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Group Name:

SURA/Jefferson Science Associates

Effective Date:

04/01/2014

Uniform Summary of Benefits and Coverage (SBC)

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.optimahealth.com/member or by calling 1-800-741-9910. Reference #2704

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0 person/$0 family in-network	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $2,500 person/$5,000 family in-network. $6,350 person/$12,700 family for prescription drugs.	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, healthcare this plan does not cover, pre-authorization penalties, and prescription drugs.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Does this plan use a network of providers?	Yes, For a list of participating providers, see www.optimahealth.com or call 1-800-741-9910.	If you use a participating provider or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 4. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Copayment	Not covered	--none--
	Specialist visit	$25 Copayment	Not covered	--none--
	Other practitioner office visit	Not covered	Not covered	--none--
	Preventive care/screening/immunization	No charge	Not covered	--none--
If you have a test	Diagnostic test (x-ray, blood work)	$25 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 www.optimahealth.com/member.	Selected Generic drugs	$10 Copayment retail prescription/$20 mail order prescription	$10 Copayment retail prescription/$20 mail order prescription	Coverage is limited to FDA-approved prescription drugs. If brand drugs are used when a generic is available, you must pay the difference in cost plus the Copayment. One Copayment 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.
	Selected brand and other generic drugs	$20 Copayment retail prescription/$40 mail order prescription	$20 Copayment retail prescription/$40 mail order prescription	
	Non-selected brand drugs	$40 Copayment retail prescription/$80 Copayment mail	$40 Copayment retail prescription/$80 Copayment mail	

		order prescription	order prescription	
	All other drugs	$40 Copayment retail prescription/$80 Copayment mail order prescription	$40 Copayment retail prescription/$80 Copayment mail order prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copayment/ admission	Not covered	Pre-Authorization required.
	Physician/ surgeon fees	No charge	Not covered	--none--
If you need immediate medical attention	Emergency room services	$200 Copayment/visit	$200 Copayment/visit	--none--
	Emergency medical transportation	$100 Copayment	Not covered	--none--
	Urgent care	$25 Copayment	Not covered	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copayment/day	Not covered	Pre-Authorization required. $500 maximum Copayment per admission.
	Physician/surgeon fee	No charge	Not covered	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 Copayment / visit	Not covered	Pre-Authorization required for intensive outpatient program and electro-convulsive therapy.
	Mental/Behavioral health inpatient services	$100 Copayment/day	Not covered	Pre-Authorization required for all inpatient services and partial hospitalization services. $500 maximum Copayment per admission.
	Substance use disorder outpatient services	$10 Copayment / visit	Not covered	Pre-Authorization required for intensive outpatient program and electro-convulsive therapy.
	Substance use disorder inpatient services	$100 Copayment/day	Not covered	Pre-Authorization required for all inpatient services and partial hospitalization services. $500 maximum

				Copayment per admission.
If you are pregnant	Prenatal and postnatal care	$100 Global Copayment	Not covered	Pre-Authorization required.
	Delivery and all inpatient services	$100 Copayment/day	Not covered	$500 maximum Copayment per admission.
If you need help recovering or have other special health needs	Home health care	$10 Copayment	Not covered	Pre-Authorization required. Coverage is limited to a maximum benefit of 100 visits per person per plan year.
	Rehabilitation services	$25 Copayment	Not covered	Pre-Authorization required. Coverage is limited a maximum benefit, per person per plan year, of: 30 combined visits for physical and occupational therapies; 30 combined visits for cardiac, pulmonary, vascular, and vestibular therapies; and 30 visits for speech therapy.
	Habilitation services	Not covered	Not covered	--none--
	Skilled nursing care	No charge after in-patient Copayment met	Not covered	Pre-Authorization required. Coverage is limited to a maximum benefit of 100 days per person per stay.
	Durable medical equipment	No charge	Not covered	Pre-Authorization required for single items over $750, all rental items, and repair and replacement.
	Hospice service	No charge	Not covered	Pre-Authorization required.
If your child needs dental or eye care	Eye exam	No charge	$30 Reimbursement	Coverage is limited to one exam every 12 months. Additional cost may apply for contact lens exam.

	Glasses	$100 allowance	Not covered	Coverage is limited to one every 12 months.
	Dental check-up	Not covered	Not covered	--none--

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- Habilitation Services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-741-9910. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

For group health coverage subject to ERISA, you may 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 (Toll Free), or bureauofinsurance@scc.virginia.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact Member Services at the number on the back of your member ID card, 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 (Toll Free), or bureauofinsurance@scc.virginia.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218, 1-877-310-6560, or http://www.scc.virginia.gov/boibureauofinsurance@scc.virginia.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-741-9910.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-741-9910.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-741-9910.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-741-9910.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,480
- **Patient pays** $1,060

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$910
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,060**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,680
- **Patient pays** $720

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$640
Coinsurance	$0
Limits or exclusions	$80
Total	**$720**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Welcome to Optima Health

This Benefit Information Guide answers general questions about primary care physicians, emergencies,urgent care, and more. If you need additional information, please contact us by website, phone, or mail.

Our Plans
Optima Health offers several different plan options to meet our customers' needs. This Benefit Information Guide outlines basic information and answers to common questions about the health maintenance organization (HMO) and point-of-service (POS) health plans. Remember, plan information such as Copayments, Coinsurance, and applicable Deductibles are referenced in your specific Plan benefit, a benefit structure that is chosen by your employer. Refer to your Plan documents for more details.

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 can depend on your PCP for routine medical assistance and guidance when seeking care within the Optima Health network. 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:

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

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

Optima Design Vantage and Optima Design POSA Plans
Optima Design Vantage is a Health Reimbursement Arrangement (HRA) coupled with a consumer-directed HMO plan. Similarly, Optima Design POSA is an HRA coupled with a high-deductible POSA plan. Benefits of Optima Design Vantage 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.

Use the Find a Doctor feature on
optimahealth.com/members
to locate an Optima Health Plan Provider

Optima Equity Vantage and Optima Equity POSA Plans
Optima Equity Vantage/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.

Optima Equity Vantage has an established network of Plan providers. Except for emergency services, all care must be received from Plan providers in the Optima Health network. Optima Equity POSA members can choose to receive services from in-network or out-of-network providers.

Provider Network
It is important to understand your Plan and your Plan's network in order to ensure your care is covered by Optima Health.

In-network or Plan Providers
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-service 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 or Non-Plan Providers
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. These providers can charge whatever they want for their services. Typically, when Plan members who have out-of-network benefits 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.

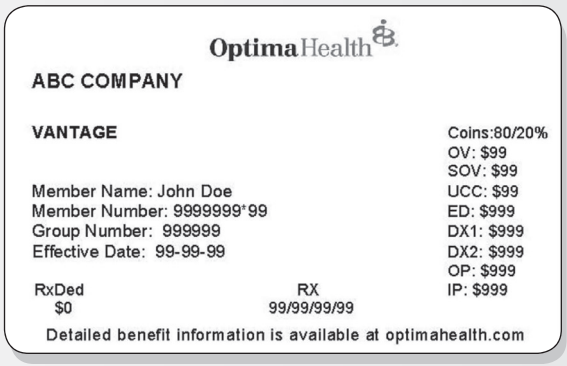
Member ID Cards

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

Member ID Card Abbreviations:

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

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



Welcome to OptimaHealth®

What is a plan primary care physician and why do I need one?

Your plan primary care physician (PCP) is your point of contact to coordinate your healthcare needs. They can provide both the first contact for an undiagnosed health concern as well as continuing care of varied medical conditions. Depending on your PCP for routine medical care and guidance when seeking care within the Optima Health network can increase your satisfaction with the plan and with your care. You will be asked to select an in-network or plan PCP for yourself and each of your eligible dependents when you enroll.

How do I choose or change a plan PCP?

When you enroll in an Optima Health Plan, you will be asked to choose a PCP for yourself and each of your dependents. New members can often continue relationships with their present doctor or select a doctor with an office more convenient to their 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 MyOptima 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 or 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 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 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.

How do new federal health reform changes affect my access to PCPs and OB/GYNs?

You have the right to choose any PCP who participates in our network and who is available to accept you and/or your family members. For children, you may choose a pediatrician as the PCP.

You do not need pre-authorization from Optima Health or from any other person (including a PCP) 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.

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.

FAQ's 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 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 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 amounts. 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. 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 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, simply 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, 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.

Pre-Authorization FAQ's

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 the Plan's benefit criteria for coverage. The provider of the service is responsible for obtaining pre-authorization. Licensed medical professionals such as LPNs, RNs, behavioral health professionals, clinicians, and medical doctors perform the process of pre-authorization by the Plan.

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

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.

POS Members: If you are a POS member who chooses to use your out-of-network benefits, you have the responsibility of ensuring that your non-Plan provider has obtained preauthorization from Optima Health prior to the procedure. The Plan may deny coverage or apply a $500 penalty for members who do not follow the Plan's pre-authorization procedures. Always check with Member Services or go online to optimahealth.com/members to ensure that your services have been pre-authorized before seeking treatment.

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.

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

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

How do I ensure pre-authorization has been obtained?

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

What if I need to be hospitalized?

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

FAQ's 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.

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

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

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

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

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

What should I do if I have an emergency?

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

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

How can I tell if it is an emergency?

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

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

What conditions generally do not require emergency department treatment?

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

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

What is the difference between an emergency department and an urgent care center?

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

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

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

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

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

FAQ's Emergency Care

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, a case manager will follow your case from beginning to end. He or she will review your chart daily, check your progress, and arrange for your continuing care needs after you leave the hospital.

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.

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

How will my prescription drugs be covered under Optima Health?

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

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 preferred tier (tier 1).

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

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

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

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

Are there any restrictions on filling my prescriptions?

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

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

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

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

FAQ's Member Services

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 resources such as a TDD phone line (1-800-225-7784). Members who are non-English speaking can connect to a language interpretation service by calling the number on the back of their member ID card. If you need assistance with any accommodations in accessing healthcare, contact Member Services at the number on the back of your member ID card or call toll-free, 1-877-552-7401.

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

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

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

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

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

- If you have dependents with a different last name from your own, you may need to produce legal documentation to support your relationship (e.g. birth certificate, marriage certificate, court order, adoption papers, etc.).
- If you have dependents that exceed the maximum dependent age, you will be asked to provide current documentation to support their disabled status. Be sure to contact Member Services to see if dependents exceeding the maximum dependent age are eligible for coverage.
- If your plan has a pre-existing condition exclusion, be sure to provide the Certificate of Creditable Coverage from your former health plan. Pre-existing condition exclusions do not apply to children under age 19.

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

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

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

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

The itemized bill should contain the name, address, tax ID number, and NPI number of the provider; the name of the member receiving services; the date, diagnosis, and type of services the member received, and the charge for each type of service. Your claim will be processed in accordance with out-of-network benefits.

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

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

How does Optima Health pay providers?

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

What is the Optima Health Quality Improvement Program designed to do?

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

How does Optima Health evaluate and determine coverage for new medical technologies?

Since healthcare is constantly changing, the Optima Health team of health professionals are always researching and evaluating new medical technologies and applications of existing technologies by the following:

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

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) and a Uniform Summary of Benefits and Coverage (SBC). Your EOC 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. 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 and SBC online at optimahealth.com/members, or to request a paper copy.

How can I find out what doctors and hospitals are in the Optima Health Provider Network?

When you enroll with Optima Health, you are entitled to a list of providers that are in the plan's network. You can find this list on optimahealth.com/members or you can call Member Services at anytime to find out if your provider is in the plan's network.

How does Optima Health use my personal information?

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

How does Optima Health protect my personal information?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. Optima Health will not use or further disclose HIPAA protected health information (PHI) except as necessary for treatment, payment, and health plan operations, as permitted or required by law, or as authorized by you. A complete description of your rights under HIPAA can be found in the Sentara Healthcare Integrated Notice of Privacy Practices. A copy of the notice will be included in your EOC 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. Under HIPAA, you have the right to request an accounting of certain disclosures of the information and under certain circumstances, amend the information. You have the right to file a complaint with Optima Health or with the Secretary of the U.S. Department of Health and Human Services, if you believe your rights under HIPAA have been violated.

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

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

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

FAQ's Important Regulatory Information

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 toll-free at 1-877-552-7401.

Why is a Certificate of Creditable Coverage important to my dependents and me?

A Certificate of Creditable Coverage is intended to help you and your dependents in case you lose or change health plan coverage. Under a federal law known as HIPAA, you or your dependents may need evidence of coverage to reduce a pre-existing condition exclusion period under another plan, to help get special enrollment in another plan, or to get certain types of individual health coverage. When you change healthcare coverage, or if you or your dependents lose coverage under a health plan, the plan sponsor is usually required to provide written certification of how long you and your dependents were covered under that plan. You or your dependents can also request a Certificate of Creditable Coverage if one is not automatically provided to you. When you enroll in an Optima Health plan, we ask that you include a copy of Certificates of Creditable Coverage for you and your dependents so that we may ensure you receive credit for your prior coverage against any pre-existing condition exclusion periods under your Optima Health plan. Please call Member Services if you have any questions about obtaining a Certificate of Creditable Coverage.

What is a pre-existing condition exclusion?

A pre-existing condition is any medical condition, other than pregnancy, for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period ending on the enrollment date.

