Optima Health

http://www.optimahealth.com

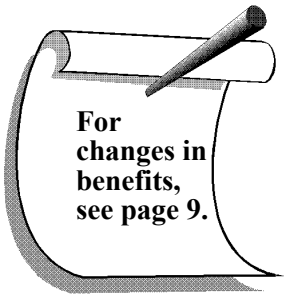
OptimaHealth

2012

A Health Maintenance Organization (high and standard option)

Serving: Hampton Roads, Charlottesville, Fredericksburg , Lynchburg, Richmond & the Roanoke areas of Virginia

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Enrollment code for this Plan:

9R1 High Option - Self Only

9R2 High Option - Self and Family

9R4 Standard Option - Self Only

9R5 Standard Option - Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

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Important Notice from Optima Health About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Optima Health's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048.

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Introduction

This brochure describes the benefits of Optima Health under our contract (CS 2842) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Optima Health administrative offices is:

Optima Health

4417 Corporation Lane

Virginia Beach, VA 23462

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are a some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Optima Health.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Healthcare and Insurance, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud– Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 757-687-6326, or 1-866-826-5277 and explain the situation.

-If we do not resolve the issue:

CALL THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise);

Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misreprentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.

- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medications or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medications.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

  "Exactly what will you be doing?"

  "About how long will it take?"

  "What will happen after surgery?"

  "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Optima Health preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply and what protections apply to a non-grandfathered health plan may be directed to us at Optima Health, 4417 Corporation Lane, Virginia Beach, VA 23462. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov .

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from you primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Except for emergencies outside the service area, we will not pay for care or services from non-Plan providers unless it has been authorized by us. You are responsible for making sure that a provider is a Plan provider. If you use a non-Plan provider without our prior authorization, you may be responsible for charges.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Optima Health is a not for profit health maintenance organization fully licensed under the laws of the Commonwealth of Virginia to arrange for the provision of health care services to its members.
- Optima Health is one of the first HMOs in the Hampton Roads area of Virginia operating since 1984.
- Optima Health pays providers on a fee for service basis according to a fee schedule. You may find some additional information about the Plan's providers in this brochure in Section 3 "Where you get covered care". If you would like information about the Plan's provider network, including participating hospitals, physician education, and board certification, and whether or not physicians are accepting new patients, you may check your provider directory, or the Plan's web site at www.optimahealth.com or call Member Services at 757-552-7550 or 1-800-206-1060.

- If you have questions about appeals, customer satisfaction measures, or how Optima Health manages your care or makes coverage decisions please call Member Services. If you want more information about us, call Member Services, or write to Optima Health, 4417 Corporation Lane, Virginia Beach, VA 23462. You may also contact us by fax at 757-552-8919 or visit our web site at www.optimahealth.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area in the State of Virginia:

Cities of:

Bedford, Buena Vista , Charlottesville, Chesapeake, Danville, Emporia, Franklin, Fredericksburg, Hampton, Harrisonburg, Lexington, Martinsville, Newport News, Norfolk, Petersburg, Poquoson, Portsmouth, Radford, Richmond, Roanoke, Salem, Staunton, Suffolk, Virginia Beach, Waynesboro, Williamsburg and Winchester.

Counties of:

Alleghany, Amelia (to include 23002, 23083, 23105), Amherst, Appomattox, Augusta, Bath, Bedford, Botetourt, Brunswick, Campbell, Caroline (to include 22427, 22428, 22559, 22446, 22501, 22514, 22535, 22538, 22546, 22552, 22580), Charles City, Charlotte, Chesterfield, Clarke, Covington, Craig, Culpeper, Cumberland, Dinwiddie, Essex, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Greensville, Halifax, Hanover (to include 23005, 23015, 23047, 23059, 23069, 23111, 23116, 23192, 23146, 23162), Henrico, Henry, Highland, Isle of Wight, James City, King George (to include 22401, 22402, 22404, 22407, 22408, 22448, 22451, 22481, 22485, 22526, 22544, 22547, 22534, 22553 and 22565), King and Queen, King William, Lancaster, Louisa, Lynchburg, Lunenberg, Matthews, Mecklenburg, Middlesex, Montgomery, New Kent, Northumberland, Nottoway, Page, Patrick, Pittsylvania, Powhatan, Prince Edward, Prince George, Pulaski, Rappahannock Richmond, Roanoke, Rockbridge, Rockingham, Shenandoah, Spotsylvania, Stafford, Sussex, Warren, Westmoreland and York.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2012

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to High Option only

- Your share of the non-Postal premium will increase/decrease/stay the same for Self Only or increase/decrease/stay the same for Self and Family. See page 81.
- Outpatient Mental Health copayment will increase to $15.00
- Urgent Care Center copayment will increase to $30.00
- Durable Medical Equipment will now be covered at 70% and the annual limit of $1000 has been removed
- Orthopedic and Prosthetic Devices will now be covered at 70% and the annual limit of $2000 has been removed
- Early Intervention annual limit of $5,000 has been removed
- Provide coverage for the diagnosis of Autism Spectrum Disorder (ASD) and treatment for ASD in individuals from age 2 to 6, subject to an annual maximum benefit of $35,00 for applied behavior analysis

