



Optima Health Plan

<http://www.optimahealth.com>

2002

A Health Maintenance Organization

Serving: Hampton Roads, Virginia area

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



This Plan has excellent accreditation from the NCQA. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

9R1 Self Only

9R2 Self and Family

Authorized for distribution by the:



**United States
Office of Personnel Management**
Retirement and Insurance Service
<http://www.opm.gov/insure>



Table of Contents

| | |
|--|----|
| Introduction | 4 |
| Plain Language | 4 |
| Inspector General Advisory | 4 |
| Section 1. Facts about this HMO plan | 5 |
| How we pay providers | 5 |
| Your Rights..... | 5 |
| Service Area..... | 6 |
| Section 2. How we change for 2002 | 7 |
| Program-wide changes..... | 7 |
| Changes to this Plan..... | 7 |
| Section 3. How you get care | 8 |
| Identification cards | 8 |
| Where you get covered care..... | 8 |
| • Plan providers..... | 8 |
| • Plan facilities | 8 |
| What you must do to get covered care..... | 8 |
| • Primary care | 8 |
| • Specialty care | 9 |
| • Hospital care..... | 9 |
| Circumstances beyond our control..... | 10 |
| Services requiring our prior approval | 10 |
| Section 4. Your costs for covered services | 11 |
| • Copayments | 11 |
| • Deductible | 11 |
| • Coinsurance | 11 |
| Your out-of-pocket maximum | 11 |
| Section 5. Benefits..... | 12 |
| Overview..... | 12 |
| (a) Medical services and supplies provided by physicians and other health care professionals | 13 |
| (b) Surgical and anesthesia services provided by physicians and other health care professionals..... | 24 |
| (c) Services provided by a hospital or other facility, and ambulance services | 28 |
| (d) Emergency services/accidents..... | 31 |
| (e) Mental health and substance abuse benefits..... | 33 |
| (f) Prescription drug benefits | 35 |
| (g) Special features | 38 |
| • Flexible benefits option | 38 |

| | |
|--|------------|
| • After Hours Program | 38 |
| • High risk pregnancies | 38 |
| • Centers of excellence for transplant surgery..... | 38 |
| • Services for deaf and hearing impaired | 38 |
| (h) Dental benefits | 39 |
| (i) Non-FEHB benefits available to Plan members..... | 40 |
| Section 6. General exclusions -- things we don't cover | 41 |
| Section 7. Filing a claim for covered services | 42 |
| Section 8. The disputed claims process | 43 |
| Section 9. Coordinating benefits with other coverage | 45 |
| When you have... | |
| •Other health coverage | 45 |
| •Original Medicare | 45 |
| •Medicare managed care plan | 48 |
| TRICARE/Workers' Compensation/Medicaid..... | 49 |
| Other Government agencies..... | 49 |
| When others are responsible for injuries..... | 49 |
| Section 10. Definitions of terms we use in this brochure..... | 50 |
| Section 11. FEHB facts..... | 51 |
| Coverage information | 51 |
| • No pre-existing condition limitation..... | 51 |
| • Where you get information about enrolling in the FEHB Program..... | 51 |
| • Types of coverage available for you and your family | 51 |
| • When benefits and premiums start | 52 |
| • Your medical and claims records are confidential..... | 52 |
| • When you retire | 52 |
| When you lose benefits..... | 52 |
| • When FEHB coverage ends..... | 52 |
| • Spouse equity coverage | 52 |
| • Temporary Continuation of Coverage (TCC)..... | 52 |
| • Converting to individual coverage..... | 53 |
| • Getting a Certificate of Group Health Plan Coverage..... | 53 |
| Long Term Care..... | 54 |
| Index..... | 55 |
| Summary of benefits..... | 57 |
| Rates..... | Back cover |

Introduction

Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462

This brochure describes the benefits of Optima Health Plan under our contract (CS 2842) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 757-552-7550, or 1-800-206-1060 and explain the situation.

If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202-418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud: Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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 only pay 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.

How we pay providers

We contract with individual physicians, medical groups, hospitals and other ancillary services providers to provide the benefits in this brochure. These Plan providers accept a negotiated fee from us, and you will only be responsible for your copayments or coinsurance. We will not pay for care or services from non-Plan providers unless it has been authorized by us. If you use a non-Plan provider you may be responsible for all charges.

Your Rights

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

- Optima Health Plan 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 Plan is one of the first HMOs in the Hampton Roads area of Virginia operating since 1984.
- Optima Health Plan is jointly owned by Sentara Healthcare and Bon Secours Health System.
- Optima Health Plan 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 1-800-206-1060.
- If you have questions about appeals, customer satisfaction measures, and how Optima Health Plan manages your care or makes coverage decisions please call Member Services.

Optima Health Plan wants to provide you with all the information you need to make informed health care decisions. If you want information about us, please call 757/552-7401 or 1-800-206-1060, or write to Optima Health Plan, 4417 Corporation Lane, Virginia Beach, VA 23462. You may also contact us by fax at 757/552-8919, or visit our website at www.optimahealth.com.

Facts about this HMO plan, continued on next page

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 is: The Hampton Roads area of Virginia including the cities of Chesapeake, Franklin, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach, and Williamsburg, as well as the counties of Charles City, Gloucester, Isle of Wight, James City, King William, Mathews, New Kent, Surry and York.