If your plan has a pre-existing condition exclusion or waiting period, you will not be covered for those specific pre-existing conditions for a period of 12 months. Pre-existing condition exclusions do not apply to children under age 19. You may receive credit to reduce or eliminate the pre-existing condition waiting period for any creditable coverage if you were continuously covered under another health plan with no more than a 63-day break in coverage. Please refer to the Notice of Pre-Existing Condition Exclusion included with your plan documents, if applicable.

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

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

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

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

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

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

What rights do I have under Maternity Benefits?

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

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

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

What can I do to prevent Healthcare Fraud?

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

- Do not give your plan identification (ID) number or other personal information over the telephone or email it to people you do not know, except for your healthcare providers or Optima Health representatives.
- Do not go to a doctor who says that an item or service is not usually covered, but they know how to bill the health plan to get it paid. Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- Carefully review explanation of benefits (EOB) statements that you receive from the health plan. If you suspect a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, contact the provider for an explanation. There may be an error.

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

Optima Health Fraud & Abuse Hotline: **1-866-826-5277**

Email: **compliancealert@sentara.com**

Mail: **Optima Health**
c/o Special Investigations Unit
4417 Corporation Lane
Virginia Beach, VA 23462

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, Children, and Teens	Under 2	Every 2-3 months
	2-18	Yearly

Preventive Screening Reminders

SCREENING	AGE	RECOMMENDATION
Adult Immunizations		
Influenza (Flu Shot)		Annually
Tetanus/Diptheria	18+	Every 10 years
Pneumonia Shot	65+ 50+ for those at risk	1 dose 1-2 doses
Colorectal Screening		
Fecal Occult Blood Test or	50+	Yearly
Colonoscopy or	50+	Age 50, then every 10 years
Sigmoidoscopy	50+	Age 50, then every 5 years
Early Cancer Detection - Female*		
Pap Smear	21+	Per physician recommendation
Clinical Breast Exam	20-39 40+	At least every 3 years Yearly
Mammogram	40+	Yearly
Early Cancer Detection - Male*		
Digital Rectal Exam	50+ 40+ for those at risk	Annually
PSA (prostate-specific antigen)		Per physician recommendation

Call 1-800-736-8272 for information on 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 2012.

Immunizations

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 (if child has not received second dose.) Influenza yearly HPV (3 doses)	HPV (3 doses)
11-12 Years	Meningococcal (Meningitis shot) Talk with your doctor about when this immunization is needed. HPV (3 doses)	

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 2012 Clinical Guidelines
- CDC Recommended Childhood and Adolescent Immunization Schedule 2012 and CDC Recommended Adult Immunization Schedule 2012

Flu Vaccine

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

Optima Health members may visit the following locations to receive a flu shot[1]:

Your doctor:

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

Your local pharmacy:

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

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

Pneumonia Vaccine

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

Optima Health recommends the pneumococcal vaccine once for all patients 65 years and older. Additional high-risk groups include institutionalized persons over age 50; patients with chronic cardiac or pulmonary disease, diabetes mellitus, anatomic/functional asplenia; and immunocompromised patients. Those patients who are vaccinated prior to age 65 are considered for one revaccination five years from the initial vaccination date (for a total of two vaccinations).

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

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

Health and Preventive Services

Overview

Health and Preventive Services of Optima Health provides individual and group programs to improve health and prevent disease. The department offers a wide range of services including direct mail reminders, health screenings, self-learning programs, Internet education, flu shots, and selected classes. Many health education programs can be conducted on-site.

Personal Health Assessment & Health Coaching

The completion of a Personal Health Assessment (PHA) includes the identification of health risks for members and targeted interventions to reduce risks and improve health. Members receive health risk information targeted at their readiness to change and high-risk individuals are assigned to a health coach for follow up. The individual benefits by identification of his or her individual health risks and stage of readiness to change behaviors. In addition, the individual is identified for eligibility into the clinical care management and lifestyle coaching programs. The organization also benefits by risk stratification and behavior change readiness of their population. This allows the organization to identify population health management trends and participation in clinical care and lifestyle coaching programs.

The Personal Health Assessment completion process for the user includes five simple steps:

1. Learn about the PHA and incentive through promotion and communication efforts
2. Self-report of clinical information (e.g. BP, TC/HDL, height, weight) from screening or physician visit
3. Take the PHA online by visiting optimahealth.com/members and selecting “Start your Personal Health Assessment”
4. Consent to receive incentive and/or follow up intervention
5. Receive results of PHA and resources available for behavioral change

Optima Health has a powerful resource to help members adopt healthy behaviors, reduce health risks and lower their lifetime cost of care.* Through a partnership with Healthyroads®, members are provided health and wellness solutions that are designed and managed by clinical experts, fully integrated with the health plan, with an emphasis on improving the health of all members – not just at-risk members.

Optima Health provides this unique resource that includes: a health improvement website, personalized wellness plans, and access to health coaches. The comprehensive health coaching program is principally telephone-based with strong Internet tools, and educational resources to support the member in their goal to improve their health. Members complete a personal health assessment that is used to develop an individualized wellness plan. Members also have access to customized exercise planners, meal planners, over 40 wellness and fitness trackers, and over 100 online self-guided coaching classes. In addition, the health coaching program takes a family approach to behavior change. There is programming available by phone or website to family member’s age five years and over. A health coach will work with the entire family to guide them on a journey to better health. The program tracks include obesity, tobacco cessation, and healthy living.

Self-reported and claims data combine for better targeting, permitting outreach and interactions that are well coordinated and “member centric” rather than “disease centric.” Since members have access to health coaches and receive a personalized wellness plan, this resource promotes total population health management. Optima Health provides our most effective, individually focused intervention that seeks to change health behaviors and improve health. In turn, employers are better positioned to manage employee productivity and continue to offer competitive health benefits.

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

On-Site Screenings

Health and Preventive Services by Optima Health supports the Sentara Healthcare initiative, Is Your Number Up? This health improvement effort promotes blood pressure and cholesterol measurements for all adults. The Health and Preventive Services clinical staff arranges Know Your Numbers health screenings for health plan employer groups. These on-site events measure blood pressure, cholesterol, and weight, including BMI calculation, and offer opportunities for members to complete personal health assessments.

Members receive information about ways to reduce their identified health risks and improve health. Following a health screening event, a confidential group summary report outlining the results of the screening is mailed or delivered to the benefits administrator or designated contact within five business days.

Personal health assessments and on-site health screenings provide opportunities for adults to learn about their health risks and actions they can take to prevent cardiovascular disease. These preventive healthcare measures improve employee health and reduce unnecessary health costs.

Healthy Publications

Health and Preventive Services by Optima Health provides a variety of publications to members. Upon request, members receive Healthwise Handbook, featuring information about health improvement, common illnesses, and preventive healthcare. Pregnant members receive Planning a Healthy Pregnancy Self-Care Handbook upon the health plan's notification of their pregnancy.

Current and timely publications encourage members to take care of themselves and provide strategies to improve health. An informed member is a wiser consumer of healthcare.

Patient Identification Manager Reminder System

The Patient Identification Manager (PIM) Reminder System is a computer-based direct mail program designed to reach members and physicians every month to promote health. These initiatives support HEDIS®[2] improvement requirements. Mailings and communications include:

- Birthday cards: All plan members age three and over receive a birthday card or email during their birthday month from the Plan. Part of this mailing to members ages 18 and over includes information to remind members of the preventive health guidelines they should follow to achieve their personal best health; the mailing to members aged 3-17 years includes a bookmarker with games and puzzles to remind their family to schedule annual checkups. This card has replaced the need for five separate mailings to members so all requirements are met using one mailing instead of five.
- Mammography reminders: Women 40 and older who have not had a mammogram in the previous 12 months receive a letter or email during their birthday month.
- Cervical cancer screening reminders: Women 21 and older who have not had a cervical cancer screening in the previous 12 months receive a postcard or email during their birthday month.
- Healthy pregnancy mailings: Once the health plan learns of a member's pregnancy, she receives the following:
    1. The Planning a Healthy Pregnancy Self-Care Handbook
    2. A letter and magnet featuring the childhood immunization schedule and our wishes for a healthy delivery (sent once member is in her seventh month of pregnancy)
    3. Referral to the Optima Health Partners in Pregnancy program
- Immunization postcards and letters: Parents receive a postcard for their child at ages 6, 12, and 18 months emphasizing the basic immunization schedule.
- Physician notifications: Physicians receive monthly lists of their patients (our members) who were reminded through the PIM System and are still non-compliant for their immunizations and preventive screenings.
- Telephonic reminder system: Each month noncompliant members are reminded to get their necessary testing with regard to asthma treatment, medication compliance, well child visits, and antibiotic usage.

[2]HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Health and Preventive Services

Healthy Programs

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

Get Off Your Butt: Stay Smokeless for Life

This award-winning education and support program helps people who want to quit smoking. The program is available in a group or individual format, and includes information about nicotine addiction and effective ways to stop tobacco use. The program proudly boasts a higher “quit rate” than the national average.*

Healthy Heart

This self-paced program includes a guide for a healthy heart, Healthy Heart Yoga Booklet, and a guided meditation CD. Your Guide to a Healthy Heart tells you what you need to know about heart disease, what your risk factors are, how to talk to your doctor, and how you can take charge of your cardiovascular health. The Healthy Heart Yoga Booklet helps you begin stretching and strengthening exercises and the guided meditation CD gives you a technique to deal with the stressors in your life.

Eating for Life

This is a self-learning DVD and educational program that is mailed directly to the member’s home. It provides information about nutrition, wise food choices, and weight management. Participants complete the program in a time and place convenient to their schedule.

WalkAbout with Healthy Edge

This walking program promotes walking to increase physical activity throughout the day. By simply wearing a pedometer, the participant can measure the number of steps they take and work to increase their effort to reach 10,000 steps per day. This program is available at all on-site health screenings or by calling 1-800-SENTARA.

Flu Patrol

This on-site benefit is offered to selected worksites to administer influenza vaccines to health plan members from October through December. Sites are chosen to reach individuals with health considerations that would make it difficult for the member to recover from the flu. Information about wise self-care during flu season is also provided. There is a charge for these vaccines.*

Healthy Heart Yoga

This DVD is for people who want to maintain their cardiovascular health. It is intended for those who are capable of moderate physical activity. Healthy Heart Yoga can make a real difference in the health of your heart by strengthening your body, relaxing you both mentally and physically, and allowing you to better manage your stress reactions. The regular practice of Yoga can help you create a sense of union of your body, mind, and spirit, and bring balance to your life.

Healthy Heart Chair Yoga

This DVD is intended for people who need stretching and strengthening exercises, yet have difficulty getting up and down from the floor. Healthy Heart Chair Yoga can make a real difference in the health of your heart by strengthening your body, relaxing you both mentally and physically, and allowing you to better manage your stress reactions.

Tai Chi Qigong Shibashi

Regular practice of the 18 movements of Tai Chi Qigong Shibashi teaches your body to mentally and physically relax. The movements enhance your blood flow, release muscle tension, improve your balance, and help you maintain a high quality of life.

Workforce Assessment

A health education expert will review summary data with the employer to establish the best series of prevention programs. Employers may be offered an individual class designed for the workplace on topics such as self care, reducing cardiovascular health risks, women's health; lowering cholesterol, starting an exercise program, and managing high blood pressure.

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.

* These classes require a minimum number of employees to hold on-site and may not be available in all Optima Health markets. Contact your benefits administrator for more information.

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

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

Resolving Member Complaints and Appeals

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

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

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

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

Additional resources include:

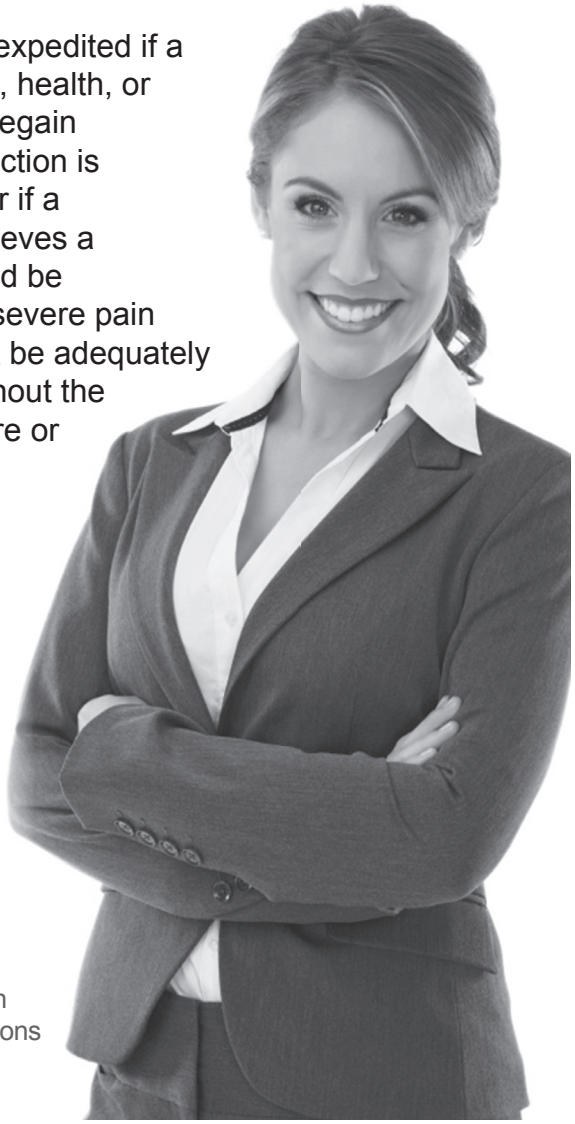
The Managed Care Ombudsman is available through the Bureau of Insurance to help Virginia consumers who experience problems with or have questions about managed care. The Managed Care Ombudsman can assist Optima Health members in understanding and exercising their rights of appeal of adverse decisions.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

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

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

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

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



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

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

Member Rights and Responsibilities

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

Member Rights

With Optima Health, you have the right to:

- Be treated in a manner reflecting respect for your privacy and dignity as a person.
- Be informed regarding your diagnosis, treatment, and prognosis in terms you can reasonably be expected to understand.
- Receive sufficient information to enable you to give informed consent prior to the initiation of any procedure and/or treatment.
- Participate with practitioners in decision making about your healthcare and refuse treatment to the extent permitted by law, and be made aware of the potential medical consequences of such action.
- A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Expect that all communications and records pertaining to your healthcare will be treated as confidential. Any data shared with employers is not implicitly or explicitly memberidentifiable unless specific consent has been obtained. No records will be released without your written authorization to protect access to your medical information. In the case of a minor, release of information is allowed only by authorization of a legal guardian.
- Express complaints or appeals to Optima Health about the managed care organization or care provided, and expect a response to that complaint or appeal within a reasonable period of time.
- Reasonable access to necessary medical services.
- Be informed of the Optima Health policies and procedures regarding services, benefits, practitioners, providers, and member rights and responsibilities, and be notified of any significant changes in those policies and procedures.
- Discuss your medical record with your plan doctor and receive, upon request, a summary of that record (at a nominal charge) as required under state law. Optima Health staff can only release records with your plan doctor's approval and signed consent.
- Obtain from Optima Health a Certificate of Creditable Coverage that shows prior, continuous coverage. With the certificate, you may be able to receive coverage under your next health plan with either no waiting period for pre-existing conditions or a reduced waiting period.
- Make recommendations regarding member rights and responsibilities.

