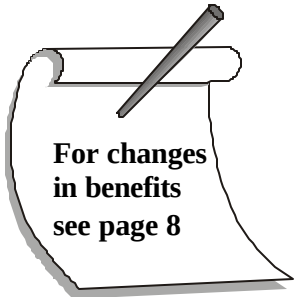
Optima Health Plan

http://www.optimahealth.com

Optima HEALTH PLAN

2003

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 7 for requirements.

This Plan has excellent accreditation from the NCQA. See the 2003 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

FEHB
Federal Employees Health Benefits Program

RI 73-253

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative).
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations).
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

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Introduction

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. The address for Optima Health Plan administrative offices is:

Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language 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 fehbwebcomments@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.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 757/552-7401 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

- Do not maintain as a family member on your policy:
  - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - your child over age 22 (unless he/she is disabled and incapable of support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Section 1. Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You 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. **Except for emergencies outside the service area, we will not pay for care or services from non-Plan providers unless it has been authorized by us. You are responsible for making sure that a provider is a Plan provider. If you use a non-Plan provider without our prior authorization, you may be responsible for the 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 2003

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

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 33.6% for Self Only or 31.7% for Self and Family.
- Your Copay for a Specialist Office Visit has increased from $15 to $20 per specialist visit.
- For Lab, X-ray, and other diagnostic testing, you now pay a $20 copay if you receive tests outside of your office visit.
- For physical, occupational, and speech therapies your copay has increased from $15 to $20 per specialist treatment, office visit or home health care visit.
- Your Copay for maternity care, such as prenatal care, delivery, and postnatal care has increased from $50 to $100 per pregnancy. You will also pay a $250 copayment per inpatient hospital admission.
- For inpatient hospital services, including room and board and other hospital services and supplies, you now have a copay of $250 per inpatient hospital admission.
- For outpatient hospital or ambulatory surgical center services you now have a copay of $100.
- For urgent care center visits your copay has decreased from $25 to $20 per visit.
- For hospital emergency room visits your copay has increased from $50 to $100 per visit.
- For mental health and substance abuse services provided as an inpatient at a hospital or other inpatient facility you now have a $250 copay per admission.
- For outpatient mental health and substance abuse services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers, your copay has increased from $15 to $20 per specialist visit.
- For injectable contraceptive drugs under family planning services, you will no longer pay $15 per injection. You will only pay the $10 primary care physician or the $20 specialist office visit copayment.
- For the fitting and insertion of intrauterine devices (IUDs) and cervical caps under family planning you will no longer pay a $15 copayment for the device. You will only pay the $10 primary care physician or the $20 specialist office visit copayment.
- For allergy testing your copay has decreased from $25 to $10 primary care physician or $20 for specialist office visit.
- For allergy injections your copay has changed from $5 per single injection and $10 per multiple injections, and $0 copayment for serum to $10 primary care physician or $20 specialist office visit copayment.

Clarifications for 2003

- You are responsible for making sure that a provider is a Plan provider. This includes laboratory testing sent to a non-Plan lab testing facility. You should ask and verify that your provider uses a Plan facility for lab testing. We will not pay for care or services provided by non-Plan providers without our prior authorization. If you use a non-Plan provider without our prior authorization, you may be responsible for the charges.
- Maternity services require pre-authorization.

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 or write to us at Optima Health Plan, 4417 Corporation Lane, Virginia Beach, VA 23456. You may also request replacement cards through our website at www.optimahealth.com.

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.

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. 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.

- **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

How you get care, continued on next page

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.

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

How you get care, continued on next page

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;
- Growth Hormone Therapy (GHT);
- Maternity Services;
- All services from Non-Plan Providers except for emergencies outside the service area; and
- Certain prescription drugs.