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

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

Section 2. How we change for 2002

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

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-Postal premium will increase by 10.6% for Self Only or 8.6% for Self and Family.
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- Your coinsurance for diabetic equipment and supplies is 20% of the Plan Allowance.
- Your copay for Standard Tier pharmacy benefit prescription drugs is \$20 or \$40 for mail order pharmacy benefit prescription drugs
- You pay a copayment based on the place of service for Early Intervention Services.
- Your out-of-pocket maximum copayment is now \$1,500 per person or per each family member not to exceed \$3,000 per self and family enrollment.
- The Plan's pharmacy benefit prescription drug supply has changed from a 34-day supply to a 31-day supply. (Section 5(f))
- The Plan has contracted with Walgreen's Healthcare Plus Prescription Drug Program to administer the Plan's mail order prescription drug program. (Section 5(f))
- The Plan has contracted with Cole Vision Services, Inc., to administer the Plan's preventive vision care and services. (Section 5(a))

Section 3. How you get care

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 (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 757-552-7550 or 1-800-206-1060.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments or coinsurance and 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. Optima Health Plan has developed a partnership with approximately 1,779 physicians in the Hampton Roads Area. The Plan has approximately 633 primary care doctors, and 1,146 specialists participating.

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 and 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. There are approximately 12 participating hospitals in the service area. 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 website.

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.

When you enroll, you and each covered member of your family must select a Primary Care Physician (PCP) from the list of family practice doctors, internal medicine doctors, or pediatricians in the Plan’s provider directory.

• 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, or give you a referral to see a specialist.

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.

How you get care, continued on next page

· Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, women age 13 or older may see their OB/GYN once a year for a routine annual exam without a referral from their PCP.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval from the Plan beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. 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, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or 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 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 in the hospital when your enrollment in our Plan begins, call Member Services immediately at 757-552-7550 or 1-800-206-1060.

How you get care, continued on next page

If you are new to the FEHB Program, we will arrange for you to receive care.

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.

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.

Services requiring our prior approval

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

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for the following services:

- 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 for Treatment Studies on Cancer;
- Hospice Services;
- Oral Surgery;
- TMJ Services;
- Transplant Services;
- Inpatient or Outpatient Mental Health Services; and
- Growth Hormone Therapy (GHT).

Pre-authorization is an evaluation process, that assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care. Pre-authorization is a certification of medical necessity and not a guarantee of payment. Your PCP or Specialist is responsible for obtaining pre-authorization from the Plan for medically necessary treatment, services, and supplies. The Plan may not pay for services that have not been pre-authorized.

Section 4. Your costs for covered services

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

· **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of \$10 per 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. We do not have a deductible.

· **Coinsurance**

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

Example: In our Plan you pay 50% of our Plan allowance for infertility services, and you pay 20% of our Plan allowance for diabetic supplies.

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments

After your copayments and/or coinsurance totals \$1,500 per person or \$1,500 per each family member, not to exceed \$3,000 per Self and 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 out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription Drugs
- Vision Care and Services
- Outpatient mental conditions and substance abuse services

The Plan will notify you when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 57 for a benefits summary.)

NOTE: This benefits section is broken into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the *General Exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 757-552-7550 or 1-800-206-1060 or at our website at www.optimahealth.com.

| | |
|--|-------|
| (a) Medical services and supplies provided by physicians and other health care professionals | 13-23 |
| •Diagnostic and treatment services | |
| •Lab, X-ray, and other diagnostic tests | |
| •Preventive care, adult | |
| •Preventive care, children | |
| •Maternity care | |
| •Family planning | |
| •Infertility services | |
| •Allergy care | |
| •Treatment therapies | |
| •Physical and occupational therapies | |
| •Speech therapy | |
| •Hearing services (testing, treatment, and supplies) | |
| •Vision services (testing, treatment, and supplies) | |
| •Foot care | |
| •Orthopedic and prosthetic devices | |
| •Durable medical equipment (DME) | |
| •Home health services | |
| •Chiropractic | |
| •Alternative treatments | |
| •Educational classes and programs | |
| (b) Surgical and anesthesia services provided by physicians and other health care professionals..... | 24-27 |
| •Surgical procedures | |
| •Reconstructive surgery | |
| •Oral and maxillofacial surgery | |
| •Organ/tissue transplants | |
| •Anesthesia | |
| (c) Services provided by a hospital or other facility, and ambulance services..... | 28-30 |
| •Inpatient hospital | |
| •Outpatient hospital or ambulatory surgical center | |
| •Extended care benefits/skilled nursing care facility benefits | |
| •Hospice care | |
| •Ambulance | |
| (d) Emergency services/accidents | 31-32 |
| •Medical emergency | |
| •Ambulance | |
| (e) Mental health and substance abuse benefits | 33-34 |
| (f) Prescription drug benefits..... | 35-37 |
| (g) Special features | 38 |
| • Flexible benefits option | |
| • After Hours Program | |
| • High risk pregnancies | |
| • Centers of excellence for transplant surgery | |
| • Services for deaf and hearing impaired | |
| (h) Dental benefits..... | 39 |
| (i) Non-FEHB benefits available to Plan members..... | 40 |
| Summary of benefits..... | 57 |

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

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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.
- Care must be arranged and received by Plan providers only. You are responsible for ensuring that referrals from your PCP are to Plan providers.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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| Benefit Description | You pay |
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| Diagnostic and treatment services | |
| Professional services of physicians <ul style="list-style-type: none"> • In physician's office • Office medical consultations • Second surgical opinion • House calls within the Plan's service area | \$10 per primary care physician visit \$15 per specialist visit |
| Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility | Nothing |
| Professional services of physicians <ul style="list-style-type: none"> • In an Urgent Care Center | \$25 per visit |
| Lab, X-ray and other diagnostic tests | |
| Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG | \$10 per primary care physician office visit \$15 per specialist office visit Inpatient or Outpatient facility: Nothing |

| Preventive care, adult | You pay |
|---|--|
| Routine screenings, such as <ul style="list-style-type: none"> • One routine physical exam annually • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 | \$10 per primary care physician office visit \$15 per specialist office visit Inpatient or Outpatient facility: Nothing |
| Prostate Specific Antigen (PSA test) – one annually for men age 40 and older Routine pap test and Annual GYN exam Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and treatment services</i> , above, Section 5(a). Routine mammogram –covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years | \$10 per primary care physician office visit \$15 per specialist office visit Inpatient or Outpatient facility: Nothing |
| <i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, travel, and care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.</i> | <i>All charges.</i> |
| Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over | \$10 per primary care physician office visit \$15 per specialist office visit |
| Preventive care, children | |
| <ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics | Nothing |
| <ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (through age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction. – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (through age 22) | \$10 per primary care physician office visit \$15 per specialist office visit |