Changes to Standard Option only

- Your share of the non-Postal premium will increase/decrease/stay the same for Self Only or increase/decrease/stay the same for Self and Family. See page xx.
- Durable Medical Equipment will now be covered at 70% and the annual limit of $1000 has been removed
- Orthopedic and Prosthetic Devices will now be covered at 70% and the annual limit of $2000 has been removed
- Early Intervention annual limit of $5,000 has been removed
- Provide coverage for the diagnosis of Autism Spectrum Disorder (ASD) and treatment for ASD in individuals from age 2 to 6, subject to an annual maximum benefit of $35,00 for applied behavior analysis

Section 3. How you get care

Open Access HMO

Optima Health offers Open Access to our members within the plan's service area identified on page 8. You can go directly to any network specialist for covered services without a referral from your primary care physician (PCP). Whether your covered services are provided by your primary care physician (for your PCP copay) or by any other participating provider in the network (for the specialist copay), you will be responsible for payment which may be in the form of a copay (flat dollar amount) or coinsurance (a percentage of covered expenses). You still must select a PCP and notify member services of your selection. If you go directly to a specialist, you are responsible for verifying that the specialist is participating in the Plan. There are three ways you can check to see if your specialty provider is in the Plan's network. You can call Member Services, you can check your provider directory, or you can log onto the Plan's website at www.optimahealth.com to verify that your specialty provider is in the Plan's network. Please remember that although you do not need a referral for specialty care some services, supplies, and drugs require pre-authorization. Please refer to Section 3 for pre-authorization information and to make sure which services require pre-authorization.

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 757-552-7550 or 1-800-206-1060 or write to us at Optima Health, 4417 Corporation Lane, Virginia Beach, VA 23462. You may also request replacement cards through our web site at www.optimahealth.com .

Where you get covered care

If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. You will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. You should receive a directory when you enroll, or you can call Member Services to request a directory. Look in the directory to find a doctor's specialty, office location, telephone number, and notes on whether or not the doctor is accepting new patients. You may want to call the doctor to check to see if he or she is still participating in the Plan. You can also call Member Services, or check the Plan's web site to find out if a doctor participates in the Plan.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically, or you can call Member Services to find out if a hospital or other facility is a participating provider. The list is also on our web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

You do not need a referral from your primary care physician (PCP) for specialty care from a plan provider.

Here are some other things you should know about specialty care:

• If you are seeing a specialist when you enroll in our Plan, you must make sure that he or she participates with us. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

• If you are seeing a specialist and your specialist leaves the Plan, you may receive services from your current specialist until we can make arrangements for you to see someone else.

• If you have a chronic and disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause; or

- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or

- reduce our service area and you enroll in another FEHB Plan.

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new Plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call Member Services immediately at 757-552-7550 or 1-800-206-1060. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB Plan to us, your former Plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center; or
- the day your benefits from your former Plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your Plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new Plan begin on the effective date of enrollment .

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other Services**

Your primary care physician has authority to refer you for most services. For certain services, however, you physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Transplants,
- scheduled ambulance transport,
- outpatient surgery and services,
- inpatient hospitalization,
- durable medical equipment,
- artificial limbs,
- prosthetic and orthopedic appliances,
- home health care services,
- skilled nursing facility care,
- physical therapy, occupational therapy, speech therapy,
- cardiac rehabilitation,
- pulmonary rehabilitation, vascular rehabilitation,
- early intervention services,
- clinical trials,
- hospice services,
- oral surgery,
- TMJ services,
- mental health services,
- growth hormone therapy,
- maternity services,
- Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CT) Scans,
- services from non-Plan providers,
- certain prescription drugs.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 757-552-7550 or 1-800-206-1060 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

You must share the costs of some services. You are responsible for:

Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician you pay a copayment of $15 per office visit and when you go in the hospital, you pay $200 per admission.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for infertility services and 20% of our allowance for diabetic supplies.
Your catastrophic protection out-of-pocket maximum	After your copayments and/or coinsurance total $2,100 per person or $5,100 per family enrollment in any calendar year for the High Option; $1,800 per person or $4,800 per family enrollment in any calendar year for the Standard Option, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services: • Prescription drugs • Vision care and services We will notify you when you reach the maximum.
When Government facilities bill us	Facilities of the Department Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High and Standard Option Benefits

See page 9 for how our benefits changed this year. Page 69 and page 71 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 757-552-7550 or at our Web site at www.optimahealth.com

Each option offers unique features.

- **High Option**
  - $15 copayment for primary care physician office visits
  - No copayment for primary care physician office visits for preventive care
  - No referral needed to see a specialist
  - $10 copayment for Preferred prescription drugs
  - Protection against catostrophic costs (out of pocket maximum) is $2,100/Self Only or $5,100/Family enrollment per year
- **Standard Option**
  - Affordable premiums
  - $20 copayment for primary care physician office visits
  - No copayment for primary care physician office visits for preventive care
  - No referral needed to see a specialist
  - $5 copayment for Preferred prescription drugs
  - Protection against catostrophic costs (out of pocket maximum) is $1,800/Self Only or $4,800/Family enrollment per year

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Diagnostic and treatment services		
Professional services of physicians • In physician's office • Office medical consultation • Second surgical opinion • At home house calls within the Plan's service area	$15 per visit to your primary care physician $30 per visit to a specialist	$20 per visit to your primary care physician $30 per visit to a specialist
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing	Nothing
Professional services of physicians • In an Urgent Care Center	$20 per visit	$30 per visit
Lab, X-ray and other diagnostic tests		
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise $15 per primary care physician office visit or $30 per specialist office visit	Nothing if you receive these services during your office visit; otherwise, $20 per primary care physician office visit or $30 per specialist office visit
MRI, CAT Scans and PET Scans	$50 copayment, pre-authorization required	20% of the Plan allowance, pre-authorization required