Member Rights and Responsibilities

Member Responsibilities

You also have the responsibility to:

- Work with your Plan doctor to help establish the proper patient/doctor relationship.
- Schedule appointments and arrive on time for those appointments or notify the doctor's off ice if you must cancel or come late for a scheduled appointment. Charges for missed appointments are not covered by Optima Health.
- Meet the financial obligations regarding member premiums and Copayments, Coinsurance, and Deductibles when services are rendered.
- Ask any questions and understand the answers about your illness and/or treatment.
- Get and carefully consider all information necessary to give informed consent for a procedure or treatment.
- Weigh the potential consequences of any refusal to comply with Plan doctor instructions or recommendations.
- Follow the plans and instructions for care that you have agreed to with your practitioners.
- Be courteous, considerate, and cooperative in dealing with your Plan doctor, his/her office staff, and employees of Optima Health, and respect the rights of fellow Optima Health members.
- Express opinions, concerns, or complaints in a constructive manner to avoid similar problems in the future.
- Read and be aware of all material distributed by Optima Health explaining policies and procedures regarding services and benefits, and follow those policies and procedures when receiving care.
- Provide Optima Health and providers with complete and accurate information necessary to care for you, for your medical record, and for Optima Health membership records. This includes notifying Optima Health of any changes in status such as phone number, address, and number of dependents (i.e., birth, marriage, divorce, etc.), and information regarding other health insurance coverage for coordination of benefits purposes.
- Assist Optima Health in compiling a complete medical record by providing or by authorizing Optima Health to obtain necessary medical information. Ultimately, it is your responsibility to furnish Optima Health with any medical records needed to process a complaint, grievance, or appeal of a denied claim when Optima Health has been unable to obtain this information.

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

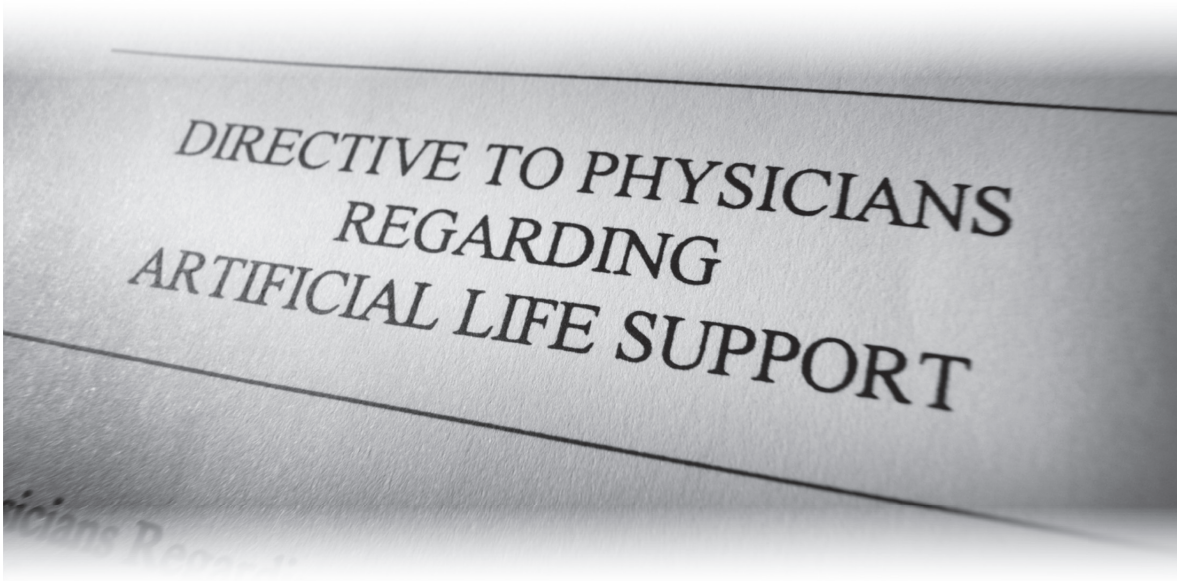
Procedures

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.



Summary of Benefits

SURA/Jefferson Science Change Sheet for 4/1/2014 Renewal

Beginning January 1, 2014 (upon a group's renewal) the following changes will occur. These changes are based on Optima's understanding of current Virginia and ACA regulations and requirements for plans renewing on or after 1/1/2014. Revised Summary of Benefits will be available once benefits are finalized.

1. ***Pharmacy:*** Optima Health is complying with the safe harbor (issued by HHS) allowing plans to have separate pharmacy and medical Maximum Out-Of-Pocket limits.

   What this means:
   - Covered **pharmacy** Out-of-Pocket expenses will be capped at $6,350 per member or $12,700 per family.
   - This is in addition to the **medical** Maximum Out-Of-Pocket (MOOP) limit.
   - For plans with a separate **pharmacy** MOOP, currently, on tiers 3 and 4 only, this will replace that MOOP and will apply to all tiers. The $250 cap per script will not change.

2. ***DME:*** Optima Health will be combining the Essential DME and Non-Essential DME benefit and removing the $3,000 calendar/contract per person benefit limit. Member's cost share will apply to the MOOP.

3. ***Artificial Limbs:*** Optima Health will be covering this as a core benefit, ***Prosthetics and Components***.

   Prosthetics and Components
   Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components.

   Definitions:

   "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

   "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

   "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.

   What this means:
   - Maximum $10K lifetime for adults removed.
   - Maximum for children under 18 (covered at 2x adult limit) removed.
   - Member's covered cost share will accumulate toward the plan's MOOP.

4. ***30% Coinsurance added to Artificial Limb Benefit*** for your plan.

5. ***Home Sleep Studies*:** Will be covered under Advanced Imaging with the associated Copayment or Coinsurance for the advanced imaging benefit. Pre-Authorization is required.

6. ***Coverage for Clinical Trials:*** Coverage for clinical trials will be expanded to cover phase 1 cancer and other diseases.

7. The ***In-Network Out-of-Pocket Maximum*** amount will increase by $500 per member and by $1,000 per family on the Optima Vantage 10/25.

8. ***Outpatient Dialysis Services Copayment*** on Vantage 10/25, the Copayment for Outpatient Dialysis Services will now match the specialist copayment for all places of service. Copayments will vary based on the specific plan's specialist Copayment amount.

9. ***Virtual PCP Consult:*** When furnished by providers approved by Optima Health to provide this service, Virtual PCP Consults will be covered as a PCP office visit, at the PCP Copayment amount. Copayments will vary based on the specific plan's PCP Copayment.

10. ***Ambulance Services*** Copayment changing to $100.

11. ***Home Health Visits*:** Home Health Visits will require a PCP Copayment per visit; visit limit remains at 100 visits per year. Copayments will vary based on the specific plan's PCP Copayment amount.

12. ***Physical Therapy; Occupational Therapy; Speech Therapy:*** Therapy visits will require a Specialist Copayment regardless of place of visit.

13. ***Cardiac Rehabilitation; Pulmonary Rehabilitation; Vascular Rehabilitation/Vestibular Rehabilitation:*** Rehabilitation visits will require a Specialist Copayment regardless of place of visit.

14. ***Mail Order and Specialty Drugs Provider*:** For all Optima Health Plans, the mail order drug provider transitioned from Caremark to Catamaran Home Delivery Service on 7/1/2013. In addition, the specialty drugs provider also transitioned to BriovaRx™. All specialty drugs must be obtained exclusively from BriovaRx™.

    - Members will be responsible for the applicable Copayment or Coinsurance per 31 day supply of a specialty drug.

Optima Vantage 10/25M Summary of Benefits	
Jefferson Science Associates/ SURA Effective 4/1/2014 Group #2704	
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. You must use In-Network Plan Providers for Your Covered Services. Medically Necessary Covered Services provided by a Non-Plan Provider during an emergency, or during an authorized admission to a Plan Facility, will be covered under Your In-Network benefits. All other services received from Non-Plan Providers will not be covered.	
Deductible[3]	
Your Plan Does not have a Deductible	
Maximum Out of Pocket Limit[4]	
$2,500 per Person Per Calendar Year $5,000 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 surgery[5].**	
Physician Office Visits	**In-Network Benefits Copayments/%Coinsurance[2]**
Primary Care Physician (PCP) Office Visit	$10 Copayment
Specialist Office Visit	$25 Copayment
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.	Covered at 50%
Preventive Care [10]	**In-Network Benefits Copayments/%Coinsurance[2]**
Routine Annual Physical Exam **Well Baby Exams** **Annual Gyn Exams and Pap Smears [11]** **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** **Women's Preventive Services**	Covered at 100%
Outpatient Therapy and Rehabilitation Services	
You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit.	
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] Copayment or Coinsurance applies at any place of service.	$25 Copayment per visit
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] Copayment or Coinsurance applies at any place of service.	$25 Copayment per visit

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Short Term Rehabilitation Services[6]	In-Network Benefits Copayments/%Coinsurance[2]
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] Copayment or Coinsurance applies at any place of service.	$25 Copayment per visit
Other Outpatient Treatments	**In-Network Benefits Copayments/%Coinsurance**[2]
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	$10 Copayment per PCP office visit $25 Copayment per Specialist office visit $25 Copayment per outpatient facility visit
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require prior-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.	Covered at 80%
Outpatient Dialysis Services	
	In-Network Benefits Copayments/%Coinsurance[2]
Dialysis Services Copayment or Coinsurance applies at any place of service	$25 Copayment
Outpatient Surgery	
	In-Network Benefits Copayments/%Coinsurance[2]
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.	$100 Copayment per Admission
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/%Coinsurance**[2]
Diagnostic Procedures	$25 Copayment
X-Ray **Ultrasound** **Doppler Studies**	$25 Copayment
Lab Work	$25 Copayment
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** **Pre-Authorization is required.**[5] Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	$150 Copayment

UNDERWRITTEN BY OPTIMA HEALTH PLAN

Maternity Care	
	In-Network Benefits Copayments/%Coinsurance[2]
Maternity Care[7, 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.	$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.	$100 Copayment per day up to a $500 maximum Copayment per Admission
Skilled Nursing Facilities/Services[6] **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 Services[8] **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.	$100 Copayment
Emergency Services	
	In-Network Benefits Copayments/%Coinsurance[2]
Emergency Services[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 without regard to whether the provider is in-network or out-of-network.	$200 Copayment per visit. If You are admitted the Copayment will be waived, and You will pay the Inpatient Hospital Services Copayment or Coinsurance
Urgent Care Center Services	
	In-Network Benefits Copayments/%Coinsurance[2]
Urgent Care Center Services[8] 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.	$25 Copayment
Mental/Behavioral Health Care	
Includes inpatient and outpatient services for the treatment of mental health and substance abuse. **Also includes services for Biologically Based Mental Illnesses** for the following diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.	
Mental/Behavioral Health Care	**In-Network Benefits Copayments/%Coinsurance[2]**
Inpatient Services **Pre-Authorization is required for all inpatient services, and partial hospitalization services.[5]**	$100 Copayment per day up to a $500 maximum Copayment per Admission
Outpatient Services **Pre-Authorization is required for intensive outpatient Program (IOP), and electro-convulsive therapy.[5]**	$10 Copayment per outpatient visit

UNDERWRITTEN BY OPTIMA HEALTH PLAN

Other Covered Services	
Other Services	**In-Network Benefits Copayments/%Coinsurance[2]**
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. Definitions: "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. "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.	Covered at 70%
Autism Spectrum Disorder **Pre-Authorization is required.[5]** Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder in children from age two through six. "Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder. "Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) **applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.** "Applied behavioral analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. **Coverage for Applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000 per child.[6]**	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.