| Maternity care | You pay |
|---|--|
| <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to pre-certify your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). | <p>\$50 one time charge per pregnancy</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine sonograms to determine fetal age, size or sex • Routine care and services for pregnancy outside the Plan's service area. • Delivery outside the service area after the 34th week of gestation • Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service. | <p><i>All charges</i></p> |
| Family planning | |
| <p>Voluntary sterilization:</p> <ul style="list-style-type: none"> • tubal ligation • vasectomy | <p>\$15 per specialist office visit</p> <p>Inpatient or Outpatient facility: Nothing</p> |
| <p>Note: we cover oral contraceptives under the prescription drug benefit.</p> | |
| <p>Injectable contraceptive drugs</p> | <p>\$15 per Depo Provera or Lunelle injection</p> |
| <p>Surgically implanted contraceptives. Norplant coverage is for one insertion and one removal in five years. Exceptions may be made if medically necessary. You must have the prescription filled at a Plan pharmacy and pay your copayment at the pharmacy.</p> | <p>\$15 per specialist office visit in addition to pharmacy copay</p> |
| <p>Diaphragms for fitting only. You must have the prescription filled at a Plan pharmacy.</p> | <p>\$15 per specialist office visit in addition to pharmacy copay</p> |

Family planning, continued on next page

| Family planning (<i>continued</i>) | You pay |
|---|---|
| Fitting and insertion of Intrauterine devices (IUDs) and Cervical Caps. | \$15 per specialist office visit in addition to \$15 copayment for device |
| <i>Not covered: reversal of voluntary surgical sterilization, genetic counseling, and care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.</i> | <i>All charges.</i> |
| Infertility services | |
| Diagnosis and treatment of infertility, such as: <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Endometrial biopsies • Semen analysis • Hysterosalpingography • Sims-Huhner Test (smear) • Diagnostic laparoscopy | Coinsurance: 50% of the Plan allowance |
| <i>Not covered:</i> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete GIFT and zygote ZIFT</i> - <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm including recovery and storage</i> • <i>Cost of donor egg</i> • <i>Fertility drugs</i> • <i>Reproductive material storage</i> • <i>Infertility services after voluntary sterilization</i> • <i>Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.</i> | <i>All charges.</i> |

| Allergy care | You pay |
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| Testing and treatment | \$25 per visit |
| Allergy injection | \$5 per single injection \$10 for multiple injections |
| Allergy serum | Nothing |
| <i>Not covered: provocative food testing, sublingual allergy desensitization, Radioallergosorbent Test (RAST), and food allergy ingestion testing, and care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.</i> | <i>All charges.</i> |
| Treatment therapies | |
| <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We will only cover GHT when we pre-authorize the treatment. We will ask your PCP to submit information that establishes that the GHT is medically necessary. Your PCP must ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p> | <p>\$10 per primary care physician office visit</p> <p>\$15 per specialist office visit</p> <p>Inpatient or Outpatient facility: Nothing</p> |
| <i>Not covered: Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.</i> | <i>All charges.</i> |

| Physical and occupational therapies | You pay |
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| <ul style="list-style-type: none"> • Up to three months per condition in accordance with a specific written treatment plan that has been authorized by the Plan for the services of each of the following: <ul style="list-style-type: none"> – qualified physical therapists; and – occupational therapists. <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. All services and treatment must be part of a treatment plan, which details the treatment including frequency, duration and goals. This applies to therapies done in any outpatient setting including in the member's home or outpatient therapy center.</p> | <p>\$15 per specialist visit</p> <p>Nothing per visit during covered inpatient admission.</p> |
| <p>Early Intervention Services are covered for children from birth to age three for medically necessary services limited to:</p> <ul style="list-style-type: none"> • speech, language, occupational, and physical therapy • assistive technology services and devices <p>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.</p> | <p>All charges above \$5,000 annual limit per dependent child in addition to any applicable copayments based on place of service.</p> |
| <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery, or myocardial infarction, is covered for up to 90 consecutive days from the start of rehabilitation. • Pulmonary and vascular rehabilitation is covered for up to 90 consecutive days from the start of rehabilitation. | <p>Nothing</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Any service or supplies, unless provided in accordance with a specific treatment plan pre-authorized by the Plan</i> • <i>Therapy, which is primarily educational in nature, special education, or sign language.</i> • <i>Work-hardening programs</i> • <i>Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.</i> | <p><i>All charges.</i></p> |

| Speech therapy | You pay |
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| Speech therapy is covered for up to two months per condition for medically necessary treatment. | \$15 per specialist office visit |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long Term speech therapy</i> • <i>Speech therapy not authorized by the Plan as part of a specific treatment plan.</i> • <i>Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.</i> | <i>All charges.</i> |
| Hearing services (testing, treatment, and supplies) | |
| <ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) | \$10 per primary care physician office visit \$15 per specialist office visit |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>all other hearing testing</i> • <i>hearing aids, testing and examinations for them</i> • <i>Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.</i> | <i>All charges.</i> |
| Vision services (testing, treatment, and supplies) | |
| <p>Preventive Vision Care and Services administered by Cole Vision Services, Inc. provides the following services once every 12 months:</p> <ul style="list-style-type: none"> • Annual Eye refraction including case history, visual acuity test for glasses and written lens prescription. • Screening tests for disease or abnormalities, including glaucoma and cataracts <p>Note: You should select a Cole Managed Vision (CMV) provider and call him or her directly to schedule an appointment. Pay your copayment when you receive services. If you need help or a current list of participating providers, call CMV at 1-888-610-2268 or visit www.optimahealth.com. You may receive an eye exam from a non-plan provider and receive a \$30 reimbursement.</p> | \$15 per office visit |
| <ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) | Nothing |
| <ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>) | \$10 per primary care physician office visit \$15 per specialist office visit |