Benefit Description	You pay	
Preventive care, adult		
Routine screenings, such as: • Total Blood Cholesterol • On routine physical exam annually • A fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) once every five years for adults 20 or over	Nothing	Nothing
Routines screenings such as: • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Routine Pap test	Nothing	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year At age 65 and older, one every two consecutive calendar years	Nothing	Nothing
Osteoporosis Screening • Routine screening for women 65 and older • Routine screening beginning at age 60 for women at increased risk	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving this service*	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, children		
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams up to age 22 to determine the need for vision correction - Ear exams up to age 22 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing	Nothing
Maternity care		
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	$100 one time charge per pregnancy for obstetrical prenatal, delivery and postnatal services $200 inpatient hospitalization admission	20% of the Plan allowance for obstetrical prenatal, delivery and postnatal services 20% of the Plan allowance inpatient hospitalization admission
Not covered: • *Routine care and services for pregnancy outside the Plan's service area.* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges*	*All charges*

Benefit Description	You pay	
Family planning		
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) Note: We cover oral contraceptives under the prescription drug benefit.	Included in per office visit or per inpatient/outpatient copayment per admission	Included in per office visit or per inpatient/outpatient coinsurance
• Injectable contraceptive drugs (such as Depo provera)	$15 per PCP office visit $30 per specialist office visit	$20 per PCP office visit $30 per specialist office visit
• Surgically implanted contraceptives	$30 per specialist office visit in addition to pharmacy copay	$30 per specialist office visit in addition to pharmacy copay
• Intrauterine devices (IUDs) and Cervical Caps	$30 per specialist office visit	$30 per specialist office visit
• Diaphragms limited to fitting only. You must have the prescription filled at a Plan pharmacy	$15 per primary care physician office visit in addition to pharmacy copay $30 per specialist office visit in addition to pharmacy copay	$20 per PCP office visit in addition to pharmacy copay $30 per specialist office visit in addition to pharmacy copay
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Infertility services		
Diagnosis and treatment of infertility such as: • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Endometrial biopsies • Semen analysis • Hysterosaloingography • Sims-Huhner Test (smear) • Diagnostic laparoscopy	Coinsurance: 50% of the Plan allowance.	Coinsurance: 50% of the Plan allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* • *in vitro fertilization* • *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)		
• *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs* • *Reproductive material storage* • *Infertility services after voluntary sterilization* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Allergy care		
• Testing and treatment • Allergy injections • Allergy serum	$15 per visit to your primary care physician $30 per visit to a specialist	$20 per primary care physician office visit $30 per specialist office visit
Not covered: • *Provocative food testing and sublingual allergy desensitization* • *Radioallergosorent Test (RAST), and food allergy ingestion testing* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Treatment therapies		
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 34. • Respiratory and inhalation therapy • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We will only cover GHT when we pre-authorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. You must ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services on page 50.	$15 per primary care physician office visit $30 per specialist office visit	$20 per primary care physician office visit $30 per specialist office visit
• Dialysis – hemodialysis and peritoneal dialysis	$15 per physician office visit	$20 per physician office visit

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)		
Not covered: • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Physical and occupational therapies		
Up to three months per condition per year in accordance with a specific written treatment plan that has been authorized by the Plan for the services of each of the following: • qualified physical therapists • occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. All services and treatment must be part of a treatment plan, which details the treatment including frequency, duration, and goals. This applies to therapies done in any outpatient setting including in the member's home or outpatient therapy center.	$30 per specialist office visit Nothing per visit during covered inpatient admission	$30 per specialist office visit 20% during covered inpatient admission
Early Intervention Services are covered for children from birth to age three for medically necessary services limited to: • speech, language, occupational and physical therapy • assistive technology services and devices Note: Covered services are provided to enhance functional ability without effecting a cure. Department of Mental Health, Mental Retardation, and Substance Abuse Services must certify dependents as eligible for services under Part H of the Individuals with Disabilities Act.	Any applicable Copayment or Coinsurance, depending on the type and place of treatment or service. Pre-authorization is required.	Any applicable Copayment or Coinsurance, depending on the type and place of treatment or service. Pre-authorization is required.
Autism Spectrum Disorder 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.	Any applicable Copayment or Coinsurance, depending on the type and place of treatment or service. Pre-Authorization is required. Coverage for Applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000 per child.	Any applicable Copayment or Coinsurance, depending on the type and place of treatment or service. Pre-Authorization is required. Coverage for Applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000 per child.

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)		
"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.	Any applicable Copayment or Coinsurance, depending on the type and place of treatment or service. Pre-Authorization is required. Coverage for Applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000 per child.	Any applicable Copayment or Coinsurance, depending on the type and place of treatment or service. Pre-Authorization is required. Coverage for Applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000 per child.
• Cardiac rehabilitation following a heart transplant, bypass surgery, or myocardial infarction, is covered for up to 90 consecutive days from the start of rehabilitation. • Pulmonary and vascular rehabilitation is covered for up to 90 consecutive days from the start of rehabilitation.	$30 per specialist office visit Nothing per visit during covered inpatient admission	$30 per specialist office visit 20% during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Any service or supply, unless provided in accordance with a specific treatment plan pre-authorized by the Plan* • *Therapy which is primarily educational in nature, special education, or sign language* • *Work-hardening programs* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*