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Other Services	In-Network Benefits Copayments/%Coinsurance[2]
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 listed on the Face Sheet or Schedule of Benefits.
Diabetic Supplies and Equipment Includes FDA approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. **Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment or Coinsurance per 31 day supply**. An annual diabetic eye exam is covered from an Optima Plan Provider or a participating EyeMed Provider at the applicable office visit Copayment or Coinsurance amount.	Covered at 80% for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. No Copayment or Coinsurance for insulin pumps. No Copayment or Coinsurance for outpatient self-management training and education, including medical nutritional therapy.
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, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.	Covered at 100%
Other Services	**In-Network Benefits Copayments/%Coinsurance[2]**
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 Services[6] **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.	$10 Copayment
Hospice Care **Pre-Authorization is required.[5]**	Covered at 100%

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Other Services	In-Network Benefits Copayments/%Coinsurance[2]
Vision Care and Materials Rider[6] Optima Health contracts with EyeMed Vision Services to administer this benefit. You are eligible to receive a routine eye examination, refraction; lenses and frames; or contact lenses once every 12 months from a Participating EyeMed Provider. Copayments or Coinsurance for covered services under this rider are not applied toward any Plan Maximum Out of Pocket Amount and must continue to be paid after the maximum is met. To contact EyeMed about participating Providers call 1-888-610-2268.	$0 Copayment per eye examination and materials. Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost. Lenses (single, vision, bifocal, trifocal) covered in full. Frames covered in full up to $100 retail. Contact lenses (in lieu of glasses) covered in full up to $100 retail. For eye examinations from Out-of-Network Providers Member's will be reimbursed $30 for an eye examination only.
Reduction Mammoplasty **Pre-Authorization is required.**[5] Coinsurance will apply to all services associated with Reduction Mammoplasty including but not limited to Physician, facility, surgical, and/or diagnostic services. **This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy**.	Covered at 50%
Telemedicine Services Telemedicine means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket deductible, copayment, or coinsurance amounts will not exceed the deductible, copayment or coinsurance amount you would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.

Notes

All benefits are subject to the terms and conditions in the *Evidence of Coverage* OHP.HMO.EOC.12 Words that are capitalized are defined terms listed in the Definitions section of the EOC. If Your Plan has a pre-existing condition exclusion, it will be stated in your Plan's EOC in the How Your Plan Works section. Pre-existing condition exclusions will not apply to children under age 19. Optima Health has an internal claims appeal process and an external 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's **Allowable Charge** for the Covered Service You receive.

   Allowable Charge is the amount Optima determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers Allowable Charge is the Provider's contracted rate with Optima or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full. Medically Necessary Covered Services provided by a Non-Plan Provider during an emergency, or during an authorized admission to a Plan Facility, will be covered under Your In-Network benefits. All other services You receive from Non-Plan Providers will not be Covered; and You will be responsible for payment of all charges to the Non-Plan Provider.

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. Amounts You are required to pay for outpatient prescription drugs, preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. Amounts applied to the Deductible will apply toward the Plan's Maximum Out of Pocket Limit. The Deductible does not apply to Physician office visits and You are required to pay the office visit Copayment only. Deductibles will not be reimbursed under the Plan. Any part of the

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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 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. Your Plan may have a separate Maximum Out of Pocket Limit for Outpatient Prescription Drugs. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayments or Coinsurances or 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. Balance billing amounts from Non-Plan Providers;
    3. Premium amounts;
    4. Amounts You pay as a penalty for failure to comply with the Plan's Pre-authorization procedures;
    5. Amounts You pay for Outpatient prescription drugs;
    6. Cost Sharing amounts including copayments, coinsurance, and deductibles for Covered Services that are not Essential Health Benefits including the following:
        i. Amounts You pay for Vision care;
        ii. Amounts You pay for any benefits covered under a plan rider including riders for Vision Care and Materials.
        iii. Amounts You pay for Reduction Mammoplasty benefits, except for procedures associated with reconstructive breast surgery following mastectomy.

5. This benefit requires Pre Authorization before You receive services. Your benefits for Covered Services may be reduced or denied if You do not comply with the Plan's Pre-Authorization requirements.

6. Coverage for this benefit or service is limited by a dollar amount and/or visit or day limits as stated. The Plan will not cover any additional services after the limits have been reached. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are excluded from Coverage 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 Mental/Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an Emergency Service, the Plan will have no responsibility for the cost of the treatment and You will be solely responsible for payment. 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. N/A

10. . Preventive Care includes the services listed below. You may be responsible for an office visit copayment or coinsurance when you receive preventive care. Some services may be administered under Your prescription drug benefit under the Plan.

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

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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.

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

Pharmacy Benefits

Optima Vantage $10/20/40/40
Outpatient Prescription Drug Rider Schedule of Benefits

Effective 4/1/2014

This schedule of benefits describes Your outpatient prescription drug coverage. All drugs must be FDA approved and you must have a prescription. You will need to pay Your Copayment or Coinsurance when you fill your prescription at the pharmacy. If Your Plan has a Deductible you must meet that amount before your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. Your drug coverage has specific Exclusions and Limitations so please read the next few pages carefully. Optima's Pharmacy and Therapeutics Committee places covered drugs into the following Tiers.

- **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 that 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.
- **All Other (Tier 4)** includes those drugs not classified by the Plan as Tier 1, Tier 2, or Tier 3; those drugs not excluded from Coverage; and those drugs that are not recognized by the Plan to be any more effective than other drugs available at Tier 1, Tier 2, or Tier 3 or over the counter**.**

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

Maximum Out-of-Pocket Limit	
Maximum Out-of-Pocket Limit	This Plan has a separate Maximum Out of Pocket Amount for Prescription Drug Benefits. Deductible, Copayment and Coinsurance amounts You pay for Covered prescription drugs will apply to the following amounts: $6,350 per person per calendar year; $12,700 per family per calendar year. 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.
Copayments and Coinsurances.	
For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge. Certain prescription drugs will be covered at a generic product level established by the Plan. If a generic product level has been established for a drug and You or Your prescribing Physician requests the brand-name drug or a higher costing generic, You must pay the difference between the cost of the dispensed drug and the generic product level in addition to the Copayment charge.	
Selected Generic (Tier 1)	$10 Copayment
Selected Brand & Other Generic (Tier 2)	$20 Copayment
Non-Selected Brand (Tier 3)	$40 Copayment
All Other (Tier 4))	$40 Copayment
Mail Order Pharmacy Benefit Copayments and Coinsurances	
Some Outpatient prescription drugs are available through the Plan's Mail Order Provider. <u>This does not include Specialty Drugs defined below.</u> You may call Catamaran 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 two Copayments or the applicable Coinsurance amount.	
Selected Generic (Tier 1)	$20 Copayment
Selected Brand & Other Generic (Tier 2)	$40 Copayment
Non-Selected Brand (Tier 3)	$80 Copayment
All Other (Tier 4)	$80 Copayment

Underwritten by Optima Health Plan

Coverage of Specialty Drugs.

Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional.

Specialty Drugs are only available through Optima's specialty mail order pharmacy; BriovaRx at 855-577-6512

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.

You will pay Your Copayment or Coinsurance depending on which Tier Your Specialty Drug is in. Your Specialty Drug will be delivered to Your home address. If you have a question or need to find out if your drug is considered a Specialty Drug please call Member Services at the number on Your Optima ID Card . Youcan also log onto www.optimahealth.com for a list of Specialty Drugs.

EXCLUSIONS AND LIMITATIONS AND OTHER COVERAGE TERMS.

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

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded form Coverage.
2. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.
3. 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's Allowable Charge.
4. 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.
5. 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.
6. The Plan will not cover any additional benefits after benefit Limits have been reached. You will be responsible for payment for all outpatient prescription drugs after a benefit Limit has been reached.
7. 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 Amount.
8. Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan at the same level as the Plan gives to participating pharmacies.
9. 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. Medications with no approved FDA indications are excluded from Coverage.
10. 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.
11. 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
12. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. Benefits for Covered Services may be reduced or denied for not complying with the Plan's Pre-Authorization requirements.
13. At its sole discretions Optima's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
14. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
15. 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.

16. 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.
17. Insulin, syringes, and needles are covered under the prescription drug rider. Diabetic supplies and equipment, 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, other than those listed as covered under this prescription drug rider are covered under the Plan's medical benefit. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under this rider or the Plan's medical benefit.
18. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
19. Injectables (other than those self-administered and insulin) are excluded from Coverage under this rider.
20. Medication taken or administered to the Member in the Physician's office is excluded from Coverage under this rider.
21. 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.
22. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
23. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
24. Replacement prescriptions resulting from loss, theft, or breakage are excluded from Coverage.
25. 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.
26. 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.
27. 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.
28. 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.
29. 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 excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.
30. Infertility drugs are excluded from Coverage.
31. Medications for smoking cessation, including but not Limited to Nicorette gum, nicotine patches, nicotine spray are excluded from Coverage.
32. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.

Abbreviated Preferred Drug List January-March 2014

Tier 1		Tier 2		Tier 3		Tier 4
ANTIBIOTICS (All Oral Dosage Forms)						
amoxicillin	Ery Ped	Avelox	**Suspensions/**	Augmentin XR	Tequin	
amox/clav, ES	Eryc (G)	Biaxin XL	**Liquids Only**	Ceclor CD	Vantin	
ampicillin	EryTab (G)	Dificid (PA)	Furadantin	Cefzil (tabs)		
azithromycin	erythromycin	levofloxacin	Lorabid	Cedax		
Biaxin (G)	Erythrocin (G)	PCE		Cipro XR		
Ceftin (G)	erythromycin base	Suprax		Dynabac		
cefprozil	minocycline	Zyvox		Flagyl ER		
cephalexin	nitrofurantoin	voriconazole		Floxin (G)		
cephradine	Omnicef (G)			Noroxin		
clarithromycin	penicillin VK			Spectracef		
ciprofloxacin	smz/tmp					
clindamycin	tetracycline					
dicloxacillin	trimethoprim					
EES (G)	Zithromax (G)					
ALLERGY DRUGS						
clemastine syrup	hydroxyzine HCL	Nasonex		Nasalide	Tanafed	Allegra Susp
cyproheptadine	hydroxyzine pamoate			Nasacort, AQ		Astelin
diphenydramine 50 mg	promethazine			Rhinocort		Astepro
fluticasone				Rhinocort Aqua		Clarinex, Clairnex D
guafenisin PSE						Omnaris (SE)
						Patanase
						Veramyst (SE)
ANTIDEPRESSANTS						
amitriptyline	mirtazapine			Cymbalta (SE)		Luvox CR (SE)
budeprion XL	nefazodone			Pristiq (SE)		
bupropion, SR, XL	nortriptyline			Viibryd (SE)		
citalopram	paroxetine, CR					
doxepin	sertraline					
escitalopram	trazodone					
fluvoxamine	venlafaxine					
fluoxetine	venlafaxine ER					
imipramine						
ANTIPSYCHOTIC DRUGS						
chlorpromazine	risperidone	Abilify (SE)				Invega (SE)
clozapine	thioridazine	Seroquel XR (SE)				Fanapt (SE)
fluphenazine	thiothixene					Latuda (SE)
haloperidol	trifluoperazine					Saphris (SE)
loxapine	ziprasidone					
olanzapine						
perphenazine						
quetiapine						
ASTHMA DRUGS						
aminophylline		Accolate	Maxair	Aerobid, -M	Xopenex (PA)	Brovana
cromolyn neb		Advair	Qvar	Azmacort		Perforomist
theophylline, SR		Asmanex	Serevent	Alvesco		Symbicort
budesonide		Dulera	Singulair	Proair		Tudorza Pressair (SE)
		Flovent		Proventil HFA		Zyflo CR
		Foradil	Ventolin HFA	Qvar		
		Intal				
BIRTH CONTROL PILLS						
Apri	Nortrel	EstroStep		Kariva		Beyaz
Aviane	Ocella	Femcon FE		Kelnor		Ella
Cryselle	Ogestrel	Jolessa		Seasonale		Generess FE
Enpresse	Portia	Nuvaring		Zovia		Lo Loestran Fe
Junel, FE	Previfem	Quasense				Lybrel
Lessina	Solia	Ortho Tri-Cyclen Lo				Neevo DHA
Levora	Sprintec	Ovcon				Prenexa Premier
Low-Ogestrel	Tri-nessa	Plan B				Safyral
Lutera	Tri-Previfem	Yasmin				Natafort Tab
Microgestin, FE	Tri-Sprintec					
Mononessa	Trivora					
Necon						