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 catastrophic protection 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 8 for how our benefits changed this year and page 59 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 14-24

- 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 25-28

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services.....29-31

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents 32-33

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 34-35

(f) Prescription drug benefits.....36-38

(g) Special features 39

- Flexible benefits option
- After Hours Program
- High risk pregnancies
- Services for deaf and hearing impaired

(h) Dental benefits.....40

(i) Non-FEHB benefits available to Plan members 41

Summary of benefits 59

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

IMPORTANT

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.
- Plan physicians must provide or arrange for your care. 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.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • House calls within the Plan's service area	$10 per primary care physician visit $20 per specialist visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing
Professional services of physicians • In an Urgent Care Center	$20 per visit
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	$10 per primary care physician office visit or $20 per specialist office visit if you receive these services on the same day during your office visit, otherwise $20.

Preventive care, adult	You pay
Routine screenings, such as • One routine physical exam annually • Total Blood Cholesterol – once every three years • A fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) once every five years for adults 20 or over • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50; or – Colonscopy – once every 10 years at age 50; or – Double contrast barium enema (DCBE) one every 5-10 years at age 50. • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	$10 per primary care physician office visit $20 per specialist office visit
Routine pap test and Annual GYN exam Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and treatment services*, above, Section 5(a). Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per primary care physician office visit $20 per specialist office visit
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.	*All charges.*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over	$10 per primary care physician office visit $20 per specialist office visit

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (to age 22) • Examinations, such as: – 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 (to age 22)	$10 per primary care physician office visit $20 per specialist office visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to 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).	$100 one time charge per pregnancy for obstetrical prenatal, delivery, and postnatal services. $250 inpatient hospitalization admission
Not covered: • *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.*	*All charges*
Family planning	
A range of voluntary family planning services, limited to: Voluntary Sterilization limited to tubal ligation and vasectomy (see Surgical Procedures Section 5b).	Included in per office visit or per inpatient/outpatient copayment per admission.

Family Planning continued on next page

Family planning *(continued)*	You pay
Note: we cover oral contraceptives under the prescription drug benefit.	
• Injectable contraceptive drugs (such as Depo provera)	$10 per PCP office visit $20 per specialist office visit
• Surgically implanted contraceptives (Such as Norplant. 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.)	$20 per specialist office visit in addition to pharmacy copay
• Diaphragms limited to fitting only. You must have the prescription filled at a Plan pharmacy.	$10 per PCP office visit or $20 per specialist office visit in addition to pharmacy copay
• Intrauterine devices (IUDs) and Cervical Caps.	$20 per specialist office visit
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.	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Endometrial biopsies • Semen analysis • Hysterosalpingography • Sims-Huhner Test (smear) • Diagnostic laparoscopy	Coinsurance: 50% of the Plan allowance.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and zygote ZIFT* – *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm including recovery and storage* • *Cost of donor egg* • *Fertility drugs* • *Reproductive material storage* • *Infertility services after voluntary sterilization* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges.*

Allergy care	You pay
Testing and treatment Allergy injection(s) Allergy Serum	$10 per PCP office visit $20 per specialist office visit
Not covered: provocative food testing, sublingual allergy desensitization, Radioallergosorent 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.	*All charges.*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We will only cover GHT when we pre-authorize the treatment. We will ask 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 *Services requiring our prior approval* in Section 3.	$10 per primary care physician office visit $20 per specialist office visit
Not covered: Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.	*All charges.*

Physical and occupational therapies	You pay
• Up to three months per condition per year in accordance with a specific written treatment plan that has been authorized by the Plan for the services of each of the following: – qualified physical therapists; and – occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. All services and treatment must be part of a treatment plan, which details the treatment including frequency, duration and goals. This applies to therapies done in any outpatient setting including in the member's home or outpatient therapy center.	$20 per specialist visit Nothing per visit during covered inpatient admission.
Early Intervention Services are covered for children from birth to age three for medically necessary services limited to: • speech, language, occupational, and physical therapy • assistive technology services and devices Note: Covered services are provided to enhance functional ability without effecting a cure. Department of Mental Health, Mental Retardation, and Substance Abuse Services must certify dependents as eligible for services under Part H of the Individuals with Disabilities Act.	All charges above $5,000 annual limit per dependent child in addition to any applicable copayments based on place of service.
• Cardiac rehabilitation following a heart transplant, bypass surgery, or myocardial infarction, is covered for up to 90 consecutive days from the start of rehabilitation. • Pulmonary and vascular rehabilitation is covered for up to 90 consecutive days from the start of rehabilitation.	$20 per specialist visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Any service or supplies, unless provided in accordance with a specific treatment plan pre-authorized by the Plan* • *Therapy, which is primarily educational in nature, special education, or sign language.* • *Work-hardening programs* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges.*

