving the flu vaccine.

For more information, visit
optimahealth.com/flu

OptimaHealth 



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 accounts¹, and other important health plan information. In addition, members can:



schedule virtual care visits for medical and behavioral health care



participate in wellness activities and track health progress



contact Member Services



download important documents and forms



search for nearby doctors and hospitals

and much more!



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 Account plans

Additional Resources



MYLIFE MYPLAN: My Health Assistant

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

Make checking in with My Health Assistant part of your regular routine, and you'll have what it takes to start a good health routine and stick with it. My Health Assistant, powered by WebMD Health Services, uses the goals and activities you select to create simple weekly plans that get you from start to success. During your journey, you'll enjoy an interactive online experience that's motivational, fun, and invigorating.

Focus on one or more of the following areas:

- nutrition
- exercise
- weight loss
- stress management
- emotional health
- tobacco cessation

Your Digital Health Assistant (DHA)

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



Ready - Accessing the Digital Health Assistant

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

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

Set – Setting Goals with the Digital Health Assistant

Option One - Set a DHA goal based on your Personal Health Assessment (PHA) score.

- complete the PHA questionnaire
- from your PHA results screen, click the green *Let's Go!* button to navigate to the *My Health Assistant* page and choose your goal(s)

For more information, visit
optimahealth.com/mylifemyplan



MYLIFE MYPLAN, continued

Option Two - Set a DHA goal without taking the Personal Health Assessment.

- from your personalized WebMD wellness home page, select the *Healthy Living* tab at the top of the page
- select *My Health Assistant*
- choose which goal(s) you would like to work towards by clicking *Manage My Goals*

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

Success – Reaching Goals with the Digital Health Assistant

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

- sign in at optimahealth.com/mylifemyplan and select *Wellness Tools* from the menu
- from your personalized WebMD wellness home page, select the *Healthy Living* tab at the top of the page and choose *My Health Assistant*
- click on the icon that best represents your daily activities towards each goal
- sign in daily or weekly to record your activities: weeks begin on Sunday and end on Saturday (you may only back-track and record past activities completed since Sunday of the current week)

DHA	How to Record Your Daily Activities
Eat Better	Click On Track, A Little Off, or Off Track
Enjoy Exercise	Click More than 20 Minutes, 20 Minutes, or Less than 20 Minutes
Lose Weight	Enter your current weight
Conquer Stress	Enter your current stress level on a scale from low to high
Feel Happier	Click Happy, Okay, Down, or Sad
Quit Tobacco	Enter how many times you use tobacco daily

Additional Resources



MDLIVE | Exceptional Care, Anywhere.

With MDLIVE, you can visit with a doctor 24/7 from your home, office or on the go. MDLIVE's network of board-certified doctors is available by phone or secure video to assist with non-emergency medical conditions.

Who are our doctors?

MDLIVE has the nation's largest network of telehealth doctors. On average, MDLIVE's 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. MDLIVE's doctors are committed to providing convenient, quality care and are always ready to take your call.



When should I use MDLIVE?

- 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



MDLIVE, 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. MDLIVE has 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 MDLIVE Virtual Visit.

Disclaimers: MDLIVE does not replace the primary care physician. MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. MDLIVE 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. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit mdlive.com/pages/terms.html 010113.

Treatment Cost Calculator

BETTER INFORMATION

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

BETTER DECISIONS

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

BETTER HEALTH

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

Sign in at optimahealth.com 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 estimates¹ 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.



Epic Hearing Healthcare



ListenHear • LiveWell

Welcome

to the **Listen Hear, Live Well**
Hearing Health Wellness Program

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



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 batteries¹.

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 trial 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

¹Excludes Basic Level Products



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

NOTES

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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 an Evidence of Coverage (EOC) or Certificate of Insurance (COI), and a Uniform Summary of Benefits and Coverage (SBC). Your EOC/COI is an important document. Read it carefully to understand what services are covered under Optima Health. Your copayments, coinsurances, and deductibles are also listed on the Face Sheet of the EOC/COI. Your SBC is a federally mandated document that contains clear, consistent, and comparable information about your health plan benefits. When you enroll, we will send you instructions on how to access your EOC/COI 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



Frequently Asked Questions

Regulatory Information, continued

notice will be included in your EOC/COI when you enroll. You can also go to optimahealth.com/members to see a copy of our privacy notice.

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

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

What if I decide not to enroll with Optima Health at this time? Will my dependents or I be able to enroll later?

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents with Optima Health if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after you or your dependents' other coverage ends, or after the employer stops contributing toward the other coverage.

If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Does Optima Health offers special enrollment for employees and dependents that lose eligibility under Medicaid or CHIP coverage?

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

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



Frequently Asked Questions

Regulatory Information, continued

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

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

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

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

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

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

What rights do I have under Maternity Benefits?

