Optima Health

www.optimahealth.com

757-552-7550 or 800-206-1060

OptimaHealth

2018

A Health Maintenance Organization (High Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 3 for details. This plan is accredited. See page 12.

Serving: Greater Hampton Roads region of Virginia

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 14
- Summary of benefits: Page 80

Enrollment code for this Plan:

PG1 High Option - Self Only
PG3 High Option - Self Plus One
PG2 High 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

RI 73-893

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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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 Medicare Part D 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 will 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 15 through December 7) 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 800-772-1213 (TTY): 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 (800-633-4227), TTY: 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of Optima Health under our contract (CS 2952) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This plan is underwritten by Optima Health. Customer service may be reached at 757-552-7550 or 800-206-1060 or through our website: www.optimahealth.com. The address for Optima Health's administrative offices is:

Optima Health

4417 Corporation Lane

Virginia Beach, VA 23462

This brochure is the official statement of benefits. No verbal 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. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS)website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- 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 866-826-5277 and explain the situation.
  - If we do not resolve the issue:

CALL THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also 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 (TCC).
- 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.

Discrimination is Against the Law

The Optima Health Plan complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557 the Optima Health Plan does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. 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 take notes, 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 and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- 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.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will this be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic 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 or clinic.

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 or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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.bemedwise.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.

Preventable Healthcare Acquired Conditions ("Never Events")

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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

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 to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

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.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

  See www.opm.gov/healthcare-insurance 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 that 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 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 Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. 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 Plus One or 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 Plus One or 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 Plus One or 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 are married.

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.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

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. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, 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.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **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 Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, 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. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 2018 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 2017 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 information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/.

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

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal 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 or Tribal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

  If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-741-4825 or visit or website at www.optimahealth.com.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Optima Health holds the following accreditation: National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation, please visit the following website: www.ncqa.org.

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our 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.

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 cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies). 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.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $7,300 for Self Only enrollment, and $14,700 for a Self Plus One or Self and Family.

Your rights and responsibilities

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 website (www.opm.gov/healthcare-insurance/) 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 website at www.optimahealth.com or call Member Services at 757-552-7550 or 800-206-1060.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website at www.optimahealth.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 757-552-7550 or 800-206-1060, or write to Optima Health, 4417 Corporation Lane, Virginia Beach, VA 23462. You may also visit our website at www.optimahealth.com/federal.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.optimahealth.com/federal. You can also contact us to request that we mail a copy of the Notice.

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:

Achilles, Ark, Battery Park, Bavon, Beaverlett, Bellamy, Bena, Blakes, Bohannon, Boykins, Branchville, Capron, Cardinal, Carrollton, Carrsville, Chesapeake, Claremont, Cobbs Creek, Courtland, Dendron, Diggs, Drewryville, Dutton, Elberon, Fleet, Fort Eustis, Fort Monroe, Fort Story, Foster, Franklin, Glou Point, Gloucester, Gloucester Point, Grafton, Grimstead, Gwynn, Hallieford, Hampton, Hayes, Hudgins, Isle Of Wight, Ivor, James Store, Jamestown, Lackey, Langley AFB, Lightfoot, Maryus, Mathews, Miles, Mobjack, Moon, Naval Base, Naval Weapons Station, Naxera, New Point, Newport News, Newsoms, Norfolk, Norge, North, Onemo, Ordinary, Peary, Pinero, Poquoson, Port Haywood, Portsmouth, Redart, Rescue, Schley, Seaford, Sedley, Severn, Shadow, Smithfield, Spring Grove, Suffolk, Surry, Susan, Tabb, Toano, Virginia Beach, Walters, Ware Neck, White Marsh, Wicomico, Williamsburg, Windsor, Woods Cross Roads, Yorktown, Zanoni, and Zuni.