Benefit Description	You pay	
Speech therapy		
Speech therapy is covered for up to two months per condition per year for medically necessary treatment.	$30 per specialist office visit Nothing per visit during covered inpatient admission.	$30 per specialist office visit 20% during covered inpatient admission.
Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status; *Not covered:* • *Therapies for developmental delay or abnormal speech pathology are excluded from Coverage except as covered through Early Intervention Services;* • *Therapies which are primarily educational in nature, including but not limited to, special education or lessons in sign language are excluded from Coverage;* • *Therapies performed to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering) are excluded from Coverage;* • *Therapies to maintain current status or level of care are excluded from Coverage;* • *Restorative therapies to maintain chronic level of care are excluded from Coverage;* • *Speech therapy not authorized by the Plan as part of a specific treatment plan* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)		
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	$15 per primary care physician office visit $30 per specialist office visit	$20 per primary care physician office visit $30 per specialist office visit
Not covered: • *All other hearing testing*	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)		
• *Hearing aids, testing and examinations for them* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)		
Preventive vision care and services are administered by EyeMed Vision Care. The following services are covered once every 12 months: • Annual eye refraction including care history, visual acuity test for glasses and written lens prescription. • Screening tests for diseases or abnormalities, including glaucoma and cataracts. Note: You should select a EyeMed Vision Care provider and call him or her directly to schedule an appointment. Pay your copayment when you receive services. If you need help or a current list of participating providers, call EyeMed Vision Care at 1-866-939-3633 or visit www.optimahealth.com. You may receive an eye exam from a non-Plan provider and receive a $30 reimbursement.	*Nothing*	*Nothing*
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	*Nothing*	*Nothing*
• Eye exam to determine the need for vision correction for children up to age 22 (see Preventive care, children)	Nothing per primary care physician office visit $30 per specialist office visit	Nothing per primary care physician office visit $30 per specialist office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Any eye examination, or any corrective eyeware required by an employer as a condition as employment* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*

Benefit Description	You pay	
Foot care		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$15 per primary care physician office visit $30 per specialist office visit	$20 per primary care physician office visit $30 per specialist office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics of any kind including customized or non-customized shoes, boots, and inserts, except as medically necessary and approved by the Plan for members with diabetes* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Orthopedic and prosthetic devices		
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Lenses following cataract removal • Repair and replacement Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	30% of Plan allowance	30% of Plan allowance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)		
• *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Durable medical equipment (DME)		
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Standard non-motorized wheelchairs • Crutches • Walkers • Colonostomy, iliostomy, and tracheostomy supplies • Suction and urinary catheters • Blood glucose monitors • Insulin pumps. Note: When your Plan physician prescribes this equipment we will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates.	30% of the Plan allowance	30% of the Plan allowance
Diabetic supplies and equipment including strips, lancets, meters, and external insulin pumps prescribed by a Plan physician for insulin dependent, gestational, and non-insulin dependent diabetics. Note: Members must use Liberty Medical Supplies as their provider for all diabetic supplies and equipment. Members will need to call Liberty Medical Supplies at 1-866-846-9361 to have supplies delivered to them at home.	20% of the Plan allowance No copayment is required for external insulin pumps. *Note: This benefit is not subject to the Plan's annual DME limit.*	20% of the Plan allowance No copayment is required for external insulin pumps. *Note: This benefit is not subject to the Plan's annual DME limit.*
Not covered: • *Motorized wheelchairs or scooters* • *Exercise equipment* • *Air conditioners, purifiers, humidifiers, and dehumidifiers* • *Whirlpool baths* • *Convenience items, including but not limited to hypoallergenic bed linens, water purification devices, and adaptive feeding devices*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)		
• *Telephones* • *Changes made to vehicles, residences, or places of business including, but not limited to, handrails, ramps, elevators, and stair glides* • *Repair or replacement of equipment damaged through neglect or loss* • *More than one item of equipment for the same purpose* • *Disposable medical supplies, including but not limited to medical dressings, disposable diapers* • *Durable medical equipment primarily for comfort and well being of the member* • *Care and services from non-plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Home health services		
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications • Part-time or intermittent nursing care • Part-time or intermittent home health aide services • Surgical dressings and medical appliances	Nothing	Nothing
• Physical, occupational, or speech therapy	$30 per visit	$30 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges*	*All charges*

Benefit Description	You pay	
Chiropractic		
No benefit	*All charges*	*All charges*
Alternative treatments		
No benefit	*All charges*	*All charges*
Educational classes and programs		
Coverage is provided for: • Diabetes self management Note: Members should call 1-800-SENTARA for information on classes	Nothing	Nothing
• Counseling and education for birth control options	$15 per primary care physician office visit $30 per specialist office visit	$20 per primary care physician office visit $30 per specialist office visit
• Tobacco cessation programs, including individual/group/telephone counseling, and physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRE-AUTHORIZATION FOR ALL SURGICAL PROCEDURES. Please refer to the pre-authorization information shown in Section 3.