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

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

Under Virginia State Law, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version



Frequently Asked Questions

Regulatory Information, continued

of or an official update to the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the “Standards for Obstetric-Gynecologic Services” prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and copayments that are generally no less favorable than for physical illness.

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. DMAS, CMS, OIG, BOI) 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.



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 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.



Resolving Member Grievances, 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.

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

Optima Health has a formal grievance and complaint process that allows your concern to be addressed with the appropriate department or persons within Optima Health. We will review your complaint as quickly as possible and notify you of how it will be resolved.

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. Please note that if your coverage denial involves the treatment of cancer you do not have to file an internal appeal before filing an external appeal. You can submit a request for external review to the Virginia State Corporation Commission's Bureau of Insurance:

State Corporation Commission

Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
Phone: 1-877-310-6560
Fax: 804-371-9915
Email: externalreview@scc.virginia.gov

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



Resolving Member Grievances, Complaints, and Appeals of Adverse Benefit Determinations, continued

Additional Resources

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

Office of the Managed Care Ombudsman

Bureau of Insurance

Post Office Box 1157

Richmond, VA 23218

Toll-Free: 1-877-310-6560

Richmond Metropolitan Area: 804-371-9032

Email: ombudsman@scc.virginia.gov

Virginia Department of Health

Office of Licensure and Certification

9960 Mayland Drive, Suite 401

Henrico, VA 23233

Toll-Free: 1-800-955-1819

Life & Health Division Bureau of Insurance

Post Office Box 1157

Richmond, VA 23218

804-371-9741 or In-State Toll-Free: 1-800-552-7945



EXCLUSIONS AND LIMITATIONS

Vantage/POS Products

The following is a list of Exclusions and Limitations that generally apply to all Optima Health plans. Once you are an enrolled member please refer to your Plan documents for the Exclusions and Limitations specific to your plan.

This chapter lists services that are not covered. Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

A

Abortion is covered in the first 12 weeks of pregnancy. After 12 weeks abortion is covered if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

Acupuncture is not 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 We authorize the service.

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 a Covered Service.

B

Batteries are not Covered Services except for motorized wheelchairs, left ventricular assist device (LVAD) and cochlear implants when authorized.

Blood Donors. Costs for finding blood donors are not Covered Services. Costs for transportation and storage of blood in or outside the Plan's Service Area is not a Covered Service.

Bone Densitometry Studies more than once every two years are not Covered Services unless We authorize them.

Bone or Joint treatment involving a bone or joint of the head, neck, face or jaw is covered like any other bone or joint of the skeletal structure. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone.

Botox injections are not Covered Services unless We have approved them.

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

Breast Ductal Lavage is not 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.

Chiropractic Care is not a Covered Service unless Your Plan includes a rider. Chiropractic care means diagnosis, correction, and management of vertebral subluxations or neuromusculoskeletal conditions.

Contact Lenses are not Covered Services. Fitting of lenses or eyeglasses is not a Covered Service. However, the first pair of lenses following cataract surgery including contact lens, or placement of intraocular lens or eyeglass lens only are Covered Services.

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 also 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;
- Non-medically necessary treatment or services resulting from complications due to cosmetic experimental procedures;
- Breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following mastectomy;
- Tattoo removal;
- Keloid treatment as a result of the piercing of any body part;
- Consultations or office visits for obtaining cosmetic or experimental procedures;
- Penile implants; or
- Vitiligo or other cosmetic skin condition treatments by laser, light or other methods.

Costs of Services paid for by Another Payor are not Covered Services. We do not cover the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of covered services in those cases where You received services in accordance with the Plan's authorization procedures. We will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

Court ordered examinations or treatments are not Covered 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 including, but not limited to the following:

- Residential care;
- Rest cures;
- Care from institutions or facilities licensed solely as residential treatment centers, intermediate care facilities, or other non-skilled sub-acute inpatient settings; or
- 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.
- 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 except for those 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 a Covered Service.
- Extraction of wisdom teeth is not a Covered Service unless Your plan includes a rider.

Dental Care.

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

Diagnostic tests or Surgical Procedures are not Covered Services where there is insufficient scientific evidence of its safety or efficacy 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 up to the limits stated on Your Plan's Face Sheet or Schedule of Benefits. Covered Services may be limited to an amount, supply, or type of DME that We determine will safely and adequately treat Your condition. **The following are not Covered Services:**

- 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**; or
- 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 where there is insufficient scientific evidence of the test's safety or efficacy in improving clinical outcomes are not Covered Services.

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 Covered Services. This does not include services that qualify as Early Intervention Services under the Plan's benefit; or for those services covered under Autism Spectrum Disorder benefits.

Enteral or Parenteral Feeding supplements are not Covered Services unless they are used as the sole or major source of nutrition. Over the counter infant formulas or 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, medical treatment or procedure is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment or procedure.