Counties of:

Chesapeake (City), Franklin (City), Gloucester, Hampton (City), Isle Of Wight, James City, Mathews, Newport News (City), Norfolk (City), Poquoson (City), Portsmouth (City), Southampton, Suffolk (City), Surry, Virginia Beach (City), Williamsburg (City), 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. Changes for 2018

Changes to this Plan

- Your share of the biweekly non-Postal premium will increase for Self Only, Self Plus One or Family. See page 82.
- The calendar year deductible will increase to $700 for Self Only, $1,400 combined for Self Plus One and $1,400 combined for Self and Family. Previously, it was $350 for Self Only, $700 combined for Self Plus One, and $700 combined for Self and Family. See page 20.
- The catastrophic protection out-of-pocket maximum amount will increase to $7,350 Self Only, $14,700 combined for Self Plus One, and $14,700 combined for Self and Family. Previously, it was $6,500 for Self Only, $13,000 combined for Self Plus One, and $13,000 combined for Self and Family. See page 20.
- The Primary Care Physician office visit copayment will decrease from $20 to $15 per visit. See page 25.
- The Specialist office visit copayment will increase from $40 to $50 per visit. See page 25.
- The coinsurance will increase from 20% to 30%.
- All prenatal care is covered at 100%. You will pay nothing for these services. See page 28.
- Generic oral contraceptive drugs by Retail or Mail Order are available to fill with a 12 month supply at one time. See page 54.
- The Plan will cover the following diabetic supplies under Prescription Drug benefits:
  - Disposable needles and syringes for the administration on insulin will be covered at the applicable copayment or coinsurance based on the prescription drug tier.
  - Blood glucose monitors and control solution, test strips, lancet devices, and lancets will be covered 100%. See page 54.
- 3D mammography will now be covered as a preventive diagnostic service, based on medical necessity. See page 26.

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 12. 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 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 website at www.optimahealth.com.

Where you get covered care

If you use our Plan 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 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*.

You must get prior approval for certain services. Your benefits for Covered Services may be reduced or denied if you do not comply with the Plan's Pre-Authorization requirements.

- **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, your 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, and
- 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 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 days of requested for hospital stay.

- **Non-urgent care claims**

  For non-urgent care claims, we will 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 let you know what information we need to complete our review of the claim. You will have up to 48 hours to provide the required 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.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 757-552-7550. You may also call OPM's Health Insurance 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 757-552-7550 or 800-206-1060. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  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.

- **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.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite 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

This is what you will pay out-of-pocket for covered care:

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.

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 $50 per specialist office visit.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is $700 per person. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $700. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,400. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,400.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Example: In our Plan, you pay 30% of our allowance for diabetic supplies.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $7,350 per person regardless of enrollment tier and will not exceed more than $14,700 combined per Self Plus One or $14,700 combined for Self Plus Family enrollment in any calendar year, 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:

- Balance-billed charges
- Healthcare charges this plan does not cover
- Pre-authorization penalties
- Premiums

We will notify you when you reach the maximum.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

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. Benefits

See page 13 for how our benefits changed this year and page 79 for a benefits summary.

Section 5. Benefits Overview

The benefit package is described in Section 5. Make sure that you review the benefits that are available.

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 filing advice, or more information about the benefits, contact us at 757-552-7550 or on our website at www.optimahealth.com.

Benefits:

- $15 copayment for primary care physician office visits
- $50 copayment for specialist office visits
- No copayment for primary care physician office visits for preventive care
- No referral needed to see a specialist
- $5 copayment for Tier 1 prescription drugs
- Protection against catostrophic costs (out of pocket maximum) is $7,350 for Self Only or $14,700 for Self Plus One or Self Plus 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.
- The calendar year deductible is $700 per person regardless of enrollment tier and will not exceed more than $1,400 combined per Self Plus One or $1,400 combined for Self Plus Family.
- 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 • Advance care planning	$15 copayment per visit to your primary care physician $50 copayment per visit to a specialist
Professional services of physicians • During a hospital stay • In a skilled nursing facility	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Professional services of physicians • In an Urgent Care Center	$50 copayment per visit
Telehealth Services	
• MDLIVE Virtual Office Visit ***How to get started?*** • Sign in to www.optimahealth.com and select Access MDLIVE, or call 866-648-3638. • Have your Optima Health member ID number available to register. Please note that you'll need to create an account for each covered member of your family over the age of two. • When you want to see a doctor, you can go online to request immediate access to a provider on-call via phone or schedule a time at your convenience. You can also get connected by calling 866-648-3638.	$10 copayment per visit