Benefit Description	You pay	
Surgical procedures		
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	Included in per office visit or per inpatient/outpatient admission copayment	20% of Plan allowance

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)		
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Included in per office visit or per inpatient/outpatient admission copayment	20% of Plan allowance
Not covered: • *Reversal of voluntary sterilization* • *Sex change operations* • *Routine treatment of conditions of the foot; see Foot care* • *Surgery primarily for cosmetic purposes* • *Any surgical services, other than emergent, which have not been pre-authorized by the Plan.* • *Any surgical services determined not medically necessary by the Plan.* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Reconstructive surgery		
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Included in per office visit or per inpatient/outpatient admission copayment	20% of Plan allowance

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)		
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Any surgical services, other than emergent, which have not been pre-authorized by the Plan.* • *Any surgical services determined not medically necessary by the Plan.* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges*	*All charges*
Oral and maxillofacial surgery		
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Included in per office visit or per inpatient/outpatient admission copayment	20% of Plan allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges*	*All charges*
Organ/tissue transplants		
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver	Nothing	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)		
- Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral • Pancreas These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) • Allogeneic transplants for **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	Nothing	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)		
- Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	Nothing	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)		
- Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma	Nothing	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)		
- Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma)	Nothing	20% of Plan allowance
National Transplant Program (NTP)-		
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)		
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges*	*All charges*
Anesthesia		
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	20% of Plan allowance

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRE-AUTHORIZATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require pre-certification.

Benefit Description	You pay	
Inpatient hospital		
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 per admission	20% of Plan allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Presurgical testing • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Hospitalization and anesthesia for dental procedures as determined medically necessary by a Plan physician for members under age five, severely disabled or with a medical condition requiring hospitalization for dental procedures.	Nothing	20% of Plan allowance

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)		
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *The cost of securing the services of blood donors* • *Professional dental services* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center		
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$150 per outpatient admission	20% of Plan allowance
Not covered: • *Blood and blood derivatives not replaced by the member* • *Professional dental services and procedures* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits		
Extended care benefit: The Plan provides a comprehensive range of benefits up to 100 days per calendar year when full time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	$200 per inpatient admission	20% of Plan allowance
Not covered: • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care* • *Personal comfort items such as telephone, and television* • *Blood and blood derivatives not replaced by the member* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving services*	*All charges*	*All charges*
Hospice care		
A coordinated program of home and inpatient care under the direction of a Plan doctor for the patient who is in the terminal stages of illness with a life expectancy of six months or less that includes: • Palliative Care • Supportive physical, psychological, and psychosocial services Note: Palliative care is treatment to control pain, relieve other symptoms and focus on the special needs of the patient.	Nothing	20% of Plan allowance
Not covered: • *Independent nursing* • *Homemaker services* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance		
Local professional ambulance service when medically appropriate	$25 copayment per trip	$25 copayment per trip

Section 5(d). Emergency services/accidents

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

- If the situation is life threatening, call 911 or go to the nearest hospital
- If at all possible, call your primary care physician (PCP) or the After Hours Nurse Triage Program at the number on your Plan ID card.

Emergencies within our service area:

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. The Plan will pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You must have any follow-up care recommended by non-Plan providers approved by the Plan and you must receive all follow-up care from Plan providers.

We will waive the emergency room copay if the emergency results in admission to a hospital.

For urgent or emergency mental health or substance abuse services, call Optima Behavioral Health Services Inc., at 757-552-7174 or 1-800-648-8420. The Psychiatric Emergency Response Service is available 24 hours a day, seven days per week to respond to clinical psychiatric and substance abuse emergencies

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

You must have any follow-up care recommended by non-Plan providers approved by the Plan. You must receive all follow-up care from Plan providers.

With your authorization, the Plan will pay benefits directly to non-Plan providers of your emergency care upon receipt of their claims for covered services. Physicians should submit their claims on a HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure.

Benefit Description	You pay	
Emergency within our service area		
• Emergency care at a doctor's office	$15 per primary care physician office visit $30 per specialist office visit	$20 per primary care physician office visit $30 per specialist office visit
• Emergency care at an urgent care center	$30 per visit	$30 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors services	$150 per visit (waived if admitted)	20% of Plan allowance
Not covered: • *Elective care or non-emergency care*	*All charges*	*All charges*
Emergency outside our service area		
• Emergency care at a doctor's office	$15 per primary care physician office visit $30 per specialist office visit	$20 per primary care physician office visit $30 per specialist office visit
• Emergency care at an urgent care center	$30 per visit	$30 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors services	$150 per visit (waived if admitted)	20% of Plan allowance
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance		
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	$25 per trip	$25 per trip

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (pre-authorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRE-AUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
  - Optima Behavioral Health Services administers mental health care and substance abuse services for the Plan. Optima Behavioral Health Services must authorize all treatment and services. You may reach Optima Behavioral Health Services by calling 757-552-7174.
  - For access to emergency mental health or substance abuse services, call Optima Behavioral Health Services at 757-552-7174 or 1-800-648-8420. The psychiatric emergency response service is available 24 hours a day, seven days per week to respond to clinical psychiatric and substance abuse emergencies.
  - We may limit your benefits if you do not obtain a treatment plan.

We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay	
Professional services		
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy)	$15 per office visit copay Nothing per visit per covered inpatient admission after inpatient copay is met $100 per outpatient admission	$20 per office visit copay 20% of Plan allowance per inpatient admission 20% of Plan allowance per outpatient admission