Abbreviated Preferred Drug List January-March 2014

Tier 1		Tier 2		Tier 3		Tier 4
BLOOD PRESSURE AND HEART DRUGS						
acebutolol	irbesartan, HCT	Aggrenox		Atacand (SE)		Azor (SE)
amlodipine besylate	labetalol	Betapace		Amturnide (SE)		BiDil
atenolol	lisinopril	Cardene, SR		Benicar, HCT (SE)		Bystolic
benazepril	metolazone	Catapres-TTS		Covera-HS		Coreg CR (SE)
bumetanide	losartan	DynaCirc, CR		Diovan (SE)		Exforge, HCT (SE)
candasartan HCTZ	losatan hctz	Effient		Edarbi (SE)		
captopril	metoprolol, XL	Lanoxin		Edarbyclor (SE)		
carvedilol	moexipril	Letairis		Micardis, HCT (SE)		
chlorothiazide	nicardipine	Lotrel		Tekturna,HCT(SE)		
chlorthalidone	pindolol	Procanbid		Teveten HCT (SE)		
clopidogrel	procainamide SR	Revatio		Tribenzor (SE)		
cilostazol	propranolol, SR	Verelan PM		Tekamlo (SE)		
digoxin	quinapril			Twynsta (SE)		
diltiazem CD, SR, XR	ramipril					
doxazosin	terazosin					
enalapril	timolol					
eprosartan	trandolapril					
felodipine	triamterene/HCTZ					
fosinopril	verapamil, SR					
furosemide	warfarin					
hdyrochlorothiazide	valsartan HCTZ					
indapamide						
CHOLESTEROL DRUGS						
atorvastatin	pravastatin	Niaspan		Crestor (PA)	Livalo (PA)	Lovaza (PA)
cholestyramine	simvastatin	Tricor		Juxtapid (PA)	Vytorin (PA)	Simcor (PA)
gemfibrozil		Welchol		Kynamro (PA)	Zetia	Trilipix (PA)
lovastatin (G)				Lescol, XL (PA)		
DIABETES DRUGS						
glimepiride		Actoplus Met XR	Humalog vial	Byetta		Onglyza (PA)
glipizide, XL		Avandamet	Humulin insulins, vial	Bydureon		Victoza (PA)
glyburide, micro		Avandaryl	Janumet, RX	Invokana SE		Cysloset
glyburide-metformin		Avandia	Januvia	Levemir Vial		Kombiglyze XR
metformin		Duetact	Juvisync	Novolin and Novolog insulin vials		
metformin ER		Duetact	Lantus	Prandin		
		Glyset	Lantus Solostar	Precose		
		pioglitazone	Starlix	Symlin		
		pioglitazone and metf	Tradjenta			
GI DRUGS						
cimetidine	Omeprazole 20mg	Asacol		Dexilant (SE)		Aciphex (SE)
dicyclomine	Omeprazole OTC	Carafate Susp				Nexium (SE)
diphenoxylate/atropine	pantoprazole	Colazal				Relistor (PA)
hyoscyamine, ER	sucralfate	Creon				Vimovo
lactulose	sulfasalazine	Dipentum				
metoclopramide		Pancrease MT				
misoprostol		Pentasa				
nizatadine		Prilosec OTC				
HEADACHE DRUGS						
APAP/caffeine/butalbital	butorphanol NS - PA,2 bottles/ 30 days	Depakote ER	Imitrex **brand** -9 tabs/30 days (SE)	Axert - 12 tabs/ 30 days (SE)	Maxalt, MLT - 12 tabs/30 days (SE)	Treximet - 9 tabs/ 30 days (SE)
APAP/caffeine/butalbital w/codeine	Sumatriptan 20mg-nasal 6 bottles/ 30 days	Midrin		Cambia - 9 satches/ 30 days (SE)	Zomig,ZMT – 12 tabs/ 30 days (SE)	Sumavel -inj-8 syr/ 30 days
aspirin/caffeine/butalbital	Sumatriptan -inj-8 syr/ 30 days	Migranal - 1 box/ 30 days		Frova - 12 tabs/ 30 days (SE)	Zomig nasal spray - 6 bottles/ 30 days (SE)	Alsuma-inj-8 syr/ 30 days
aspirin/caffeine/butalbital w/codeine	Sumatriptan 100mg-9 tabs/ 30 days			Relpax - 12 tabs/ 30 days		
Sumatripta 20mg n-nasal 6 bottles/ 30 days	Sumatriptan 25mg, 50mg- 18 tabs/30 days					
naratriptan 9 tabs/ 30 days						

Abbreviated Preferred Drug List January-March 2014

Tier 1		Tier 2		Tier 3		Tier 4
HORMONE DRUGS						
Camila	medroxyprogesterone	Aygestin	Ovrette	Enjuvia		Elestrin Gel
estradiol tab,patch	norethindrone	CombiPatch	Premarin	Esclim		EvaMist
esterified estrogens	Premphase	Estraderm	Prempro	Femhrt		
estropipate		Estratest, HS		Vivelle		
Jolivette		Ortho-Prefest				
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS						
diclofenac potassium	meloxicam			Arthrotec		Cambia (SE)
diclofenac sodium	nabumetone			Celebrex (PA)		Flector
etodolac	naproxen					Voltaren Gel (PA)
ibuprofen	naproxen sodium					Pennsaid (SE)
indomethacin, SR	oxaprozin					Sprix 5/5 2 refill limit
ketoprofen, SR	piroxicam					
ketorolac tabs (20/Rx)	sulindac					
meclofenamate	tolmentin					
OSTEOPOROSIS DRUGS						
alendronate		Didronel	Miacalcin injectable	Actonel (SE)	Skelid (SE)	Binosto (SE)
		Evista	Miacalcin Nasal Spray	Atelvia (SE)		
		Fosamax Plus D		Boniva		
UROLOGY DRUGS						
doxazosin	oxybutinin, XL	Caverject	Jalyn	Cialis-4tabs/30d	Staxyn-4tabs/30d	Gelnique Gel
finasteride	phenazopyridine	Detrol	Muse	Levitra-4tabs/30d		Sanctura SR
hyoscyamine XR	terazosin	Flomax	Viagra-4 tabs/30d	Detrol LA		Toviaz

PA = Prior Authorization Required; **G** = Brand name listed, but plan pays for generic product at the Preferred copay level

SE= Step Edit (prior drug therapy) required

This is an abbreviated version of the preferred, standard, premium and permium plus drug list. This is provided as a reference and is subject to change. Physician and pharmacy providers receive the entire drug list a minimum of two times per year. Updates are provided quarterly. Not all drugs are covered under every pharmacy benefit. Not all plans have a pharmacy benefit. To determine coverage, or to ask about a drug not on this list, call Member Services at the number listed on your membership card. When the drug prescribed for you is available as a generic, the generic will be dispensed unless your physician has indicated otherwise. If the brand name product is dispensed, you may be responsible for the difference between the cost of the generic drug and the brand name product.

Additional copays for multiple packages may apply, a one month supply may require the payment of multiple copays, check with your benefit plan.

This listing is not inclusive of all group benefits. Some may include or exclude additional drugs. This listing is subject to change.

Newly FDA approved medications will be classified as Premium Plus agents until reviewed by the P&T committee.

Revised: 11/26/2013, Jan-Mar 2014

Prior Authorization Required

Tiers 1 and 2

Adcirca®[T] Androgel (testosterone) Axiron (testosterone) Butorphanol Tartrate (generic Stadol Nasal Spray) Differin® (adapalene)[T]	Epogen® (erythropoietin)[T] Fentanyl (generic Actiq)[T] Kalydeco® (ivacaftor) Leukine® (sargramostim, GM-CSF)[T] Modafanil (generic Provigil)[T] Neumega® (oprelvekin)[T]	Neupogen® (filgrastim, G-CFS)[T] Oxymorphone HCL (generic Opana, Opana ER)[T] Procrit® (erythropoietin)[T] Retin-A® (tretinoin)[T] Sildenafil (generic Revatio)[T] Synarel® (nafarelin acetate)[T]	Tev-Tropin® (somatropin)[T] Tretinoin[T] Xalkori® (crizotimib) Xarelto® (rivaroxaban) Zelboraf® (verurafenib)

Tiers 3 and 4

Abstral (fentanyl sublingual)[T] Accretropin® (somatropin)[T] Acthar HP Inj (corticotropin inj)[T] Actiq® (oral transmucosal fentanyl)[T] Ampyra® (dalfampridine) Androderm (testosterone) Aranesp (darbepoetin)[T] Butrans® (buprenorphine transdermal system)[T] Celebrex® (celecoxib) Crestor® (rosuvastatin) Cimzia® (certolizumab pegol) Dificid™ (fidaxomicin)[T] Egrifta® (tesamorelin) Eliquis® (apixaban) Enbrel® (entanercept) Exalgo (hydromorphone ER tablets)[T] Fentora (fentanyl, buccal)[T]	Fortesta (testosterone) Fulyzaq® (crofelemer) Gamunex C (immune globulin)[T] Genotropin® (somatropin)[T] Gilenya® (fingolimod) Hizentra ® (immune globulin subcutaneous)[T] Humatrope® (somatropin)[T] Humira™ (adalimumab) Iclusig™ (ponatinib) Increlex, Iplex® (mecasermin rinfabate)[T] Invokana® (canagliflozin) Juxtapid® (lomitapide) Kineret® (anakinra) Kynamro® (mipomersen) Lazanda® (fentanyl)[T] Lescol XL® (fluvastatin) Livalo® (pitavastatin) Lovaza® (omega-3-acid ethyl ester)	Neulasta® (pegfilgrastim)[T] Nexavar® (sorafenib tosylate) Norditropin® (somatropin)[T] Nucynta™ (tapentadol)[T] Nucynta ER ™ (tapentadol)[T] Nuedexta® (dextromethorphan/quinidine sulfate) Nutropin® (somatropin)[T] Nuvigil ® (armodafinil)[T] Onsolis (fentanyl film)[T] Opana, Opana ER (oxymorphone HCL)[T] Orencia® (abatacept)[T] Oxecta (oxycondone immediate release)[T] OxyContin® (oxycodone controlled release)[T] Pennsaid® (diclofenac sodium 1.5% solution) Pomalyst® (pomalidomide) Pradaxa ® (dabigatran etexilate) Promacta® (eltrombopag)	Provigil ® (modafinil)[T] Revlimid (lenalidomide) Saizen® (somatropin)[T] Samsca (tolvaptan)[T] Sancuso (granisetron) Serostim® (somatropin)[T] Simcor® (niacin and simvastatin) Simponi® (golimumab) Stivarga (regorafenib) Subsys® (fentanyl sublingual spray)[T] Sutent® (sunitinib malate) Testim (testosterone) Tykerb® (lapatinib) Ulesfia™ (benzyl alcohol) Voltaren Gel (diclofenac) Vytorin™ (eztimibe/simvastatin) Xeljanz® (tofacitinib) Xyrem (sodium oxybate)[T] Zorbtive (somatropin)[T]

Drugs with Step-Edits

Abilify
Trial/failure of 2 antipsychotics
Actonel
Trial/failure of alendronate or ibandronate
Adoxa
Trial/failure of doxycycline
Alsuma
Trial/failure of sumatriptan injection
Amturnide
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Atelvia
Trial/failure of alendronate or ibandronate
Aubagio
Trial/failure of two of the following: Avonex, Copaxone or Rebif
Avidoxy DK
Trial/failure of doxycycline
Axert
Trial/failure of sumatriptan or naratriptan
Azor
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Benicar, HCT
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Bepreve
Trial/failure of one of the following: azelastine, epinastine, or ketotifen
Betaseron
Trial/failure of two of the following: Avonex, Copaxone or Rebif
Binosto
Trial/failure of alendronate or ibandronate
Byetta and Bydureon ***(Family Care Only)***
Trial/failure of Januvia/ Janumet or Tradjenta/ Jentadueto
Cambia
Trial/failure of 1generic triptan
Cardura XL
Trial/failure of Cardura
Conzip
Trial/failure of tramadol
Coreg CR
Trial/failure of Coreg
Daytrana
Trial/failure of methylphenidate CR, Methylphenidate ER, methylphenidate SR, or dextroamphetamine/amphetamine, and Vyvanse
Dexilant
Trial/failure of a generic PPI
Deprizine Kit
Trial/failure of ranitidine
Diovan
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Doryx
Trial/failure of doxycycline
Edarbi
Trial/failure of a generic ARB
Edarbyclor
Trial/failure of a generic ARB
Edluar
Trial/failure of temazepam, zolpidem, zolpidem CR or zaleplon
Emadine
Trial/failure of one of the following: azelastine, epinastine, or ketotifen
Exforge, HCT
Trial/failure of a generic ARB
Extavia
Trial/failure of two of the following: Avonex, Copaxone or Rebif
Fanapt
Trial/failure of 2 antipsychotic
Ferriprox
Trial/failure of Exjades
Frova
Trial/failure of sumatriptan or naratriptan
Fycompa
Trial/failure of 2 anticonvulsants
Gralise
Trial/failure of gabapentin
Horizant
Trial/failure of pramipexole, ropinirole, or gabapentin
Intermezzo
Trial/failure of temazepam, zolpidem, zolpidem CR or zaleplon
Intuniv
Trial/failure of guanfacine
Invega
Trial/failure of 2 antipsychotics
Invokana
Trial/failure of metformin and 2 additional diabetic therapies
Kazano
Trial/failure of Janumet or Janumet XR and Jentadueto
Kombiglyze XR
Trial/failure of Janumet or Janumet XR and Jentadueto
Lastacaft
Trial/failure of one of the following: azelastine, epinastine, or ketotifen
Latuda
Trial/failure of 2 antipsychotics
Lindane
Trial/failure of Ovide
Liptruzet
Trial/failure of atorvastatin, pravastatin, or simvastatin
Lumigan
Trial/failure of latanoprost or Travatan Z
Lunesta
Trial/failure of temazepam, zolpidem, zolpidem CR or zaleplon
Lyrica
Trial/failure of gabapentin