Speech therapy	You pay
Speech therapy is covered for up to two months per condition per year for medically necessary treatment.	$20 per specialist office visit
Not covered: • *Long Term speech therapy* • *Speech therapy not authorized by the Plan as part of a specific treatment plan.* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per primary care physician office visit $20 per specialist office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges.*
Vision services (testing, treatment, and supplies)	
Preventive Vision Care and Services administered by Cole Vision Services, Inc. provides the following services once every 12 months: • 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 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.	$15 per office visit
• 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
• Eye exam to determine the need for vision correction for children through age 17 (see *Preventive care, children*)	$10 per primary care physician office visit $20 per specialist office visit

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

Vision services (testing, treatment, and supplies) *(continued)*	You pay
Not covered: • *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.*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See *Orthopedic and Prosthetic devices* for information on podiatric shoe inserts.	$10 per primary care physician office visit $20 per specialist office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics of any kind including customized or non-customized shoes, boots, and inserts, except as medically necessary and approved by the Plan for members with diabetes.* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges.*
Orthopedic and prosthetic devices	
• 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.	All charges in excess of the first $2,000 per member per year

Orthopedic and prosthetic devices, continued on next page

Orthopedic and prosthetic devices *(continued)*	**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 • External prosthetic device (such as arms or legs) • Repair and Replacement	All changes in excess of the first $3,000 per year
Not covered: • *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* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges.*
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: • 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 including strips, lancets, and meters 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) *(continued)*	You pay
Not covered: • *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.*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. • Part-time or intermittent nursing care • Part-time or intermittent home health aide services • Surgical dressings, and medical appliances	Nothing
• Physical, occupational, or speech therapy	$20 per visit
Not covered: • *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*	*All charges.*
Chiropractic	
No benefit	All charges.

Alternative treatments	You pay
No benefit	All charges.
Educational classes and programs	
Coverage is limited to: • Diabetes self-management Note: Members should call 1-800-SENTARA for information on classes	Nothing
• Counseling and education for birth control options.	$10 per primary care physician office visit $20 per specialist office visit

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

IMPORTANT

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.
- Plan physicians must provide or arrange your care. 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.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity -- 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. 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. • Voluntary sterilization limited to tubal ligation and vasectomy.	Included in per office visit, or per inpatient/outpatient admission copayment.

Surgical Procedures continued on next page

Surgical procedures *(continued)*	You pay
Not covered: • *Reversal of voluntary sterilization* • *Sex change operations* • *Routine treatment of conditions of the foot; see Foot care.* • *Surgery primarily for cosmetic purposes* • *Any surgical services, other than emergent, which have not been pre-authorized by the Plan.* • *Any surgical services determined not medically necessary by the Plan.* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	Included in per office visit, or per inpatient/outpatient admission copayment.
• All stages of breast reconstruction surgery following a mastectomy, such as: – 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) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Included in per office visit, or per inpatient/outpatient admission copayment.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Any surgical services, other than emergent, which have not been pre-authorized by the Plan.* • *Any surgical services determined not medically necessary by the Plan.* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service.*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Included in per office visit, or per inpatient/outpatient admission copayment.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*
Organ/tissue transplants	
Limited to: • 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. • Autologus tandem transplants for testicular or other germ cell tumors. • Your physician must authorize any transplant services with the Plan.	Included in per office visit, or per inpatient/outpatient admission copayment.

Organ/tissue transplants, continued on next page

Organ/tissue transplants *(continued)*	**You pay**
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. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Included in per office visit, or per inpatient/outpatient admission copayment.
Not covered: • *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*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Included in per office visit, or per inpatient/outpatient admission copayment.