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)		
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$15 per office visit copay Nothing per visit per covered inpatient admission after inpatient copay is met $100 per outpatient admission	$20 per office visit copay 20% of Plan allowance per inpatient admission 20% of Plan allowance per outpatient admission
Diagnostics		
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$30 per outpatient visit Nothing per visit per covered inpatient admission after inpatient copay is met	$30 per outpatient visit 20% of Plan allowance during covered inpatient admission
MRI, CAT Scans and PET Scans	$50 copay per test	20% of Plan allowance
Inpatient hospital or other covered facility		
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$200 per inpatient admission	20% of Plan allowance per inpatient admission
Outpatient hospital or other covered facility		
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$15 per office visit copay $100 per outpatient admission	$20 per office visit copay 20% of Plan allowance per outpatient admission
Not covered		
• Services that are not part of a pre-authorized approved treatment plan. • Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the services.	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some drugs require pre-authorization from the Plan in order to be covered. The prescribing physician is responsible for obtaining pre-authorization.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** Prescriptions are covered when written by a licensed physician or dentist.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or a non-Plan pharmacy that has agreed to accept our reimbursement as payment in full. You may also use our mail order program.
- **We use a formulary.** All covered outpatient prescription drugs must be FDA approved, and require a prescription from a Plan doctor or dentist. Some drugs require pre-authorization from the Plan in order to be covered. Your physician is responsible for obtaining pre-authorization. We cover non-formulary drugs prescribed by a Plan physician. Covered drugs are placed into the following tiers which will determine what your copayments will be:
  - **Preferred**: The majority of widely dispensed generic drugs. We cover Preferred drugs at the lowest copayment level. Some brand-name drugs may be included in this category if the Plan recognized they show documented long-term decreases in illness and death. Large published peer-reviewed clinical trials are used to make this determination.
  - **Standard:** The brand-name equivalents of the generic Preferred drugs, plus certain brand-name drugs that are not available as generic drugs. Members are responsible for paying the difference between the cost of a Standard drug and it's Preferred counterpart, if any, in addition to the copayment charge unless your physician has specified "dispense as written.
  - **Premium:** Prescription drugs that are not included on the list of Preferred or Standard drugs, and are not specifically listed as drugs excluded from coverage.
  - **Premium Plus:** Those drugs that are not recognized by the health plan to be any more effective than other drugs available at the other tier levels or found over the counter. Premium Plus drugs are covered at the highest copayment level.
- **These are the dispensing limitations.** For a single copayment you will receive:
  - Up to a consecutive 31-day supply of a covered outpatient drug.
  - Up to a 31-day supply of syringes, needles, or disposable syringes with needles. (Limited to a maximum of 100.)
  - A one-cycle supply of oral contraceptives. You may receive up to three cycles of oral contraceptives at one time, but you must pay the appropriate copayment for each cycle.
  - One diaphragm.
  - Four (4) pills for Viagra to treat sexual dysfunction.

You may use the Plan's mail order prescription drug benefit and purchase a 90 day supply of maintenance drugs, for two prescription drug copayments. If you have a question about the mail order prescription drug program, or if you want to find out if your prescription is available through the program, you may call Caremark Pharmacy Services at 1-(888)766-5495 Monday through Friday, 8 a.m. to 9 p.m., and Saturday 9 a.m. to 5 p.m. (EST). You may also write to Caremark Pharmacy Services, P.O. Box 94467, Palatine, IL 60094-4467.

If you are called to active duty, or in time of national or other emergency please call Member Services for assistance in obtaining a medium term supply of your prescription drugs.

- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug, or a higher costing generic, when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic in addition to your copayment. The Plan limits the quantities of drugs you will receive for your copayment. Please read the information below to determine what you will receive for your prescription drug copay. If you have any questions about your prescription drug benefit please call Member Services.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the brand name is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you -and us- less than a brand name prescription.
- **When you do have to file a claim.** Members will be reimbursed for outpatient prescription drugs obtained from other than a Plan-participating pharmacy (or a non-Plan pharmacy that has agreed to accept reimbursement as payment in full for their services at rates applicable to Plan participating pharmacies) when:
  - Ordered in connection with an out-of-area emergency
  - Ordered by a Plan provider for immediate use because of a medical necessity and because no Plan –participating pharmacy was open for business a the time
  - Reimbursement will be limited to a quantity sufficient to treat the acute phase of the illness.

Benefit Description	You Pay	
Covered medications and supplies		
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Rescue and maintenance inhalers • Oral contraceptive drugs • Contraceptive diaphragms (Fitting is covered under Section 5(a) • Contraceptive Cervical caps, and IUDs: (Devices, fitting and insertion covered under Section 5 (a) • Norplant - one insertion/removal in five years. (Insertion and removal are covered under Section 5 (b) • Insulin • Insulin syringes and needles • Disposable needles and syringes for the administration of covered medications • Viagra – 4 pills per prescription • Intravenous fluids and medication for home use. Note: Injectable contraceptive drugs are covered under Family Planning Section 5(a). Here are some things to keep in mind about our prescription drug program:	Pharmacy Copayment: $10 per Preferred Tier Drug $25 per Standard Tier Drug $50 per Premium Tier Drug $75 per Premium Plus Tier Drug Mail Order Copayment for 90 day supply of Maintenance Drugs: $20 per Preferred Tier Drug $50 per Standard Tier Drug $100 per Premium Tier Drug $150 per Premium Plus Tier Drug Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	Pharmacy Copayment: $5 per Preferred Tier Drug $25 per Standard Tier Drug 50% per Premium Tier Drug up to an annual maximum of $3,000 50% per Premium Plus Tier Drug up to an annual maximum of $3,000. Mail Order Copayment for 90 day supply of Maintenance Drugs: $10 per Preferred Tier Drug $50 per Standard Tier Drug 50% per Premium Tier Drug up to an annual maximum of $3,000 50% per Premium Plus Tier Drug up to an annual maximum of $3,000 Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)		
• A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic drug in addition to your copay. • We administer an open formulary. If your physician believes a name brand product is necessary or there is not generic equivalent available, your physician may prescribe a name brand drug from a formulary list. The list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. For questions about your Prescription Drug Benefit or a copy of the Plan's drug formulary call Member Services.	Pharmacy Copayment: $10 per Preferred Tier Drug $25 per Standard Tier Drug $50 per Premium Tier Drug $75 per Premium Plus Tier Drug Mail Order Copayment for 90 day supply of Maintenance Drugs: $20 per Preferred Tier Drug $50 per Standard Tier Drug $100 per Premium Tier Drug $150 per Premium Plus Tier Drug Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	Pharmacy Copayment: $5 per Preferred Tier Drug $25 per Standard Tier Drug 50% per Premium Tier Drug up to an annual maximum of $3,000 50% per Premium Plus Tier Drug up to an annual maximum of $3,000. Mail Order Copayment for 90 day supply of Maintenance Drugs: $10 per Preferred Tier Drug $50 per Standard Tier Drug 50% per Premium Tier Drug up to an annual maximum of $3,000 50% per Premium Plus Tier Drug up to an annual maximum of $3,000 Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines(over the counter medicines)* • *Appetite suppressants or other weight management medications* • *Medical supplies such as dressings and antiseptics* • *Immunization agents, biological sera, blood or blood products* *Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 28.)*	*All charges*	*All charges*