Metozolv ODT
Trial/failure of metoclopramide
Micardis, HCT
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Natroba
Trial/failure of malathion
Nesina
Trial/failure of Januvia and Tradjenta
Neupro
Trial/failure of pramipexole or ropinirole
Nexiclon XR
Trial/failure of clonidine
Nexium
Trial/failure of a generic PPI and Dexilant
Nutridox
Trial/failure of doxycycline
Oleptro ER
Trial/failure of trazodone
Omnaris
Trial/failure of fluticasone
Onglyza
Trial/failure of Januvia and Tradjenta
Oracea
Trail/failure of doxycycline
Oravig
Trial/failure of clotrimazole or fluconazole
Oseni
Trial/failure of Januvia and Tradjenta and Pioglitazone
Pataday/Patanol
Trial/failure of one of the following: azelastine, epinastine, or ketotifen
Pegasys
Trial/failure of Peg-Intron
Potiga
Trial/failure of 2 anticonvulsants
Pristiq
Trial/failure of 2 SSRIs or 1 SSRI and venlafaxine
Quillivant XR
Trial/failure of methylphenidate CR or methylphenidate SR, and Vyvanse
Rozerem
Trial/failure of temazepam, zolpidem, zolpidem CR or zaleplon
Rybix
Trial/failure of tramadol
Saphris
Trial/failure of 2 antipsychotics
Savella
Trial/failure of gabapentin
Seroquel XR
Trial/failure of 2 antipsychotics
Solodyn
Trial/failure of minocycline
Silenor
Trial/failure of doxepin
Skelid
Trial/failure of alendronate or ibandronate
Strattera
Trial/failure of methylphenidate ER, Methylphenidate LA, or dextroamphetamine/amphetamine and Vyvanse
Sumavel DosePro
Trial/failure of sumatriptan injection
Tecfidera
Trial/failure of two of the following: Avonex, Copaxone or Rebif
Tekamlo
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Tekturna, HCT
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Teveten, HCT
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Treximet
Trial/failure of sumatriptan or naratriptan
Tribenzor
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Tudorsa Pressair
Trial/failure of Spiriva
Twynsta
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Uloric
Trial/failure of allopurinol, colchicine, probenecid,or probenecid,or/colchicine
Veramyst
Trial/failure of fluticasone propionate
Victoza
Trial/failure of Byetta or Bydureon
Viibryd
Trial/ failure of 2 generic SSRI - OR – 1 generic SSRI and Effexor XR
Vimpat
Trial/failure of 2 anticonvulsants
Zioptan
Trial/failure of latanoprost or Travatan Z
Zolpimist
Trial/failure of temazepam, zolpidem, zolpidem CR or zaleplon
Zomig (nasal spray)
Trial/failure of sumatriptan or naratriptan
Zuplenz
Trial/failure of ondansetron

Drugs with Quantity Limits

Drug	*Quantity Limit*	*Drug*	*Quantity Limit*
Alsuma	8 syringes/30 days	Sancuso	2 boxes/30 days
Amerge*	9 tablets/30 days	Sprix	5 bottles/5 days; limit 2 fills per 30 days
Ampyra	60 tablets/30 days	Staxyn	4 tablets/30 days
Anzemet*	10 tablets/Rx	Sumatriptan tablets 100mg*	9 tablets/30 days
Axert*	12 tablets/30 days	Sumatriptan tablets 50 mg *	18 tablets/30 days
Butorphanol Tartrate	2 bottles/30 days	Sumatriptan tablets 25 mg*	18 tablets/30 days
Cambia	9 sachets/ 30 days	Sumatriptan Nasal Spray 5mg*	12 bottles/30 days
Cialis*	4 tablets/30 days	Sumatriptan Nasal Spray 20mg*	6 bottles/30 days
Cialis 2.5mg*	5 tablets/30 days	Sumatriptan Injection*	8 syringes/30 days
Edluar 10mg	30 tablets/30 days	Sumavel DosePro	8 syringes/30 days
Edluar 5mg	60 tablets/30 days	Tamiflu	10 capsules or 75ml/183 days
Emend	3 tablets/Rx	Temazepam 7.5, 15mg	60 capsules/30 days
Emend Pack	1 pack/Rx	Temazepam 22.5, 30mg	30 capsules/30 days
Firazyr	3 syringes/Rx	Treximet*	9 tablets/30 days
Flurazepam	30 capsules/30 days	Triazolam 0.125mg	60 tablets/30 days
Frova*	12 tablets/30 days	Triazolam 0.25mg	30 tablets/30 days
Granisetron*	15 tablets/Rx	Tussionex	120ml/30 days
Intermezzo	30 tablets/30 days	Viagra*	4 tablets/30 days
Ketorolac tablets	20 tablets/Rx	Vituz	120ml/30days
Levitra*	4 tablets/30days	Zaleplon	30 tablets/30 days
Lunesta 1mg	60 tabs/30 days	zolmitriptan	12 tablets/30 days
Lunesta 2, 3mg	30 tablets/ 30 days	Zolpidem 5mg	60 tablets/30 days
Maxalt, MLT*	12 tablets/30 days	Zolpidem 10mg	30 tablets/30 days
Migranal	8 bottles/30 days	Zolpidem ER	30 tablets/30 days
Regranex	2 tubes, lifetime limit	Zolpimist	1 bottle/30 days
Relenza	20 disks/183 days , (1 course/flu season)	Zomig Nasal Spray	12 bottles/30 days
Relpax*	12 tablets/30 days	Zuplenz	10 oral soluble film/Rx
Rozerem	30 tablets/30 days		

Catamaran Home Delivery frequently asked questions

Why should I use Catamaran™ for my prescriptions?

Catamaran Home Delivery service 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 Catamaran Home Delivery pharmacy benefit.

How do I use mail service?

1. Have your doctor write your prescription for the number of days your plan allows for mail service (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 Catamaran Home Delivery.
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:
   Catamaran Home Delivery
   PO Box 696054
   San Antonio, TX 78269
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 Catamaran Home Delivery?

Do one of the following:

- Visit our website: www.myCatamaranRx.com
- Call Catamaran Home Delivery 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 Catamaran Home Delivery.

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 Catamaran Home Delivery. 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 Catamaran Home Delivery 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 www.myCatamaranRx.com 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, Catamaran Home Delivery also offers expedited shipping for an extra charge.

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

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

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

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

Catamaran Home Delivery frequently asked questions

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 myCatamaranRx.com 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 Catamaran Home Delivery 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 Catamaran Home Delivery?

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 Catamaran Home Delivery. To verify coverage please go to www.myCatamaranRx.com, or call our toll-free number.

How much will my medicine cost me?

The easiest way to determine the cost of your prescription is to log in to www.myCatamaranRx.com.

How can I pay for my mail service 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 www.myCatamaranRx.com. 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 Catamaran 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, Catamaran Home Delivery 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.

Mental Health and Employee Assistance Program

Optima Vantage Plan
Behavioral Health and Substance Abuse Benefit

Behavioral healthcare and substance abuse services are included as part of the healthcare coverage.

How to receive services
Behavioral healthcare and substance abuse services may be accessed in the following ways:

- Call 1-800-648-8420 to be directed to a participating behavioral health provider. It is not necessary to go through the Primary Care Physician (PCP); or
- Contact a participating behavioral health provider directly to arrange for an initial authorization.

If hospitalization is required, the behavioral health provider will arrange for admission to the appropriate In-Network facility. Pre-Authorization must be obtained prior to receiving inpatient services.

Pre-Authorization penalty
Failure to pre-authorize inpatient services may result in the member's responsibility to pay a $500 penalty.

Emergency services
If currently in treatment, contact the attending behavioral health provider.

If not currently receiving care, call 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, weekends, and holidays.

Please call 911 or go directly to an emergency department facility if any covered member is engaged in behaviors that pose an immediate danger to themselves or to the life of another.

Exclusions
Non-medical ancillary services are not covered. These may include, but are not limited to: vocational rehabilitation services, employment counseling, health education, and expressive therapies. Residential Treatment is not covered by the Plan. A complete list of exclusions can be found in the Evidence of Coverage.

Additional information
Current members with questions regarding benefits should call Member Services at the number on the back of their member ID card.

If you are considering enrolling for the first time and have questions, please consult with the group's Benefit Administrator.

A Telecommunications Device for the Deaf (TDD) can be accessed by dialing 1-800-225-7784.

Other Health Insurance Information

Vision Care and Materials Rider

This rider includes covered services for expanded vision care services in lieu of preventive vision care benefits.

EyeMed Vision Services administers this benefit for vision care services and materials. Each covered person is eligible to receive a routine eye examination, refraction, lenses and frames, or contact lenses once every 12 months from an EyeMed network provider at no cost.

Contact lenses examinations require the member to pay the contact lenses examination cost. Lenses (single, vision, bifocal, trifocal) are covered in full. Frames are covered in full up to $100 retail. Contact lenses (in lieu of glasses) are also covered in full up to $100 retail.

If an eye examination is received from an Out-of-Network provider, the member will be responsible for paying the provider in full at the time services are rendered. For covered services, members will be reimbursed according to the Out-of-Network benefit on the Face Sheet.

Copayments or Coinsurance for covered services under this rider are not applied toward any Plan out-of-pocket maximum amount and must continue to be paid after the maximum is met.

To receive covered services

- Select a participating EyeMed Vision Services network provider from the Plan's provider directory or by calling EyeMed at 1-888-610-2268. Automated location information is available 24 hours a day. Customer service representatives are available Monday through Friday 9 a.m. - 9 p.m., and Saturday 9 a.m. - 5 p.m.

- Visit or call the participating provider and identify yourself as a member by providing your Member ID information. The provider will verify eligibility, your Plan's covered services and any applicable Copayment or Coinsurance. Payment is due when you receive services.

- If the vision provider determines that you need additional medical care you should contact your Plan physician.

Additional Information

Current members with questions regarding benefits should call Member Services at the number on the back of their member ID card. If considering enrolling for the first time and you have questions, please consult with the group's Benefits Administrator.

Preventive Vision Discount Fee Schedule

A Defined Materials Discount

Vision Care Services	Member Cost
Complete Pair of Glasses Purchased*: Frame, lenses, and lens options must be purchased in the same transaction to receive full discount.	
Standard Plastic Lenses:	
Single Vision	$ 50
Bifocal	$ 70
Trifocal	$105
Frames: Any frame available at provider location	40 percent discount off retail price
Lens Options:	
UV Coating	$15
Tint (solid and gradient)	$15
Standard Scratch-Resistance	$15
Standard Polycarbonate	$40
Standard Progressive (add-on to bifocal)	$65
Standard Anti-Reflective Coating	$45
Other Add-ons and Services	20 percent discount
Contact Lens Materials:	
(Discount applied to materials only)	
Disposable	No discount on disposable
Conventional	15 percent discount off retail price
Laser Vision Correction:	
Lasik or PRK	15 percent discount off retail price or 5 percent discount off promotional price

**Items purchased separately will be discounted 20 percent off the retail price.*

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.

EyeMed VISION CARE

Out-Of-Network Claim Form

Most EyeMed Vision Care plans allow members the choice to visit an in-network or out-of-network vision care provider. You only need to complete this form if you are visiting a provider that is not a participating provider on the EyeMed network. Not all plans have out-of-network benefits, so please consult your member benefits information to ensure coverage of services and/or materials from non-participating providers.

If you choose an out-of-network provider, please complete the following steps prior to submitting the claim form to EyeMed. Any missing or incomplete information may result in delay of payment or the form being returned. Please complete and send this form to EyeMed within 1 year from the original date of service at the out-of-network provider's office.

1. When visiting an out-of-network provider, you are responsible for payment of services and/or materials at the time of service. EyeMed will reimburse you for authorized services according to your plan design.
2. Please complete all sections of this form to ensure proper benefit allocation. Plan information may be found on your benefit ID Card, or via your human resources department.
3. EyeMed will only accept **itemized paid receipts** that indicate the services provided and the amount charged for each service. The services must be paid in full in order to receive benefits. Handwritten receipts must be on the provider's letterhead. Attach itemized paid receipts from your provider to the claim form. If the paid receipt is not in US dollars, please identify the currency in which the receipt was paid.
4. Please include a copy of your Explanation of Benefits if submitting for a Secondary Insurance Benefit.
5. If the reimbursement is to be sent to someone other than the primary subscriber, a copy of a cancelled check or credit card receipt (in addition to the paid itemized receipt) must be included. A copy of a receipt showing payment in cash is also acceptable.

If applicable, check the box for payment to be addressed to the patient in lieu of the subscriber.

☐ By signing below, you are representing that you are legally divorced or separated and the patient is entitled to the reimbursement. If it is later determined that the patient was not entitled to the reimbursement, you agree to refund EyeMed in full.

6. Sign the claim form below.

Date of Service: ___/___/_____

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birth Date: _____

Plan Information:

Subscriber Name

Last:_____ First: _____ MI: _____

Plan Name: _____

Subscriber ID: _____

Request For Reimbursement –Please Enter Amount Charged. Remember to include itemized paid receipts:			
Exam: $_____	Frames: $_____	Lenses: $_____	Contact Lenses – (includes fit and follow-up, please submit $_____ all contact related charges at the same time)
If lenses were purchased, please circle type: Single Bifocal Trifocal Progressive			

I hereby understand that without prior authorization from EyeMed Vision Care LLC for services rendered, I may be denied reimbursement for submitted vision care services for which I am not eligible. I hereby authorize any insurance company, organization employer, ophthalmologist, optometrist, and optician to release any information with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct.