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

| Vision services (testing, treatment, and supplies) <i>(continued)</i> | You pay |
|---|--|
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eyeglasses or contact lenses and, after age 17, examinations for them • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery • Any eye examination, or any corrective eyewear required by an employer as a condition of employment. • Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service. | <p><i>All charges.</i></p> |
| <p>Foot care</p> | |
| <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See <i>Orthopedic and Prosthetic devices</i> for information on podiatric shoe inserts.</p> | <p>\$10 per primary care physician office visit \$15 per specialist office visit</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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. | <p><i>All charges.</i></p> |
| <p>Orthopedic and prosthetic devices</p> | |
| <ul style="list-style-type: none"> • External prosthetic devices, and braces; • lenses following cataract removal; • artificial eyes; • stump hose; • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy; • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. | <p>All charges in excess of the first \$2,000 per member per year</p> |

Orthopedic and prosthetic devices, continued on next page

| Orthopedic and prosthetic devices <i>(continued)</i> | You pay |
|--|---|
| Repair and Replacement Note: The maximum allowance of \$500 is for orthopedic/prosthetic devices and durable medical equipment combined. | All charges in excess of the first \$500 per member per year |
| Artificial Limb Services <ul style="list-style-type: none"> • External prosthetic device (such as arms or legs) • Repair and Replacement | All changes in excess of the first \$3,000 per year |
| <i>Not covered:</i> <ul style="list-style-type: none"> • Orthopedic and corrective shoes • arch supports • foot orthotics • customized or non-customized shoes, boots, or inserts • heel pads and heel cups • lumbosacral supports • corsets, trusses, elastic stockings, support hose, and other supportive devices • prosthetic replacements provided less than 3 years after the last one we covered • Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service. | <i>All charges.</i> |
| Durable medical equipment (DME) | |
| Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, and authorized as medically necessary by the Plan, such as oxygen and dialysis equipment. Under this benefit, we also cover: <ul style="list-style-type: none"> • hospital beds; • standard non-motorized wheelchairs; • crutches; • walkers; 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. | All Charges in excess of the Plan's \$1,000 annual limit |
| Diabetic supplies and equipment prescribed by a Plan physician for insulin dependent, gestational, and non-insulin dependent diabetes. Note: Members will need to call National Diabetic Pharmacies at 1-888-306-7337 to have supplies delivered to them at home. Members may get prescribed supplies directly from a vendor and pay the total cost of the supplies and submit receipts to the Plan for reimbursement. | Coinsurance: 20% of the Plan allowance Note: This benefit is not subject to the Plan's annual DME limit. |
| Repair and Replacement Note: The maximum allowance of \$500 is for orthopedic/prosthetic devices and durable medical equipment combined. | All charges in excess of the first \$500 per member per year. |

Durable medical equipment (DME), continued on next page

| Durable medical equipment (DME) <i>(continued)</i> | You pay |
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| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Motorized wheel chairs • 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 • Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service. | <p><i>All charges.</i></p> |
| Home health services | |
| <ul style="list-style-type: none"> • 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 | <p>Nothing</p> |
| <ul style="list-style-type: none"> • Physical, occupational, or speech therapy | <p>\$15 per visit</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. • Nursing care requested by, or for the convenience of, the patient or the patient's family; • 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 | <p><i>All charges.</i></p> |
| Chiropractic | |
| <p>No benefit</p> | <p>All charges.</p> |

| Alternative treatments | You pay |
|---|--|
| No benefit | All charges. |
| Educational classes and programs | |
| Coverage is limited to: <ul style="list-style-type: none"> • Diabetes self-management Note: Members should call 1-800-SENTARA for information on classes | Nothing |
| <ul style="list-style-type: none"> • Counseling and education for birth control options. | \$10 per primary care physician office visit \$15 per specialist office visit |

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

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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.
- Care must be arranged and received by Plan Providers only. You are responsible for ensuring that referrals from your PCP are with Plan Providers.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRE-AUTHORIZATION OF ALL SURGICAL PROCEDURES.** Please refer to the pre-authorization information shown in Section 3.

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| Benefit Description | You pay |
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| Surgical procedures | |
| <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 -- 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. • Treatment of burns • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. <p>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.</p> | <p>\$10 per primary care physician office visit</p> <p>\$15 per specialist office visit</p> <p>Inpatient or Outpatient facility: Nothing</p> |
| <ul style="list-style-type: none"> • Voluntary sterilization including tubal ligation and vasectomy | <p>\$10 per primary care physician office visit</p> <p>\$15 per specialist office visit</p> <p>Inpatient or Outpatient facility: Nothing</p> |

Surgical procedures, continued on next page

| Surgical procedures (<i>continued</i>) | You pay |
|--|---------------------------|
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Sex change operations</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> • <i>Surgery primarily for cosmetic purposes</i> • <i>Any surgical services, other than emergent, which have not been pre-authorized by the Plan.</i> • <i>Any surgical services determined not medically necessary by the Plan.</i> • <i>Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service</i> | <p><i>All charges</i></p> |
| <p>Reconstructive surgery</p> | |
| <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – 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; webbed fingers; and webbed toes. | <p>Nothing</p> |
| <ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>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.</p> | <p>See above</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> • <i>Any surgical services, other than emergent, which have not been pre-authorized by the Plan.</i> • <i>Any surgical services determined not medically necessary by the Plan.</i> • <i>Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.</i> | <p><i>All charges</i></p> |

| Oral and maxillofacial surgery | You pay |
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| <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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. | Nothing |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)</i> • <i>Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service</i> | <i>All charges</i> |
| Organ/tissue transplants | |
| <p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas. • Your physician must authorize any transplant services with the Plan. | Nothing |

Organ/tissue transplants, continued on next page

| Organ/tissue transplants <i>(continued)</i> | You pay |
|--|--------------------|
| <p>Limited Benefits - Clinical Trials For Treatment Studies on Cancer are covered if treatment or studies are being conducted in a Phase II, III, or IV clinical trial. We will provide coverage for a Phase I clinical trial on a case by case basis if approved by the Plan. The clinical trial must meet all eligibility requirements of the Plan to be included for coverage under this benefit. Clinical trials must be approved by The National Cancer Institute (NCI), an NCI Cooperative group or NCI center, or other facility as approved by the Plan.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> | Nothing |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • 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 | <i>All charges</i> |
| Anesthesia | |
| <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office | Nothing |

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

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Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. You are responsible for ensuring that referrals from your PCP are with Plan Providers.
- 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 covered in Section 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-authorization.