Benefit Description	You pay
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 after satisfying the annual deductible, 30% coinsurance of our Plan allowance
MRI, CAT Scans and PET Scans Note: Pre-authorization required. See Section 3, *How you get care*.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Preventive care, adult	
Routine physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	Nothing
Well woman care, based on current recommendations such as: • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screening • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus. • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence.	Nothing
Routine mammogram – covered for women	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule.	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html **Women's Preventive services:** www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations, boosters, and medications for travel or work-related expenses.* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving this service.*	*All charges*
Preventive care, children	
Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: healthfinder.gov/myhealthfinder/default.aspx	

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx.	
Maternity care	
Complete maternity (obstetrical) care, such as: • Delivery	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
• Prenatal care • Screening for gestational diabetes for pregnant women • Breastfeeding support, supplies and counseling for each birth	Nothing
• Postnatal Care	$15 copayment per visit to your primary care physician $50 copayment per visit to a specialist
Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 16 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or 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. • Hospitalization services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	
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*

Benefit Description	You pay
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization for women (See Section 5(b), *Surgical Procedures)* • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Contraceptive counseling on an annual basis Note: We cover oral contraceptives under the prescription drug benefit. *Generic oral contraceptives are eligible for 100 percent coverage and no cost share to members. Brand name oral contraceptives will be covered based on the plan's formulary and the appropriate Copayment or Coinsurance will apply based on the drug tier. Please visit optimahealth.com to determine member cost share for brand name oral contraceptives.	Nothing
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*
Infertility services	
Diagnosis and treatment of infertility	*No benefit*
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (AI)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Services and supplies related to ART procedures* • *Endometrial biopsies* • *Semen analysis* • *Hysterosaloingography* • *Sims-Huhner Test (smear)* • *Diagnostic laparoscopy* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs* • *Reproductive material storage*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	
• *Infertility services after voluntary sterilization*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections • Allergy serum	$15 copayment per visit to your primary care physician $50 copayment per visit to a specialist
Not covered: • *Provocative food testing and sublingual allergy desensitization* • *Food allergy ingestion testing* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*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 38. • 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. We only cover GHT when we pre-authorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. 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* under *You need prior Plan approval* for certain services on page 16.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Applied Behavior Analysis (ABA) - Children with autism spectrum disorder Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder in children from age two through ten. "Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.	$50 copayment per specialist visit After satisfying annual deductible, 30% coinsurance of our Plan allowance

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	
"Treatment for autism spectrum disorder" shall be identified in a treatment plan and included the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine. "Applied behavioral analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. **Coverage for applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000 per child.**	$50 copayment per specialist visit After satisfying annual deductible, 30% coinsurance of our Plan allowance
• Dialysis – hemodialysis and peritoneal dialysis	$15 copayment per physician office visit
Not covered: • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*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 when a provider orders the care.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
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. Note: Pre-authorization is required.	Any applicable Copayment or Coinsurance, depending on the type and place of treatment or service.
• Cardiac rehabilitation following a heart transplant, bypass surgery, or myocardial infarction, is covered for up to 90 consecutive days from the start of rehabilitation.	$50 copayment per specialist office visit After satisfying the annual deductible, 30% coinsurance of our Plan allowance, during inpatient admission

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	
• Pulmonary and vascular rehabilitation is covered for up to 90 consecutive days from the start of rehabilitation.	$50 copayment per specialist office visit After satisfying the annual deductible, 30% coinsurance of our Plan allowance, during inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Therapies available in a school program or available through state and local funding, including sign language therapies* • *Recreation therapies, including art, dance, or music therapies* • *Sleep therapies* • *Exercise programs, or equine therapies* • *Driver evaluations as part of occupational therapy* • *Driver training* • *Functional capacity testing needed to return to work* • *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*
Speech therapy	
Speech therapy is covered for up to two months per condition per year for medically necessary treatment.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
NOTE: All therapies will be covered when necessary to treat function loss or impaired by disease, trauma, and congenital anomaly.	
Not covered: • *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*