Member/Guardian/Patient Signature (not a minor) _____ Date: _____

To Fax: 866-293-7373 To Email Form and Receipts: ooncclaims@eyemedvisioncare.com

To Mail: EyeMed Vision Care Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

EyeMed VISION CARE

Fraud Warning Statements

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Department of Insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing a false, incomplete or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

Kansas: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application or claim for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is found guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in § 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application or false claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Diabetic Equipment and Supplies

Coverage includes benefits for equipment; supplies; and in-person outpatient self-management training and education; including medical nutrition therapy, treatment of insulin-dependent diabetes, gestational diabetes, insulin-using diabetes, and non-insulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. "Equipment" and "supplies" shall not be considered durable medical equipment. This benefit is not subject to any policy or calendar-year dollar or durational benefit limitations or maximums for benefits or services.

The Member will be responsible for any applicable Copayment, Coinsurance, or Deductible as specified on the Face Sheet depending upon the type of service received. Diabetic equipment and supplies are covered when received from Plan providers only.

To qualify for Coverage under this section, diabetes in-person self-management training and education shall be provided by a certified, registered, or licensed healthcare professional. Members may call 1-800-SENTARA for information on educational classes. Members may call one of the following providers to arrange for prescribed supplies to be delivered to their home:

Liberty Medical Supplies at 1-866-846-9361;
Home Care Delivered at 1-800-867-4412;
CarePoint Medical at 1-800-935-7270; or
EdgePark Medical Supplies (after August 1, 2013) at 1-888-394-5375.

Members will be responsible for the Copayment or Coinsurance as specified on the Face Sheet.

Alternative Medicine Discount Program

Each covered individual is offered a discount on acupuncture, chiropractic, and massage therapy services administered by American Specialty Health Networks™ (ASHN). Participating providers extend up to a 25 percent discount off their usual and customary charges.

How to receive services
Select a participating complementary healthcare provider from the Plan's Benefit Information Guide or 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. A change from a participating provider is permitted at any time.

In order to receive the complementary discount, present your member ID card to the participating provider 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 ASHN's Member Services at 1-877-327-2746 or refer to the Plan's website at optimahealth.com. ASHN's Member Service representatives are available from 8 a.m. to 9 p.m. (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 Deaf (TDD) can be accessed by dialing 1-800-225-7784.

Exclusions and Limitations

EXCLUSIONS AND LIMITATIONS- *VANTAGE PRODUCTS*

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 of the Optima coverage documents for your plan. 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.

A

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

Acupuncture is not covered**.**

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

Against Medical Advice (AMA). If You decide not to follow a prescribed treatment for a medical condition the Plan will not assume any further liability for that condition unless You later decide to follow prescribed treatment under the care of the ordering physician. Coverage is subject to the terms of Your Plan.

Ambulance Service for non-emergency transportation is not covered unless We authorize the service.

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

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

Aromatherapy is not covered.

Artificial Hearts or mechanical heart devices, or their placement **is not covered.**

Autopsies are not covered.

B

Batteries are not covered except for motorized wheelchairs and cochlear implants when authorized.

Biofeedback is not covered unless We authorize it.

Blood and Blood Products are not covered. We do not cover any costs for finding blood donors. We do not cover the cost of transportation and storage of blood in or outside the Plan's Service Area.

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

Bone, or Joint treatment 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 unless We have approved them.

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

Breast Ductal Lavage is not covered.

Breast Milk from a donor is not covered.

C

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

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

Circumcision is not covered after age six weeks unless Medically Necessary.

Cold Therapy Machine is not covered.

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

Cosmetic Surgery and Cosmetic Procedures are not covered. We do not cover medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **We will not cover any of the following:**

- surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- non-medically necessary treatment or services resulting from complications due to cosmetic experimental procedures;
- breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following mastectomy;
- tattoo removal;
- keloid treatment as a result of the piercing of any body part;
- consultations or office visits for obtaining cosmetic or experimental procedures;
- penile implants;
- vitiligo **or other cosmetic skin condition** treatments by laser, light, or other methods.

Costs of Services paid for by Another Payor are not covered. We do not cover the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws, and other employers' liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of

covered services in those cases where You received services in accordance with the Plan's 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 unless they are determined to be medically necessary and We have authorized them.

Custodial Care is not covered. **We will not cover any of the following:**

- residential care;
- rest cures;
- care from institutions or facilities licensed solely as residential treatment centers, intermediate care facilities, or other non-skilled sub-acute inpatient settings;
- examination or care ordered by a court of law not authorized by the Plan to be provided at a Plan Provider.

D

Dentistry/Oral Surgery/Dental Care

Dentistry

- Restorative services and supplies necessary to treat, repair, or replace sound natural teeth are not covered.
- We will cover Medically Necessary dental services from an accidental injury. It does not matter when the injury occurred. For injuries occurring on or after Your effective date of coverage treatment must be sought within 60 days of the accident.
- We will cover Medically Necessary dental services performed during an emergency department visit immediately after a traumatic injury and in conjunction with the initial stabilization of the traumatic injury subject to utilization review for Medical Necessity.
- Cosmetic services to restore appearance are not covered.
- Dental implants or dentures and any preparation work for them are not covered.
- Dental services performed in a hospital or any outpatient facility are not covered. This does not include covered services listed under “Hospitalization and Anesthesia for Dental procedures."

Oral Surgery

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

Dental Care

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

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

Disposable Medical Supplies are not covered. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide, and other disposable supplies are not covered.

Driver Training is not covered.

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

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

E

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

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

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

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

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

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

Experimental or Investigative drugs, devices, treatments, or services are not covered. **Experimental or Investigative means any of the following situations:**

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

- The drug, device, or medical services is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment.

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

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

Eye Movement Desensitization and Reprocessing Therapy is not covered.

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

F

We **do not cover** the following **Foot Care Services** unless We authorize them:

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

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

- removal of corns or calluses;
- nail trimming;
- treatment and services for or from flat-feet, fallen arches, weak feet, or chronic foot strain;
- foot Orthotics of any kind;
- customized or non-customized shoes, boots, and inserts.

G

Genetic Testing and Counseling is not covered unless We have authorized the services.

GIFT programs (Gamete Intrafallopian Transfer) are not covered.

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

H

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

Home Births are not covered.

Home Health Care Skilled Services are not covered unless You are homebound**.** Services 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. We do not cover custodial care. We do not cover transportation.

Home Sleep Studies are not covered.

Hypnotherapy is not covered.

I

Immunizations required for foreign travel or for employment are not covered.

Implants for cosmetic breast enlargement are not covered. We do not cover cosmetic procedures or cosmetic surgery for breast enlargement or reduction. We do not cover procedures for correction of cosmetic physical imperfections. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Incarceration - We do not cover services and treatments done during incarceration in a Local, State, Federal or Community Correctional Facility, or prison.

Infertility Services are not covered unless Your Plan includes a rider. **We will not cover any of the following:**

- services, tests, medications, and treatments for the diagnosis or treatment of Infertility**;**
- services, tests, medications, and treatments for the enhancement of conception;
- services, tests, medications, and treatments that aid in or diagnose potential problems with conception;
- in-vitro Fertilization programs;
- artificial insemination or any other types of artificial or surgical means of conception;
- drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- reproductive material storage;
- treatment 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;
- semen analysis;
- Sims-Huhner test (smear); and
- drugs used to treat infertility.

J

K

Keloids from body piercing or pierced ears are not covered.

L

Laboratory Services for Vantage HMO plans:

Laboratory Services from Non-Plan providers or laboratories are not covered. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

Laboratory Services for Vantage POS plans:

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

Laser Therapy for Vitiligo, psoriasis, **or any other cosmetic skin conditions** is not covered**.**

Lung Cancer Screening Helical CT Scans are not covered.

M

Magnetic Resonance Spectroscopy is not covered**.**

Massage Therapy is not covered.

Matristem Extracellular Wound Care System is not covered.

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

Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not covered.

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.

Medication Dispensing Services in a clinic setting are not covered.

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

- exercise equipment;
- air conditioners, purifiers, humidifiers, and dehumidifiers;
- whirlpool baths;
- hypoallergenic pillows or bed linens;
- telephones;
- handrails, ramps, elevators and stair glides;
- orthotics not approved by Us;
- changes made to vehicles, residences or places of business;
- adaptive feeding devices, adaptive bed devices;
- water filters or purification devices;
- disposable Medical Supplies such as medical dressings, disposable diapers; and
- over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, and peroxide.

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

Mobile Cardiac Outpatient Telemetry (MCOT) is not covered.

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

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

N

Neuro-cognitive therapy following a neurological event, or to restore cognitive deficits is not covered.

Neuropsychological Services including psychological examinations, testing, or treatment to obtain or keep employment or insurance, or related to judicial or administrative proceedings are not covered unless approved by the Plan.

Newborns or other children of a Covered Dependent Child are not covered.

O

Obstetrical Care home births are not covered.

Oral Surgery services listed below **are not covered**:

- oral surgery which is part of an orthodontic treatment program;
- orthodontic treatment prior to orthognathic surgery;
- dental implants or dentures and any preparation work for them; and
- extraction of wisdom teeth unless Your plan includes a rider.

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

Out-Of-Network Medical, Mental Health, and Laboratory Services for Vantage HMO plans:

Out-Of-Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers are not covered. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

Out-Of-Network Medical, Mental Health, and Laboratory Services for Vantage POS plans:

Out-Of-Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers are covered under Out of Network Benefits. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

P

PARS System (Physical Activity Reward System) is not covered.

Pass Devices (Patient Activated Serial Stretch) are not covered.

Paternity Testing is not covered.

Penile implants are not covered.

Personal comfort items are not covered. 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.

PET Scans are not covered unless authorized by the Plan.

Physician Examinations are limited as follows:

- physicals for employment, insurance, or recreational activities are not covered.
- executive physicals are not covered.
- school physicals are not covered except when You have not had a health assessment with a physician during the calendar year.

- a second opinion from a Non-Plan Provider is covered only when authorized by the Plan.
- services or supplies ordered or done by a provider not licensed to do so are not covered.

Physician's Clerical Charges are not covered**.** Charges for broken appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records or correspondence to other parties, and any other clerical services are not covered.

Outpatient **Prescription Drugs** are not covered unless Your plan includes a rider.

Private Duty Nursing is not covered.

Pulsed Irrigation Evacuation System is not covered.

Q

R

Reconstructive surgery is not covered unless services follow trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. If the trauma occurred before the Member's effective date of Coverage, the reconstructive surgery is covered subject to the Plan's pre-existing condition exclusion provisions and Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is covered.

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

S

Saliva Tests are not covered.

Second Opinions – For Vantage HMO plans a second opinion from a Non-Plan Provider is covered only when authorized by the Plan. For Vantage POS plans a second opinion from a Non-Plan Provider is covered only under Out-of-Network benefits.

Services – <u>We do not cover any of the following:</u>
- 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;
- telephone consultations;
- charges for missed appointments;
- charges for completing forms;
- charges for copying medical records;
- services not listed as a covered service under this plan; and
- non-medically necessary complications of non-covered services including medical, mental health and surgical services related to the complication.

Sex Orientation or Gender Identity Disorder Treatment of any kind is not covered. This includes surgery, therapy, and any other medical or behavioral health services related to gender identity.

Sex Change Operations and treatment of gender identity disorders are not covered.

Smoking Cessation medications are not covered.

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

S**terilization**

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

T

Services delivered under a **TDO (Temporary Detention Order)** are not covered.

Therapies. Physical, Speech, and Occupational **Therapies** are limited as stated on Your face sheet or schedule of benefits. Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness, or pre-condition status. **We do not cover any of the following except for those services that are covered through Early Intervention Services; or if Your plan includes coverage for Autism Spectrum Disorder those services covered under Autism Spectrum disorder benefits:**

- therapies for developmental delay or abnormal speech pathology;
- therapies which are primarily educational in nature;
- special education services;
- treatment of learning disabilities;
- lessons for sign language;
- therapies to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering);
- therapies to maintain current status or level of care;
- restorative therapies to maintain chronic level of care;
- therapies available in a school program;
- therapies available through state and local funding;
- recreation therapies;
- art, 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; and
- remedial education and programs.

Total Body Photography is not covered.

Transplant Services. We do not cover any of the following:

- organ and tissue transplant services not listed as covered;
- organ and tissue transplants not medically necessary;
- organ and tissue transplants considered experimental or investigative;
- services from non-contracted providers unless pre-authorized by the plan; and
- services and supplies for organ donor screenings, searches and registries.

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

U

Urea Breath Testing is not covered**.**

V

Vaccines are not covered unless approved by the Plan.

Video Recording or Video Taping of any covered service procedure is not covered.

Virtual Colonoscopy is not covered unless approved by the Plan.

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

Vitiligo Treatments by laser, light, or other methods is not covered.

W

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

Wisdom Teeth extraction is not covered unless under a rider**.**

X

Y

Z

Additional Items

OptimaHealth®

Online Pharmacy Resources

Optima Health offers an online tool that can help you learn more about a prescription drug, and what your cost will be, even before you become an Optima Health member.

This tool can help you. Look up a drug to find out:

- what Tier a drug is on - which you can then match to your plan documents to know what Copayment you would owe for that drug;
- if the drug has any special requirements, such as requiring pre-authorization or a step edit drug (a drug that is required to be tried prior to the drug you are looking up);
- if there are any alternatives to the drug you are looking up; and
- if there is a generic available for the drug you are looking up.
  Note: If your prescription drug has a generic available, the generic is covered under the plan. You may choose to receive the brand name drug, however, there may be a brand buy-up charge for that brand name drug.