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| Benefit Description | You pay |
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| Inpatient hospital | |
| Room and board, such as <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> | Nothing |
| Other hospital services and supplies, such as: <ul style="list-style-type: none"> • 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 • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Hospitalization and Anesthesia for dental procedures as determined medically necessary by a Plan physician for members under age five, severely disabled or with a medical condition requiring hospitalization for dental procedures. | Nothing |

Inpatient hospital, continued on next page

| Inpatient hospital (<i>continued</i>) | You pay |
|--|--------------------|
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>The cost of securing the services of blood donors</i> • <i>Professional dental services</i> • <i>Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service</i> | <i>All charges</i> |
| Outpatient hospital or ambulatory surgical center | |
| <ul style="list-style-type: none"> • 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 <p>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.</p> | Nothing |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>blood and blood derivatives not replaced by the member</i> • <i>professional dental services and procedures</i> • <i>care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service</i> | <i>All charges</i> |
| Extended care benefits/skilled nursing care facility benefits | |
| <p>Extended care benefit:</p> <p>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:</p> <ul style="list-style-type: none"> • 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. | Nothing |
| <p><i>Not covered: custodial care, rest cures, domiciliary or convalescent care, personal comfort items such as telephone, and television, blood and blood derivatives not replaced by the member, care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service</i></p> | <i>All charges</i> |

| Hospice care | You pay |
|--|----------------------|
| <p>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:</p> <ul style="list-style-type: none"> • Palliative Care • Supportive physical, psychological, and psychosocial services <p>Note: Palliative care is treatment to control pain, relieve other symptoms and focusing on the special needs of the patient.</p> | Nothing |
| <p><i>Not covered: Independent nursing, homemaker services, care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service</i></p> | <i>All charges</i> |
| Ambulance | |
| <ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate | \$25 copay per trip. |

Section 5 (d). Emergency services/accidents

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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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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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 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 Sentara Mental Health Management at 757-552-7174 or 1-800-648-8420. The Psychiatric Emergency Response Service is available 24 hours a day, seven days per week to respond to clinical psychiatric and substance abuse emergencies.

Emergencies outside our service area:

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

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

Emergencies outside our service area, continued on next page

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 |
|--|--|
| Emergencies within our service area | |
| <ul style="list-style-type: none"> Emergency care at a doctor's office | \$10 per primary care physician office visit \$15 per specialist office visit |
| <ul style="list-style-type: none"> Emergency care at an urgent care center | \$25 per visit |
| <ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services | \$50 per visit |
| <i>Not covered: Elective care or non-emergency care</i> | <i>All Charges</i> |
| Emergencies outside our service area | |
| <ul style="list-style-type: none"> Emergency care at a doctor's office | \$15 per specialist visit |
| <ul style="list-style-type: none"> Emergency care at an urgent care center | \$25 per visit |
| <ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services | \$50 per visit |
| <i>Not Covered:</i> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery outside the service area</i> | <i>All charges.</i> |
| Ambulance | |
| Professional ambulance service, including air ambulance when medically appropriate See 5(c) for non-emergency service | \$25 per trip |

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

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When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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| Benefit Description | You pay |
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| Mental health and substance abuse benefits | |
| <p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p> | Your cost sharing responsibilities are no greater than for other illness or conditions. |
| <ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers | \$15 per visit |
| <ul style="list-style-type: none"> • Medication management | Nothing |

Mental health and substance abuse benefits, continued on next page

| Mental health and substance abuse benefits <i>(continued)</i> | You pay |
|--|---------------------|
| <ul style="list-style-type: none"> • Diagnostic tests | \$15 per visit |
| <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment | Nothing |
| <p><i>Not covered: Services we have not approved, and care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service</i></p> <p><i>Note: 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.</i></p> | <i>All charges.</i> |

Pre-authorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

- Sentara Mental Health Management (SMHM) administers mental health care and substance abuse services for the Plan. SMHM must authorize all treatment and services. You may reach SMHM by calling 757-552-7174.
- For access to emergency mental health or substance abuse services, call SMHM at 757-552-7174 or 1-800-648-8420. The Psychiatric Emergency Response Services is available 24 hours a day, seven days per week to respond to clinical psychiatric and substance abuse emergencies.
- We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

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Here are some 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.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some drugs require pre-authorization from the Plan in order to be covered. The prescribing physician is responsible for obtaining pre-authorization.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A Plan physician or licensed dentist must write the prescription
- **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 or our mail order program.
- **We use a formulary.** All covered outpatient prescription drugs must be FDA approved and require a prescription from a Plan doctor or dentist. Some drugs require pre-authorization from the Plan in order to be covered. Your Physician is responsible for obtaining pre-authorization. We cover non-formulary drugs prescribed by a Plan physician. Covered drugs are placed into the following tiers which will determine what your copayment will be:
 - **Preferred:** The majority of widely dispensed generic drugs. We cover Preferred drugs at the lowest copayment level. Some brand- name drugs may be included in this category if the Plan recognizes they show documented long-term decreases in illness and death. Large published peer-reviewed clinical trials are used to make this determination.
 - **Standard:** The brand-name equivalents of the generic Preferred drugs, plus certain brand-name drugs that are not available as generic drugs. Members are responsible for paying the difference between the cost of a Standard drug and its Preferred counterpart, if any, in addition to the copayment charge.
 - **Premium:** Prescription drugs that are not included on the list of Preferred or Standard drugs and are not specifically listed as drugs excluded from coverage. Premium drugs are covered at the highest copayment level.
- **These are the dispensing limitations.**
 - For a single copayment you will receive:
 - Up to a consecutive 31-day supply of a covered outpatient drug, unless limited by the drug manufacturer's packaging.
 - One vial, one tube of ointment/cream, 8 ounces of oral liquid, or a 31-day supply of pills.
 - Two vials of insulin.
 - Up to a 31-day supply of syringes, needles, or disposable syringes with needles. (Limited to a maximum of 100.)
 - A **one-cycle** supply of oral contraceptives. (Covered members may obtain up to three cycles of oral contraceptives at one time but must remit the appropriate copayments.)
 - One diaphragm.
 - One rescue inhaler or 2 maintenance/steroidal inhalers.
 - Four (4) pills for Viagra to treat sexual dysfunction