Benefit Description	You pay
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: See Section 5(a), *Orthopedic and prosthetic devices,* for benefits for the devices.	$15 copayment per primary care physician office visit $50 copayment per specialist office visit
Not covered: • *All other hearing testing* • *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*
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. If you need help or a current list of participating providers, call EyeMed Vision Care at 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*
• One pair of eyeglasses or contact lenses (up to $200 allowance) to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts). Please note that New technology, intraocular lens are excluded from coverage.	*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 $50 copayment 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*	*All charges*

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

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	
• *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$15 copayment per primary care physician office visit $50 copayment 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*
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.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
• *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*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 • Colostomy, 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.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Diabetic supplies and equipment including pump infusion sets, prescribed by a Plan physician for insulin dependent, gestational, and non-insulin dependent diabetics.	30% coinsurance of the Plan allowance
External insulin pumps	Nothing
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* • *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*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
• *Care and services from non-plan providers unless pre-authorized by the Plan prior to receiving the service*	*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
• Physical, occupational, or speech therapy	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
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*
Chiropractic	
No benefit	*All charges*
Alternative treatments	
No benefit	*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
• Counseling and education for birth control options	Nothing
• Tobacco Cessation programs, including: - Individual/group/telephone counseling - Two quit attempts per year - Approved tobacco cessation drugs *(see Prescription drug benefits)*	Nothing

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.
- The calendar year deductible is $700 per person regardless of enrollment tier and will not exceed more than $1,400 combined per Self Plus One or $1,400 combined for Self Plus Family.
- 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See 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., vasectomy) • Treatment of burns 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.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Not covered: • *Reversal of voluntary sterilization* • *Surgery related to gender reassignment*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• *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*
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.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
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 gender reassignment* • *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*

Benefit Description	You pay
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.	After satisfying the annual deductible, 30% coinsurance of our 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*
Organ/tissue transplants	
These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. See Other services under You need prior Plan approval for certain services on page 16. • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis 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	After satisfying the annual deductible, 30% coinsurance of our Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) **Blood or marrow stem cell transplants** The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis	After satisfying the annual deductible, 30% coinsurance of our Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- 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 - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	After satisfying the annual deductible, 30% coinsurance of our Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
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 - Chronic inflammatory demyelination polyneuropathy (CIDP) - 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) - Myelodysplasia/Myelodysplastic Syndromes - 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	After satisfying the annual deductible, 30% coinsurance of our Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Aggressive non-Hodgkin lymphomas - 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)	After satisfying the annual deductible, 30% coinsurance of our 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.*	
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*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Not covered: • *Anesthesia related to Gender Reassignment Surgery*	*All charges*

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.
- The calendar year deductible is $700 per person regardless of enrollment tier and will not exceed more than $1,400 combined per Self Plus One or $1,400 combined for Self Plus Family.
- 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.	After satisfying the annual deductible, 30% coinsurance of our 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.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Not covered:	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
• *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*
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.	After satisfying the annual deductible, 30% coinsurance of our 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*
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.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Not covered:	*All charges*

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	
• *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*
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.	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Advance Care Planning	After satisfying the annual deductible, 30% coinsurance of our 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*
Ambulance	
Local professional ambulance service when medically appropriate	$50 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.
- The calendar year deductible is $700 per person regardless of enrollment tier and will not exceed more than $1,400 combined per Self Plus One or $1,400 combined for Self Plus Family.
- 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 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 copayment per primary care physician office visit $50 copayment per specialist office visit
Emergency care at an urgent care center	$50 copayment per visit
Emergency care as an outpatient or inpatient at a hospital, including doctors services	$250 copayment per visit (waived if admitted)
Emergency outside our service area	
Emergency care at a doctor's office	$15 copayment per primary care physician office visit $50 copayment per specialist office visit
Emergency care at an urgent care center	$50 copayment per visit
Emergency care as an outpatient or inpatient at a hospital, including doctors services	$250 copayment per visit (waived if admitted)
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*