- *Visit optimahealth.com.*
- *Click on "Find Doctors, Drugs, and Facilities" and select "Drugs."*
- *A new window may open. Under Select Plan, be sure Four-Tier open Commercial is selected and click "Continue".*
- *From here, you can follow the instructions for :*
  - *"Drug Lookup;"*
  - *"Drug Price Lookup;" and*
  - *"Additional Resources."*

Once you become a member you can register online and use the custom tools available to you in your MyOptima menu. If you have any questions about your pharmacy benefits or these tools, please contact Member Services at the number listed on the back of your member ID card.

8/2013

OptimaHealth

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 best price for you. For some drugs the actual cost of the drug may be less than the advertised $4 generic program.

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

Examples of Savings with Generics

30-day supply

Drug	Quantity	What You Pay	Pharmacy $4 Program	Sample Tier 1 Copayment
Atenolol 50 mg tablets	30	$1.91	$4.00	$10.00
Fluoxetine 20 mg capsules	30	$2.01	$4.00	$10.00
Furosemide 40 mg tablets	30	$1.35	$4.00	$10.00
Hydrochlorothiazide (HCTZ) 25 mg tablets	30	$1.50	$4.00	$10.00
Ibuprofen 600 mg tablets	60	$3.02	$4.00	$10.00
Lisinopril/HCTZ 10/12.5 tablets	30	$2.06	$4.00	$10.00
Metformin 1000 mg tablets	60	$3.11	$4.00	$10.00

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.

8/2013

OptimaHealth

The Value of

Optima Health
Emergency Travel Assistance

"For the long road ahead."

When purchasing individual travel assistance, plans can begin at $275 per person per trip, or $1,500 per family per year (sometimes more). The Optima Health Emergency Travel Assistance Program, provided by Assist America, offers superior services through your health insurance plan at no additional cost. Emergency travel services are offered with advantages that many other travel assistance companies do not provide:

- **Peace of Mind**
  You can travel knowing that you are connected to Western-style healthcare anywhere in the world when you are 100 miles or more away from home.
- **Single Point of Service**
  One phone call is all it takes to activate powerful resources.
- **No Exclusions for Pre-existing Conditions**
  There is no fine print about pre-existing conditions accompanying services.
- **No Maximum Limits for Any Services**
  There is no financial cap on assistance.
- **No Territorial Exclusions**
  You are covered for medical emergencies anywhere around the world regardless of geographic or political climate.
- **No Exclusions for Sports or Hazardous Hobbies**
  Skydiving? Yes, still covered.
- **Medically Trained, Multilingual Operations Center Accessible 24/7**
  You are connected to assistance anytime, anywhere, in any language.
- **No Chargebacks**
  We pay for all the services we perform.

For more information, visit optimahealth.com/members.

assist america®

ETA_PMF_revised 05/13

Options For Care
Do You Want to Save Time and Money?

Knowing where to go when you are sick or injured can keep money in your pocket and save you valuable time. In an emergency situation, you should always go to your nearest provider. However, you have several options in a non-emergency health situation, since care in a hospital Emergency Department is the most expensive care option. Be sure your health situation is an emergency before you go to a hospital Emergency Department for care. Situations such as ear pain, throat pain, colds/flu, and rashes are often best treated by calling your doctor.

For non-emergency illness or injury:

Step 1

Call your doctor's office. For a complete list of doctors in the Optima Health network, visit optimahealth.com.

Step 2

If your doctor's office is closed, call the **Care Coordination Program/After Hours Nurse Advice Line at 1-877-817-3037**. This **free** call is your link to a licensed nurse who can assist you in determining your immediate next steps for care. If this call recommends seeking care other than your doctor's office when it re-opens, then consider steps 3 and 4.

Step 3

Consider Sentara **MDLIVE** prior to the Urgent Care Center or the Emergency Department for non-emergent matters if your primary care physician is not available. When you need to connect with a physician, call 1-866-648-3638. From there, you can choose to connect to a physician via phone right away, or you can request a video visit online.

Step 4

Urgent Care Centers may meet your needs and are usually a less expensive and faster option for treatment than a hospital Emergency Department. These facilities are usually open on evenings, weekends, and holidays when your doctor's office may be closed.

Step 5

Hospital Emergency Departments are the most expensive and often take longer than other treatment options in non-life-threatening situations. If you choose to go to an Emergency Department, knowing which hospitals participate with Optima Health can save you money.

OptimaHealth

optimahealth.com

Sentara MDLIVE
The Doctor is Always In™

OptimaHealth

What can be treated by Sentara MDLIVE?

General Health

Acne
Allergies
Asthma
Bronchitis
Cellulitis
Cold & Flu
Constipation
Diarrhea
Ear Infection
Fever
Gout
Headache
Infections
Insect Bites
Joint Aches
Nausea
Pink Eye
Poison Ivy
Rashes
Respiratory Infections
Sinus Infections
Skin Inflammation
Nausea & Vomiting
Sports Injuries

Pediatric Care

Cold & Flu
Constipation
Ear Infection
Fever
Mood Swings
Nausea & Vomiting
Smoking Addiction
Pink Eye

And more….

Empowered by: MDLIVE™

Get 24/7/365 Access to Board-Certified doctors anytime, anywhere.

Online Video
See a doctor using your computer over the Internet

Phone Call
No webcam? No problem! Talk to a doctor over the phone!

Secure E-mail Advice
Ask questions and get advice privately using secure e-mail

When to use Sentara MDLIVE

- If you're considering the emergency department or urgent care center for a non-emergency medical issue
- Your primary care doctor is not available
- Request prescriptions or get refills*

*Prescriptions are issued only when clinically appropriate. No controlled substances may be prescribed, and the availability may be restricted by law.

- Traveling and in need of medical care
- During or after normal business hours, nights, weekends, and even holidays

How to get started?

- Go to www.mdlive.com/optima – or call 1-866-648-3638
- Have your Optima Health member ID number available to register. Please note that you'll need to create an account for each covered member of your family over the age of two.
- When you want to see a doctor, you can go online to request immediate access to a provider on-call via phone or schedule a time at your convenience. You can also get connected by calling 1-866-648-3638. The cost to you will be equal to that of a Copayment to see a primary care physician normally.

1-866-648-3638

mdlive.com/optima

v4.2013

OptimaHealth

Welcome to the

EPIC Hearing Service Plan (HSP)

a value added benefit for Optima Health members

The EPIC HSP provides savings on name brand technology and access to quality care.

> "The EPIC HSP provides savings on name brand technology and access to quality care."

- National network of ear physicians and audiologists
- Testing, evaluations, and hearing aid fittings by licensed audiologists
- Brand name hearing aids - savings of 30% to 60%
- All levels of technology and hearing aid styles
- Reduced costs on services and products
- Assistance coordinating health plan benefits and hearing aid allowances to maximize savings
- Toll free telephone support throughout the process
- All payments are to EPIC HSP to ensure controlled fees
- Flexible payment plans through two nationally accredited financial institutions
- No administrative forms or paperwork to fill out
- HSP member booklet lists all makes and models for the major brand hearing aids, allowing members to price shop and compare their savings

Ear Professionals International Corporation (EPIC) is the nation's largest coalition of hearing healthcare physicians and audiologists. EPIC physicians have pioneered and developed most of the current treatment methodologies and interventions, working together with the best audiologists in the nation, recognized for their extensive professional education and experience in diagnostic techniques and rehabilitative interventions.

Steps To Accessing Hearing Care / Hearing Aid(s) Through EPIC

1. Call 1-866-956-5400 toll free and speak with a hearing counselor to assess your need and to receive your HSP booklet. The HSP price booklet outlines all plan benefits (including pricing) in detail.
2. EPIC coordinates your hearing care from start to finish. The EPIC payment process allows you to maximize your service and eliminate administrative paperwork.
3. As the third party administrator, all payments and billings are centralized and coordinated by EPIC HSP for hearing aid benefits and services.
4. EPIC manages tailored offerings to help those on fixed incomes pursue hearing aids and related care through an income dependant non profit program.

epic
HEARING HEALTH CARE

Call EPIC Today for a Referral to a Participating Provider in Your Area

Call: 1-866-956-5400 Email: hear@epicearing.com Visit: epichearing.com

OptimaHealth

Flu Prevention

Members with medical and/or pharmacy benefits administered by Optima Health will have the flu vaccine covered. According to The Centers for Disease Control and Prevention (CDC) website, "The CDC recommends a yearly flu vaccine for everyone 6 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 three main flu strains that research indicates will cause the most illness during the flu season."

Optima Health members may visit the following locations to receive a flu shot[1]:

Your doctor:

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

Your local pharmacy:

- Members should visit optimahealth.com 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 your member ID card.

[1]Optima Family Care and FAMIS members are ineligible for the Optima Health pharmacy-administered Flu Vaccination Program. Please see your provider for information on receiving the flu vaccine.

Member Application(s)

OptimaHealth
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7401

Optima Health Plan
Optima Vantage
Enrollment Application

TIPS FOR COMPLETING YOUR ENROLLMENT APPLICATION

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

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

Continuation Of Coverage For Children With A Disability:

Children over age 26 with a mental or physical disability will continue to be eligible for coverage. You will need to include a written statement from the child's physician with this application. Call member services for additional information.

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

Please make sure to include birth dates and Social Security numbers for each person who will be covered under the Plan.

Notice of Special Enrollment Opportunity for Children under Age 26.

Children under age 26 whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in your Optima Health group plan. You may request enrollment for such children for 30 days from your group effective date. Enrollment will be effective on the first day of your Optima Health group coverage. For more information contact Optima Health member services.

Notice of Lifetime Limits and Opportunity to Enroll

Lifetime limits on the dollar value of benefits under Optima Health no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan will have an opportunity to enroll in the Plan. Individuals have 30 days from your group effective date to request enrollment. For individuals who enroll under this opportunity, coverage will take effect not later than the first day of the Plan coverage effective date. For more information contact Optima Health member services.

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OptimaHealth

Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7401 (877) 552-7401

Coordination of Benefits Information Page

* Please retain a copy of this coordination of benefits page for your records.

Applicant's Name: _____ Soc. Sec. #: _____

Date of Birth: _____

NOTE: Complete section 1 and section 3 if you have additional commercial insurance.
Complete section 2 and section 3 if you have Medicare.

SECTION 1 (Commercial Insurance)

Name of other Insurance Company: _____

Address: _____

Phone Number: _____

Policy Number: _____ Effective Date: _____

Employer: _____

Group Number: _____

Policyholder's Name: _____

Birthdate: _____

List family members covered by this insurance: _____

SECTION 2 (Medicare Information)

Applicant: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Are you retired: Yes ☐ No ☐ Retirement date: _____

Spouse: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Are you retired: Yes ☐ No ☐ Retirement date: _____

SECTION 3

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

Signature of Applicant:	**Date:**

OptimaHealth
www.optimahealth.com

FOR PLAN USE ONLY
Subscriber #: _____
Date: _____

Optima Health Plan
Optima Vantage
Enrollment Application

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

Section 4 To be completed by employer Group No. _____ (For Office Use Only) Sub Group No. _____ (For Office Use Only)

O **NEW** O **Open Enrollment** O **Request for Individual Conversion** O **C.O.B.R.A.** O **PCP or Address Change**

O **Cancel All** O **Add Dependent/Spouse** O **Cancel Dependent/Spouse** O **Reinstatement**

Employer Name: _____ **Effective/Expiration Date of Coverage:** _____ **Empolyee's Social Security No.** _____ **Hire Date:** _____

Section 5 TO BE COMPLETED BY EMPLOYEE- **(PLEASE PRINT LEGAL NAME)**

Last Name: _____ First Name: _____ Middle Init. _____

Address: _____ Primary Language: _____

City/State/Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Section 6 **Additional Coverage-**

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

Will any of the persons listed below have any other medical health insurance in addition to Optima Health Plan, when this coverage takes effect? O Yes O No

If Yes, please complete Sections 1, 2, and 3 on the Coordination of Benefits form attached.

Section 7 **Communication-**

Please select the method in which you would prefer to receive communications from Optima Health.

	Print	Electronic	
EOBs: *Explanation of Benefits*	☐	☐	**Email Address:** ***(Required)***
SBC: *Summary of Benefits & Coverage*	☐	☐	_____
Other Communications: *Newsletters etc.*	☐	☐	_____

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Section 8

Please list below all persons to be covered by the enrollment application. Choose a primary care physician by consulting the online provider directory or you may call member services. You may choose a different primary care physician for each member of your family. Although referrals to see specialists are not required, we will need your choice of both a primary care physician and location in order to process this application.

Social Security No.		Last Name	First Name, MI	Date of Birth MO/DAY/YR	M/ F	Primary Care Physician & ID #	Current Patient
	SELF			/ /		DR.	YES / NO
	SPOUSE			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO

IF ADDING TO POLICY, DATE OF QUALIFYING EVENT (BIRTH, MARRIAGE) _____

Section 9

Authorization-

I am applying for Optima Health Plan (OHP)coverage for myself and the family members listed, and agree that once issued I and my family members will abide by the provisions of coverage in the Group Agreement and Evidence of Coverage under which we will be enrolled.

I understand that misrepresentation in answering questions on this application, or non-payment of premiums may result in cancellation of coverage. I understand that this application serves as a contract between myself and OHP, and that all monies will be returned if the application is not accepted.

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

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

Any information received by OHP pursuant to this application is subject to restrictions on disclosure to others as set forth under state and Federal laws. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may not longer be protected by federal rules governing privacy and confidentiality.

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

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

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

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

Signature of Applicant _____ Date _____

Benefit Administrator _____ Date _____

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