Section 5(g). Dental benefits

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Care must be received by Plan providers only.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits and coverage for hospitalization and anesthesia for dental procedures. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit	You Pay	
Accidental injury benefit		
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Included in per office visit or per inpatient or outpatient admission copay.	Included in per office visit or per inatient or outpatient coinsurance.
Dental benefits		
We have no other dental benefits.	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
After Hours Nurse Triage Program	The After Hours Nurse Triage Program lets you talk to a professional nurse who can answer your questions and advise you where to get care on evenings, weekends, and holidays. When you call the After Hours Nurse Triage Program have your Plan ID card handy, and describe your medical situation in as much detail as possible. Please remember that the After Hours Nurse Triage program professional cannot diagnose medical conditions or write prescriptions. The After Hours Nurse Triage Program is available Monday through Friday from 5 p.m. to 8 a.m. On Saturday, Sunday, and holidays the program is available 24 hours a day. You can call the After Hours Nurse Triage Program at 757-552-7250 or 1-800-394-2237.
Services for deaf and hearing impaired	TDD number: 757-552-7120 or 1-800-225-7784
High risk pregnancies	A Plan Care Manager will assist with a treatment plan prescribed by your OB/GYN physician.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, 757-552-7550 or 1-800-206-1060 or visit their website at www.optimahealth.com .

My Life My Plan - Optima's spectrum of services, tools and programs to help members attain and maintain good health.

- ***Staying Healthy*** offers a set of unique, self-paced, award winning educational, fitness and screening programs that can be customized for each member. This broad selection of programs is designed to help members prevent illness and stay healthy.
- **Award winning S*ignature* Prevention Programs**
  - Healthy Heart - *Improve your heart health*
  - Get Off Your Butt: Stay Smokeless for Life - *Stop using tobacco and benefit your health*
  - Eating for Life - *Develop healthy eating and exercise habits*
  - Yoga - *Stretching and strengthening exercises*
  - WalkAbout with Healthy Edge - *Walk your way to better health*
- ***Healthyroads*** is a health coaching and wellness program for employees utilizing effective coaching interventions and self-help Internet tools.

The comprehensive suite of ***Healthyroads*** services we are including for employees includes:

- ***Healthyroads Online Program***: a comprehensive interactive internet site for wellness and health improvement including a personal health assessment, online fitness coach with personalized resistance and cardio exercise planning and demonstration, meal and nutrition planning and health library.
- ***Healthyroads Coaching Program***: a comprehensive health-coaching program for weight management, tobacco cessation and healthy living. This program is principally telephone based with internet and printed tools to support members. Telephone sessions are 30 minutes in length and include over 50 sessions annually. Sessions are goal driven based on the participant's interests and needs.
- ***Improving Health*** offers programs that address all aspects of member health by assembling a LifeCoach team dedicated to developing a health plan based on member-specific health status and needs.
- ***Saving More*** provides discounts and savings for products and services that help members get, and stay, healthy. These discounts include fitness centers, massage therapy, natural supplements, eyewear, hearing aids and more.
- ***Managing Your Meds*** is an innovative pharmacy program that helps ensure the safety, effectiveness, and affordability of the prescription medication covered by member pharmacy benefits.
- ***Partners in Pregnancy*** is a multi-disciplinary team that coaches expectant mothers through their pregnancies and encourages good prenatal behavior and regular physician checkups.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see Emergency services/accidents);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 757-552-7550 or 1-800-206-1060, or at our Web site at www.optimahealth.com.

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Claims

P.O. Box 5028

Troy, MI 48007-5028.

Other supplies or services

For EyeMed Vision Care non-Plan provider or out-of-network provider claims, please send your health plan name, your name, member ID number, current address, telephone number and your itemized statement. Claims must be submitted within six months of the time services are received.

Submit your claims to:

EyeMed Vision Care

Attn: OON Claims

P.O. Box 8504

Mason, OH 45040-7111

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.optimahealth.com/federal.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: Optima Health Appeals Department, 4417 Corporation Lane, Virginia Beach, VA 23462; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e) Include your e-mail address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

If you do not agree with our decision, you may ask OPM to review it.

3 You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or

- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (757) 552-7550 or 1 (800) 206-1060. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age;
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan– You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 757-552-7550 or 1-800-206-1060 or see our Web site at www.optimahealth.com.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

We do not waive any costs if the Original Medicare Plan is your primary payor.