Benefit Description	You pay
Ambulance	
Professional ambulance service when medically appropriate Note: See Section5(c) for non-emergency service.	$50 copayment each way

Section 5(e). Mental health and substance misuse disorder 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.
- The calendar year deductible is $700 per person regardless of enrollment tier and will not exceed more than $1,400 combined per Self Plus One or $1,400 combined for Self Plus Family.
- 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.
- 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 misuse disorder treatment 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.
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) • 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 misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$15 copayment per office visit copay After satisfying the annual deductible, 30% coinsurance of our Plan allowance

Benefit Description	You pay
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance misuse disorder treatment 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 • MRI, CAT Scans and PET Scans	After satisfying the annual deductible, 30% coinsurance of our 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	After satisfying the annual deductible, 30% coinsurance of our Plan allowance per 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, full-day hospitalization, or facility-based intensive outpatient treatment	After satisfying the annual deductible, 30% coinsurance of our Plan allowance
Not covered	
Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the services.	*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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- 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.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **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. Specialty drugs must be filled through our Specialty mail order vendor, Proprium Pharmacy. You may also use our mail order program for maintenance medications.
- **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. Optima's Pharmacy and Therapeutics Committee places covered drugs into the following Tiers:
  - **Selected Generic (Tier 1):** includes commonly prescribed generic drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.
  - **Selected Brand & Other Generic (Tier 2)** includes brand-name drugs, and some generic drugs with higher costs than Tier 1 generics, that are considered by the Plan to be standard therapy.
  - **Non-Selected Brand/Other (Tier 3)** includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a generic equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers.
  - **Specialty Drugs (Tier 4)** includes Specialty Drugs that have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional**.**
- **We have 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.
- **Coverage of Specialty Drugs:** Specialty Drugs are only available through Proprium Pharmacy at 757-553-3568 or 855-553-3568 (toll free). Specialty Drugs include the following:
  - Medications that treat certain patient populations including those with rare diseases;
  - Medications that require close medical and pharmacy management and monitoring;
  - Medications that require special handling and/or storage;
  - Medications derived from biotechnology and/or blood derived drugs or small molecules; and
  - Medications that can be delivered via injection, infusion, inhalation, or oral administration.

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

- **These are the dispensing limitations.** Prescription drugs dispensed at a Plan pharmacy will be dispensed for up to a 31-day supply. You may receive up to a 90-day supply of a prescribed maintenance medication through our mail-order program or at one of our retail pharmacies. Specialty drugs are limited to a 31-day supply.

You may use the Plan's mail order prescription drug benefit for Tier 1, 2 or 3 drugs 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 Catamaran Home Delivery at 866-244-9113, 24 hours a day, 7 days a week. You may also write to Catamaran Home Delivery, P.O. Box 696054, San Antonio, TX 78269-6054.

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 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 at 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 • Insulin • Drugs for sexual dysfunction (limited to four pills per month) • Intravenous fluids and medication for home use Note: Injectable contraceptive drugs are covered under Family Planning Section 5(a).	**Retail Pharmacy:** $5 copayment per Tier 1 Drug $45 copayment per Tier 2 Drug 50% coinsurance per Tier 3 Drug **Mail Order (90 day supply of Maintenance Drugs):** $10 copayment per Tier 1 Drug $90 copayment per Tier 2 Drug 50% coinsurance per Tier 3 Drug **Specialty Drugs are only available through Proprium Pharmacy (limited to a 31 day supply):** 50% coinsurance per Tier 4 Specialty Drug