You may use the Plan's mail order prescription drug benefit and purchase a 90 day supply of maintenance drugs, limited to manufacturer's packaging, for two prescription drug copayments. If you have a question about the mail order prescription drug program or want to find out if your

Dispensing limitations, continued on next page

prescription is available through the program, you may call Walgreens Healthcare Plus Prescription Drug Program at 1-800-999-2655 Monday through Friday, 8 a.m. to 8 p.m. and Saturday 8 a.m. to noon (EST). You may also write to Walgreens Healthcare Plus, 7357 Greenbriar Parkway, Orlando, FL 32819-8917.

Certain prescription drugs will be covered at a generic product level established by the Plan. If a generic product level has been established for a drug and you or your physician request the brand-name drug or a higher costing generic, you must pay the difference between the cost of the dispensed drug and the generic product level in addition to your copayment charge. 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.

- **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 name brand prescription.
- **When you 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 that 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 | |
| <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through mail order program:</p> <ul style="list-style-type: none"> • Drugs and medications that by federal law of the United States require a physician’s prescription for their purchase except those listed as not covered. • Rescue inhaler and maintenance inhalers • Oral contraceptive drugs • Injectable contraceptive drugs • Contraceptive diaphragms, cervical caps, and IUDs; (Devices covered under Section 5(a). Fitting and insertion are covered under Section 5(a) and 5(b)). • Norplant – one insertion/removal in five years. (Insertion and removal are covered under Section 5(b)). • Insulin • Diabetic supplies, including insulin syringes and needles • Disposable needles and syringes need to inject covered prescribed medication • Viagra – 4 pills per prescription to treat sexual dysfunction • Intravenous fluids and medication for home use. | <p>Pharmacy Copayment: \$10 per Preferred Tier Drug \$20 per Standard Tier Drug \$40 per Premium Tier Drug</p> <p>Mail Order Copayment for 90 day supply of Maintenance Drugs: \$20 per Preferred Tier Drug \$40 per Standard Tier Drug \$80 per Premium Tier Drug</p> <p>NOTE: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> |

Covered medications and supplies, continued on next page

| Covered medications and supplies <i>(continued)</i> | You pay |
|---|---------------------------|
| <p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic in addition to your copay. <p>We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This 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.</p> | |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines (Over the Counter medicines)</i> • <i>Appetite suppressants or other weight management medications</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Fertility drugs</i> • <i>Smoking cessation drugs and medications</i> • <i>Immunization agents, biological sera, blood or blood products</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at non-Plan pharmacies except for out-of-area emergencies.</i> | <p><i>All Charges</i></p> |

Section 5 (g). Special features

| Feature | Description |
|---|---|
| Flexible benefits option | <p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. |
| After Hours Program | <p>The After Hours 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 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 cannot diagnose medical conditions or write prescriptions. The After Hours 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 After Hours at 757-552-7250 or 1-800-394-2237.</p> |
| High Risk Pregnancies | <p>A Plan Case Manager will assist with treatment plan prescribed by your OB/GYN physician.</p> |
| Services for deaf and hearing impaired | <p>TDD number: 757-552-7120 or 1-800-225-7784</p> |

Section 5 (h). Dental benefits

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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.
- Care must be received by Plan Providers only. You are responsible for ensuring that referrals from your PCP are with Plan Providers.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below. Read Section 5(c) about coverage for hospitalization and anesthesia for dental procedures.
- 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.

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| Accidental injury benefit | You pay |
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| <p>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.</p> | <p>\$10 per primary care physician office visit \$15 per specialist office visit</p> <p>Nothing for an Inpatient or Outpatient facility</p> |

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| Dental benefits |
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We have no other dental benefits.

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

- **Health Education and Prevention Programs.** The Plan offers or coordinates a number of programs such as weight management (PCP referral required), health education, and preventive care for high-risk pregnancies. The member may be responsible for costs associated with these programs. Please contact a Member Services representative for further details.
- **Dental care.** Members will be offered a 20% discount off usual and customary charges for all services provided, excluding orthodontics, from Plan participating dentists. You may schedule an appointment directly with one of the Plan's participating dentists. You may call Member Services to find out which dentists are participating.
- **Vision Services.** Cole Vision Services Inc., offers a 15% discount off the cost of LASIK surgery (or 5% off a promotional price if lower). If you are interested in laser vision correction, call 1-888-705-2020 to select a participating provider. Replacement of contact lenses are available through a mail order program. Call Contacts Direct at 1-800-987-5367. A discount schedule from Cole is available for savings on lenses, frames, and contact lenses. Call 1-888-610-2268.
- **Fitness Center Discount.** Sentara Health and Fitness Center offers a reduced initiation fee and a reduced monthly fee to Plan members. The center is located at 300 Butler Farm Road in Hampton. Call 757-552-7361 for more information.
- **Healthwise Handbook.** For your free copy of the *Healthwise Handbook*, and to learn more about self-care, contact Health and Preventive Services at 757-552-7361.
- **Healthy Edge Magazine.** This publication is mailed to members and includes a variety of articles covering preventive health issues, Plan news and updates.
- **Complementary Alternative Medicine.** Through the Plan's arrangement with American Specialty Health Networks (ASHN), you are eligible to receive a discount, typically 25 percent off charges from participating fitness centers, acupuncturists, chiropractors and massage therapists. There are no visit limitations and a physician referral is not necessary.