You can find more information about how our plan coordinates benefits with Medicare by calling Member Services at 757-552-7550 or 1-800-206-1060.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov .

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

• You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

• OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

If you are a participant in a clinical trial, this health Plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan covers some of these costs, providing the plan determines the services are medically necessary. For more specific information, we encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this Plan does not cover these costs.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care or services that can be provided by a non-medically skilled person. Such services help the patient with daily living activities, and include but are not limited to: walking, dressing, bathing, exercising, preparing meals, moving the patient, acting as a companion, administering medication which can usually be self-administered, and rest cures. Custodial care that lasts 90 days or more is sometimes known as long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13. We do not have a deductible.

Experimental or investigational service

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and approval for marketing has not been given at the time it is furnished. Note: Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if:

1. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

2. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only:

- Published reports and articles in the authoritative medical and scientific literature;

- The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Group health coverage A plan or contract that provides coverage for health care services to eligible employees and their dependents.

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity Services, treatment, or supplies provided by a hospital, skilled nursing facility, physician, or other provider required to identify or treat your illness or injury and that as determined by your primary care physician and the Plan are:

- Consistent with the symptoms, diagnosis and treatment of your condition, disease, injury, or ailment;
- In accordance with recognized standards of care for your condition
- Appropriate standards of good medical practice
- Not solely for your convenience, or the convenience of your primary care physician, Plan provider, hospital or other provider;
- The most appropriate supply or level of service, which can be safely provided to you. As an inpatient this means that your medical symptoms or condition requires that the diagnosis, treatment or service cannot be safely provided to you as an outpatient.

Plan allowance Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: We use a fee schedule which means our Plan providers accept a negotiated fee from us and you will only be responsible for your copayments or coinsurance.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require pre-certification, prior approval, or a referral and (2) where failure to obtain pre-certification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-serve claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

	If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 757-552-7550 or 1-800-206-1060. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to Optima Health.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends;
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2012 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2011 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary BEFORE taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** dependent day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (as long as you have earned income for the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

Dental Insurance

All dental plans will provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557) or visit www.ltcfeds.com

Pre-existing Condition Insurance Program - PCIP

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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Summary of benefits for the High Option of the Optima Health Plan - 2012

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies**.**

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $30 specialist	19
Services provided by a hospital:		
• Inpatient	$200 per admission copay	40
• Outpatient	$150 per admission copay	41
Emergency benefits:		
• In-area	$150 per Emergency Room visit $30 per Urgent Care Center visit	45
• Out-of-area	$150 per Emergency Room visit $30 per Urgent Care Center visit	45
Mental health and substance abuse treatment:	Regular cost-sharing	47
Prescription drugs:		
• Retail pharmacy	$10 per Preferred Tier Drug $25 per Standard Tier Drug $50 per Premium Tier Drug $75 per Premium Plus Tier Drug	50
• Mail order	Mail Order Copayment for 90 day supply of Maintenance Drugs: $20 per Preferred Tier Drug $50 per Standard Tier Drug $100 per Premium Tier Drug $150 per Premium Plus Tier Drug	50
Dental care:	No benefit.	52
Vision care:	Covered at 100% per eyeglass exam once every 12 months	27
Special features: After Hours Nurse Triage Program, High Risk Pregnancy Case Manager		53

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $2,100/Self Only or $5,100/ Family enrollment per year. Some costs do not count toward this protection including: prescription drugs and vision copayments.	13

Summary of benefits for the Standard Option of the Optima Health Plan - 2012

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $30 specialist	19
Services provided by a hospital:		
• Inpatient	20% of Plan allowance	40
• Outpatient	20% of Plan allowance	41
Emergency benefits:		
• In-area	20% of Plan allowance per Emergency Room visit $30 per Urgent Care Center visit	45
• Out-of-area	20% of Plan allowance per Emergency Room visit $30 per Urgent Care Center visit	45
Mental health and substance abuse treatment:	Regular cost-sharing	47
Prescription drugs:		
• Retail pharmacy	$5 per Preferred Tier Drug $25 per Standard Tier Drug 50% per Premium Tier Drug up to an annual maximum of $3,000 50% per Premium Plus Tier Drug up to an annual maximum of $3,000.	50
• Mail order	$10 per Preferred Tier Drug $50 per Standard Tier Drug 50% per Premium Tier Drug up to an annual maximum of $3,000 50% per Premium Plus Tier Drug up to an annual maximum of $3,000	50
Dental care:	No benefit	52
Vision care:	Covered at 100% per eyeglass exam once every 12 months	27

Standard Option Benefits	You pay	Page
Special features:	After Hours Nurse Triage Program, High Risk Pregnancy Case Manager	53
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $1,800/Self Only or $4,800/ Family enrollment per year. Some costs do not count toward this protection including: prescription drugs and vision copayments.	13

2012 Rate Information for Optima Health

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Hampton Roads, Charlottesville, Fredericksburg, Lynchburg, Richmond & the Roanoke areas of Virginia							
High Option Self Only	9R1	$185.75	$76.99	$402.46	$166.81	$56.36	$53.78
High Option Self and Family	9R2	$414.35	$207.32	$897.76	$449.19	$161.28	$155.52
Standard Option Self Only	9R4	$129.23	$43.07	$279.99	$93.33	$28.43	$26.71
Standard Option Self and Family	9R5	$305.77	$101.92	$662.50	$220.83	$67.27	$63.19