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 unless the plan includes a rider for vision materials. Fitting of lenses or eyeglasses is not a Covered Service except for 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 is not a Covered Service.

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

F

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 We have authorized the services. Counseling is a Covered Service only as part of the approved genetic test unless considered preventive care.

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

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

H

Hearing Aids are not Covered Services unless Your plan has a rider. Fittings, molds, batteries or other supplies are not Covered Services unless Your plan has a rider.

Home Births are not a Covered Service.

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

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not Covered Services.

Implants for cosmetic breast enlargement are not Covered Services. 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.

Unless listed as a Covered Service in this EOC, or under a Rider, **Infertility 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;
- Services, tests, medications, and treatments for the enhancement of conception;
- In-vitro Fertilization programs;
- Artificial insemination or any other types of artificial or surgical means of conception;
- Drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- Reproductive material storage;

- Treatment or testing 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;
- Drugs used to treat infertility;
- Surrogate pregnancy services.

J

K

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

L

M

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

Matristem Extracellular Wound Care System is not a Covered Service.

Maximum Benefit Amounts are stated on Your Plan's Face Sheet or Schedule of Benefits. Additional services or treatments 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 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; or
- 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 covered wellness services or screening visits. Nutritional formulas and dietary supplements that are available over the counter and/or without a written prescription are not Covered 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 unless Your plan includes a rider, and services have been **authorized by the Plan for Members who meet established criteria.**

Motorized or Power Operated Vehicles or chair lifts are not Covered Services unless authorized by the Plan. This does not include wheelchairs or scooters.

N

Neuro-cognitive therapy is not a Covered Service.

Newborns or other children of a Covered Dependent Child are not Covered Persons under the Plan unless mutually agreed to by the Plan and the Group.

O

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; or
- Extraction of wisdom teeth unless Your plan includes a rider.

Orthoptics or vision or visual training and any associated supplemental testing are not Covered Services.

For Optima Health Vantage HMO plans:

Services or treatment You receive from **Out-of-Network Non-Plan Providers** will not be Covered Services except in the following situations:

- If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits;
- Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket amounts.

For Optima Health POS and Patient Optional Point of Service plans:

Services or treatment You receive from **Out-of-Network Non-Plan Providers** will be Covered Services only under Your Out-of-Network benefits except in the following situations:

- If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits;
- Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket amounts.

P

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

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

Paternity Testing is not a Covered Service.

Penile implants are not a Covered Service.

Personal comfort items such as, but not limited to, telephones, televisions, extra meal trays, personal hygiene items, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs and any other similar items for personal comfort are not Covered 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 when authorized by the Plan. A second opinion by a Plan Provider does not require authorization.
- 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 Medically Necessary and surgery follows trauma which causes anatomic functional impairment, or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. 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 **are not Covered Services.**

Residential or Sub-Acute Level of Care or treatment is not a Covered Service.

S

Second Opinions from Plan providers do not require authorization. A second opinion from a Non-Plan provider is a Covered Service only when a Plan provider is not available and authorized by the Plan.

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; or
- Any service or supply that is a direct result of a non-covered service.

Spinal Manipulation is not a Covered Service unless covered under a Chiropractic Care Rider.
Sterilization

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

T

Non-interactive **Telemedicine Services** such as fax, telephone only conversations, email, or online questionnaire are not Covered Services under the Plan's Telemedicine benefits.

Therapies. Physical, Speech, and Occupational **Therapies** are limited as stated on Your Face Sheet or 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. **The following are not Covered Services except for those services that are listed under Early Intervention Services or under Autism Spectrum Disorder:**

- 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 or developmental 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 therapy; or
- Remedial education and programs.

Total Body Photography is not a Covered Service.

Transplant Services **-The following are not Covered Services:**

- Organ and tissue transplant services not listed as a Covered Service;
- 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; or
- Services related to donor complications following a transplant.

Transportation by Ambulance. Ambulance services that are not Emergency Services are Covered Services only when approved and authorized by Us.

Travel, Lodging and other Transportation expenses are not Covered Services unless approved and authorized by Us.

For Optima Health Vantage Plans:

Treatment and services, other than Emergency Services, received while **traveling outside of the United States of America** are not Covered Services.

For Optima Health POS and Patient Optional Point of Service Plans:

Treatment and services, other than Emergency Services, received while **traveling outside of the United States of America** are Covered Services only under Your Out-of-Network benefits.

U

V

Video Recording or Video Taping of any service or procedure is not a Covered Service. Treatment of **varicose veins** or **telangiectatic dermal veins** (spider veins) for cosmetic purposes are not Covered Services.

Virtual Consults do not include the following:

- Electronic mail message;
- Facsimile transmission; or
- Online questionnaire.

W

Wigs or cranial prostheses for hair loss for any reason are not Covered Services.

Wisdom Teeth extraction is not a Covered Service unless under a rider.

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

X

Y