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	
Diabetic supplies limited to: • Disposable needles and syringes for the administration of covered medications	Applicable copayment or coinsurance
• Test strips, lancet devices and lancets • Blood glucose monitors and control solution	Nothing
• Women's contraceptive drugs and devices, including the morning after pill • Tobacco cessation drugs Note: The above over-the-counter drugs and devices approved by the FDA require a written prescription by an approved plan provider. Some restrictions apply.	Nothing
Preventive care medications to promote better health as recommended by ACA. The following are covered: • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-2 years • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Bowel Evacuant drugs • Tamoxifen and Raloxefin for women • Generic and over-the-counter tobacco cessation medications • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-7 Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browserecommendations	Nothing
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 (except Vitamin D, as stated above)* • *Over-the-counter medicines, except as noted above*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	
• *Appetite suppressants or other weight management medications* • *Medical supplies such as dressings and antiseptics* • *Immunization agents, biological sera, blood or blood products*	*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.
- The calendar year deductible is $700 per person regardless of enrollment tier and will not exceed more than $1,400 combined per Self Plus One or $1,400 combined for Self Plus Family.
- 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.	Applicable copayment or coinsurance
Dental benefits	
We have no other dental benefits.	*All charges*

Section 5(h). Wellness and Other 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 800-394-2237.
Services for deaf and hearing impaired	TDD number: 757-552-7120 or 800-225-7784
High risk pregnancies	A Plan Care Manager will assist with a treatment plan prescribed by your OB/GYN physician.
Wellness Tools - My Life My Plan Connection	Through a partnership with **WebMD**, we offer our members flexible programs, expert guidance, and inspiration to take charge of their own health—whether they are continuing healthy behaviors, or making a change to improve their health. It all begins when the member completes a Personal Health Assessment—and creates the foundation for their Health Record and coaching program. Our health-coaching partner, WebMD, offers a comprehensive online activities tool, known as the Digital Health Assistant (DHA). The DHA delivers a personalized, interactive, and motivational experience to help members take action and sustain healthy behaviors in a fun way.

INDIVIDUAL SELF-PACED PROGRAMS: Our unique, self-paced, and award-winning individual wellness programs are offered at no cost to all Optima Health members. Members simply call 800-736-8272 to register and receive materials via U.S. postal service. The programs use a variety of media to engage the member in learning about the risks and benefits of their behavior and offer tools for the member to take charge and make healthy changes. Examples of program materials include guided meditation CDs, exercise DVD's, pedometers, progress charts, workbooks, slide-rule calorie counters and more, including the following:

Healthy Heart Yoga: Healthy Heart Yoga can make a real difference in heart health by strengthening the body, and relaxing both mentally and physically and better managing stress reactions.

Healthy Heart Chair Yoga: This DVD is intended for people who need stretching and strengthening exercises yet have difficulty getting up and down from the floor.

Eating for Life: This DVD and workbook program helps adults learn about healthy eating and exercise.

Guided Meditation – A Journey Toward Health: The music and words invite the listener to experience a 20-minute retreat from everyday stressors and move into peace, calm, and tranquility.

Tai Chi Qigong Shibashi: Regular practice of the 18 movements of Tai Chi Qigong Shibashi teaches your body to mentally and physically relax.

Get Off Your Butt: Stay Smokeless for Life: This education and support program helps people who want to quit using tobacco.

Walkabout with Healthy Edge: Over the course of six months, participants receive information, encouragement, and incentives to reach 10,000 steps per day. Participants receive a pedometer, walking log, walking tips mailed to their homes, and incentives for walking.

The comprehensive suite of Wellness Services we are providing for employees includes:

- ***WebMD Online Programs***: a comprehensive interactive internet site for wellness and health improvement including a personal health assessment, online fitness coach.
- ***WebMD 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 –services, drugs and supplies we do not 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 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.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.

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 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.
Notice Requirements	If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

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. To make your request, please contact our Customer Service Department by writing Optima Health, 4417 Corporation Lane, Virginia Beach, VA 23462 or calling 800-206-1060.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take in account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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 file a lawsuit, 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 file a lawsuit 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 800-206-1060. We will expedite 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.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan.You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits

Section 9. Coordinating benefits with Medicare and 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' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.optimahealth.com/federal.

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.