To receive services, select a participating complementary health care provider from the Plan's Provider Directory or Web site under *Alternative Treatments™* at www.optimahealth.com. Then call and schedule an appointment. Be sure to show your ID card to obtain the discount and pay the provider directly for their service.

ASHN Member Services can be reached at 1-877-327-2746 if you have any questions or would like more information about the discount program

Over 1,200 health and wellness products at guaranteed low pricing and educational information on Complementary Alternative Medicine can also be located on the Plan's Web site listed above.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services Requiring Our Prior Approval* on page 10.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are 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;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 757-552-7550 or 1-800-206-1060.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name 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 payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

**Submit your claims to: Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462**

Other supplies or services

For Cole Managed Vision out-of-network provider exam claims, please send your health plan name, your name and 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: Cole Vision Services, Inc.
1925 Enterprise Parkway
Twinsburg, Ohio 44098
Attn: Vision Care Department**

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.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for pre-authorization:

| Step | Description |
|----------|---|
| 1 | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Optima Health Plan 4417 Corporation Lane, Virginia Beach VA 23462; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| 2 | <p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial—go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |
| 3 | <p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p> |
| 4 | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3620</p> |

The disputed claims process, continued on next page

The Disputed Claims process (*Continued*)

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.

Note: If you want OPM to review different claims, 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.

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

5 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.

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

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

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

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 757-552-7550 or 1-800-206-1060 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You can call OPM's Health Benefits Contracts Division 2 at 202-606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage You must tell us if you are covered or a family member is covered under another group health plan or have 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

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

· What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and 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 two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800 MEDICARE 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.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

· 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, like prescription drugs.

Coordinating benefits with other coverage, continued on next page

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. Your care must continue to be authorized by your Plan PCP, or pre-authorized as required. When Medicare is the primary payer, and you have met your deductible, we will waive our copayments and coordinate benefits with the primary payer.

(Primary payer chart begins on next page.)

The following chart illustrates whether the **Original Medicare** Plan or this Plan should be the primary payer 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.

| Primary Payer Chart | | |
|---|--|---------------------------|
| A. When either you -- or your covered spouse -- are age 65 or over and ... | Then the primary payer is... | |
| | Original Medicare | This Plan |
| 1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability), | | ✓ |
| 2) Are an annuitant, | ✓ | |
| 3) Are a reemployed annuitant with the Federal government when... a) The position is excluded from FEHB, or b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.) | ✓ | |
| | | ✓ |
| 4) 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), | ✓ | |
| 5) Are enrolled in Part B only, regardless of your employment status, | ✓ (for Part B services) | ✓ (for other services) |
| 6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty, | ✓ (except for claims related to Workers' Compensation.) | |
| B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and... | | |
| 1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD, | | ✓ |
| 2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD, | ✓ | |
| 3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision, | ✓ | |
| C. When you or a covered family member have FEHB and... | | |
| 1) Are eligible for Medicare based on disability, and a) Are an annuitant | ✓ | |
| | | ✓ |
| c) Are a former spouse of an annuitant, or | ✓ | |
| d) Are a former spouse of an active employee | | ✓ |

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare

Claims process when you have the Original Medicare Plan ¾ You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call Member Services at 757-552-7550 or 1-800-206-1060.

We waive some costs when you have the Original Medicare Plan ¾ When Original Medicare is the primary payer, and you have met your deductible, we will waive our copayments and coordinate benefits with the primary payer.

• **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan—a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and another plan’s Medicare managed care plan: You may enroll in another plan’s Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan’s network and/or service area (if you use our Plan providers), and you have met your deductible, we will waive our copayments and coordinate benefits with the primary payer. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 Medicare managed care plan’s service area.

• **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can’t get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents or military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you 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. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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. |
| Coinsurance | Coinsurance is the percentage of our allowance that you must pay for your care. See page 11. |
| Copayment | A copayment is a fixed amount of money you pay when you receive covered services. See page 11. |
| 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, rest cures. |
| Experimental or investigational services | Our Plan considers published peer-reviewed medical literature about the efficacy and improvement outcomes of technology, along with the United States Food and Drug Administration approval for marketing of medical devices, drugs, or biologicals for a particular diagnosis or condition. |
| Group health coverage | A plan or contract that provides coverage for health care services to eligible employees and their dependents. |
| 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: <ul style="list-style-type: none">• 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. |
| Us/We | Us and we refer to Optima Health Plan |
| You | You refers to the enrollee and each covered family member. |

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- 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;
- When your enrollment ends; and
- 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.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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.

FEHB Facts, continued on next page

When benefits and premiums start

The benefits in this brochure are effective on 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. 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 your coverage.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

· Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

• Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

FEHB Facts, continued on next page.

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

· **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance Is Coming Later in 2002

- Many FEHB employees think their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *It can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy, I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of American's believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed \$50,000. Home care for only three 8-hour shifts a week can exceed \$20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "Not covered" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

- Accidental injury 19, 25, 31, 39
Allergy tests 17
Alternative treatment 12, 22, 23, 40
Allogeneic (donor) bone marrow transplant 26
Ambulance 2, 10, 28, 30, 31, 32,
Anesthesia 24, 27-29, 39,
Autologous bone marrow transplant 17, 26
Biopsies 16
Birthing centers 28
Blood and blood plasma 29
Breast cancer screening 14
Casts 28-29
Catastrophic protection 57
Changes for 2002 7
Chemotherapy 17
Childbirth 12, 15, 28, 50
Chiropractic 12, 22
Cholesterol tests 7
Claims 7-8, 23, 32, 38, 42-44, 47-48
Coinsurance 11, 42, 49
Colorectal cancer screening 14
Congenital anomalies 24, 25
Contraceptive devices and drugs 15, 55
Coordination of benefits 45
Covered charges 48
Covered providers 8, 31, 41, 42
Crutches 21
Deductible 5, 7, 11, 13, 24, 31, 33, 39, 42, 46, 48, 50
Definitions 3, 13, 24, 28, 31, 33, 49
Dental care 40, 57
Diagnostic services 34
Disputed claims review 3, 32, 38, 44, 43
Donor expenses (transplants) 12, 17, 26, 27
Dressings 22, 28, 29, 37
Durable medical equipment (DME) 6, 10, 12, 20, 21, 22
Educational classes and programs 12, 23
Effective date of enrollment 51
Emergency 2, 5-6, 12, 19, 31, 32, 34, 36, 41, 42, 55
Experimental or investigational 41,
Eyeglasses 19-20
Family planning 7, 12, 15-16
Fecal occult blood test 14
General Exclusions 12, 41
Hearing services 12, 19,
Home health services 10, 12, 22,
Hospice care 10, 12, 30
Home nursing care 22, 28
Hospital 5, 7, 8-10, 13, 15, 27, 31, 32, 34, 39, 42, 55
Immunizations 5, 14, 15
Infertility 16, 37,
In hospital physician care 13
Inpatient Hospital Benefits, 28
Insulin 21, 35, 36
Laboratory and pathological services 14, 28
Machine diagnostic tests 14
Magnetic Resonance Imagings (MRIs) 13
Mail Order Prescription Drugs 35
Mammograms 14
Maternity Benefits 15, 28
Medicaid 48, 54
Medically necessary 7, 10, 13, 15, 16-18, 20, 21, 24, 25, 28, 31, 35, 39, 41,
Medicare 24, 31, 33, 35, 39, 42, 45, 46, 47
Mental Conditions/Substance Abuse Benefits 33, 34
Newborn care 15
Non-FEHB Benefits 40
Nurse 15, 58
Licensed Practical Nurse 22
Nurse Anesthetist 28
Registered Nurse 22
Nursery charges 15
Obstetrical care 9, 15, 38
Occupational therapy 10, 12, 18
Ocular injury 19
Office visits 5, 13-23, 32,
Oral and maxillofacial surgery 26
Orthopedic devices 10, 20, 21, 24
Out-of-pocket expenses 11
Outpatient facility care 9-11, 24, 27, 32, 34, 39
Oxygen 21, 22, 28
Pap test 14
Physical examination 5, 14
Physical therapy 10, 18
Physician 8, 9, 13
Pre-admission testing 27-30
Pre-authorization 44
Preventive care, adult 5, 14
Preventive care, children 5, 15
Prescription drugs 35-37
Preventive services 5-15
Prior approval 10, 17, 18, 24, 25, 27, 33-35, 43, 44
Prostate cancer screening 14
Prosthetic devices 7, 10, 20, 21, 24
Psychologist 33, 34
Psychotherapy 33, 34
Radiation therapy 17
Renal dialysis 45, 46
Room and board 28
Second surgical opinion 13
Skilled nursing facility care 29
Smoking cessation 37
Speech therapy 10, 22
Splints 28
Sterilization procedures 16, 25
Subrogation 49
Substance abuse 33, 34
Surgery 7, 10, 24-26
• Anesthesia 24, 27, 28
• Oral 10, 26
• Outpatient 7, 10, 24-26
• Reconstructive 25
Syringes 35, 36
Temporary continuation of coverage (TCC) 52
Transplants 12, 17, 26
Treatment Therapies 17
Vision services 11, 15, 19, 40, 42, 55
Well child care 5, 15
Wheelchairs 21
Workers' compensation 48
X-rays 13

NOTES:

Summary of benefits for Optima Health Plan - 2002

- **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 |
|---|---|----------------|
| Medical services provided by physicians: • Diagnostic and treatment services provided in the office..... | Office visit copay: \$10 primary care; \$15 specialist | 13 |
| Services provided by a hospital: • Inpatient..... | Nothing | 28 |
| • Outpatient..... | | 29 |
| Emergency benefits: • In-area..... | \$50 per Emergency Room visit or \$25 per Urgent Care visit | 32 |
| • Out-of-area..... | | 32 |
| Mental health and substance abuse treatment..... | Regular benefits | 32 |
| Prescription drugs..... | \$10 per Preferred Tier Drug \$20 per Standard Tier Drug \$40 per Premium Tier Drug | 36 36 36 |
| Dental Care..... | No benefit. | 39 |
| Vision Care..... | \$15 per exam once every 12 months. | 19 |
| Special features: After Hours 24 Hour Nurse Line, High Risk Pregnancy Case Manager | | 38 |
| Protection against catastrophic costs (your out-of-pocket maximum)..... | Nothing after \$1,500/Self Only or \$3,000/Family enrollment per year Some costs do not count toward this protection including: prescription drugs, vision, outpatient mental health and substance abuse services | 11 |

2002 Rate Information for Optima Health Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, RI 70-2B, and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

| Type of Enrollment | Code | Non-Postal Premium | | | | Postal Premium | |
|--------------------|------|--------------------|------------|-------------|------------|----------------|------------|
| | | Biweekly | | Monthly | | Biweekly | |
| | | Gov't Share | Your Share | Gov't Share | Your Share | USPS Share | Your Share |

Peninsula/Southside Hampton Roads

| | | | | | | | |
|-----------------|-----|----------|----------|----------|----------|----------|---------|
| Self Only | 9R1 | \$97.86 | \$39.38 | \$212.03 | \$85.32 | \$115.52 | \$21.72 |
| Self and Family | 9R2 | \$223.41 | \$101.34 | \$484.06 | \$219.57 | \$263.75 | \$61.00 |