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 your injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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 or by phone at 877-888-3337, (TTY 877-889-5680), 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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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.
- 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. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

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 (800-633-4227), (TTY 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 HMO plan in limited geographic areas (Chesapeake, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, and Virginia Beach). Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. 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. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

- **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 800-772-1213, (TTY 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 800-206-1060 or see our website 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.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Medical Cost Without Medicare	Medical Cost with Medicare
Deductible	$700 per Member	Medicare Part A: $1,260 per benefit period Medicare Part B: $147
Out of Pocket Maximum	$7350 per Member	Not applicable
Primary Care Physician	$15 Copayment	After Part A deductible, 20% coinsurance of Medicare allowed amount
Specialist	$50 Copayment	After Part A deductible, 20% coinsurance of Medicare allowed amount
Inpatient Hospital	30% Coinsurance of our Plan allowance	• $1,260 deductible for each benefit period • Days 1-60: $0 coinsurance for each benefit period • Days 61-90: $315 coinsurance per day of each benefit period • Days 91 and beyond: $630 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)
Outpatient Hospital	30% Coinsurance of our Plan allowance	After Part A deductible, 20% coinsurance of Medicare allowed amount
Rx	Tier 1 - $5 Tier 2 - $45 Tier 3 – 50% Coinsurance Tier 4 - Specialty (30 day supply) – 50% Coinsurance	Part D benefit varies by plan
Rx – Mail Order (90 day supply)	2x retail copay (No mail order for Tier 4 drugs)	Part D benefit varies by plan

You can find more information about how our plan coordinates benefits with Medicare at www.optimahealth.com

- **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 (800-633-4227), (TTY 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). However, 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.

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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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
- 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 are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

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

Copayment

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

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. The deductible is $350 per person regardless of enrollment tier and will not exceed more than $700 combined per Self Plus One or $700 combined for Self Plus Family.

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.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

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-service 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 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. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about four 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. Participating employees save an average of about 30% on products and services they 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.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

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 $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,600 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, 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).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **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 out-of-pocket 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).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** dependent day care expenses for your children 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, 877-372-3337 (TTY 1-866-353-8058), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **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 12-month waiting period. **Most FEDVIP plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

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/dental and www.opm.gov/vision. 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 877-888-3337, (TTY 877-889-5680).

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 800-LTC-FEDS (800-582-3337), (TTY 800-843-3557), or visit www.ltcfeds.com.

Peace of Mind for You and Your Family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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Notes

Summary of benefits Optima Health Plan - 2018

- 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.

Benefits	You pay	Page
Deductible	$700 per person regardless of enrollment tier and will not exceed more than $1,400 combined per Self Plus One or $1,400 combined for Self Plus Family.	20
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: $15 primary care; $50 specialist	25
Services provided by a hospital:		
• Inpatient	30% coinsurance of Plan allowance, after deductible	44
• Outpatient	30% coinsurance of Plan allowance, after deductible	45
Emergency benefits:		
• In-area	$250 copayment per Emergency room visit $50 copayment per Urgent Care Center visit	48
• Out-of-area	$250 copayment per Emergency Room visit	48
Mental health and substance misuse disorder treatment:	Regular cost-sharing	50
Prescription drugs:		
• Retail pharmacy	Retail copayment/coinsurance per 31 day supply: $5 per Tier 1 Drug $45 per Tier 2 Drug 50% per Tier 3 Drug 50% per Specialty Drug - Specialty Drugs must be obtained through Proprium Pharmacy	53
• Mail Order	Mail Order copayment/coinsurance for 90 day supply of Maintenance Drugs: $10 per Tier 1 Drug $90 per Tier 2 Drug 50% per Tier 3 Drug	53

Benefits	You pay	Page
Dental Care:	No benefit	56
Vision care:	Covered at 100% per eyeglass exam once every 12 months	33
Wellness and other special features:	Nothing	57
Protection against catastrophic costs (out-of-pocket maximum):	$7,350 per person regardless of enrollment tier and will not exceed more than $14,700 combined per Self Plus One or $14,700 combined per Self Plus Family. Some costs do not count toward this protection including: Balance-billed charges, Healthcare charges this plan does not cover, Pre-authorization penalties or Premiums.	14, 20, 24

2018 Rate Information

For 2018 FEHB plan premium information, please see:

https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribal employer's Human Resources department.