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

IMPORTANT

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.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$250 copayment per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • 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.	Included in inpatient copayment per admission.

Inpatient hospital, continued on next page

Inpatient hospital *(continued)*	You pay
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *The cost of securing the services of blood donors* • *Professional dental services* • *Care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$100 per outpatient admission
Not covered: • *blood and blood derivatives not replaced by the member* • *professional dental services and procedures* • *care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Extended care benefit: The Plan provides a comprehensive range of benefits up to 100 days per calendar year when full time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	$250 per inpatient admission
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	*All charges*

Hospice care	You pay
A coordinated program of home and inpatient care under the direction of a Plan doctor for the patient who is in the terminal stages of illness with a life expectancy of six months or less that includes: • Palliative Care • Supportive physical, psychological, and psychosocial services Note: Palliative care is treatment to control pain, relieve other symptoms and focusing on the special needs of the patient.	Nothing
Not covered: Independent nursing, homemaker services, care and services from non-Plan providers unless pre-authorized by the Plan prior to receiving the service	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	$25 copay per trip.

Section 5 (d). Emergency services/accidents

IMPORTANT

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.

IMPORTANT

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	
• Emergency care at a doctor's office	$10 per primary care physician office visit $20 per specialist office visit
• Emergency care at an urgent care center	$20 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$100 per visit (Waived if admitted)
Not covered: Elective care or non-emergency care	*All Charges*
Emergencies outside our service area	
• Emergency care at a doctor's office	$20 per specialist visit
• Emergency care at an urgent care center	$20 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$100 per visit (Waived if admitted)
Not Covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery outside the service area*	*All charges.*
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

IMPORTANT

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.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
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. 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.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers	$20 per visit
• Medication management	Nothing

Mental health and substance abuse benefits, continued on next page

Mental health and substance abuse benefits *(continued)*	You pay
• Diagnostic tests	$20 per visit
• 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	$20 per office visit copay $250 per inpatient admission $100 per outpatient admission
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 *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.*	*All charges.*

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

IMPORTANT

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.

IMPORTANT

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	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through mail order program: • 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 (covered under Family Planning section 5(a)) • 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 • Insulin syringes and needles • Disposable needles and syringes need to inject covered prescribed medication • Viagra – 4 pills per prescription to treat sexual dysfunction • Intaveneous fluids and medication for home use.	Pharmacy Copayment: $10 per Preferred Tier Drug $20 per Standard Tier Drug $40 per Premium Tier Drug 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 NOTE: If there is no generic equivalent available, you will still have to pay the brand name copay.

Covered medications and supplies, continued on next page

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • 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. 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.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines (Over the Counter medicines)* • *Appetite suppressants or other weight management medications* • *Medical supplies such as dressings and antiseptics* • *Fertility drugs* • *Smoking cessation drugs and medications* • *Immunization agents, biological sera, blood or blood products* • *Drugs to enhance athletic performance* • *Drugs obtained at non-Plan pharmacies except for out-of-area emergencies.*	*All Charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to 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	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.
High Risk Pregnancies	A Plan Case Manager will assist with treatment plan prescribed by your OB/GYN physician.
Services for deaf and hearing impaired	TDD number: 757-552-7120 or 1-800-225-7784

Section 5 (h). Dental benefits

IMPORTANT

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.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Included in per office visit or per inpatient or outpatient admission copay.

Dental benefits

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 or visit www.optimahealth.com for further details.

Being a Plan member, you have more opportunities than ever before to save money on the following healthy products and services through *Optima's Healthy, Wealthy & Wise Program*™. The program entitles you to the following benefits:

- **Dental care**. Members will be offered a 20 percent 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 or visit www.optimahealth.com to obtain a list of participating dental providers.
- **Hearing Care**. Members are eligible to receive a 20 percent discount off the cost of hearing aids from participating providers. Along with this discount, members will also receive a free screening, one-year warranty, post-fitting evaluation, adjustments, and testing for one year after purchase. To receive services, select a participating provider by contacting a Member Services representative or visit www.optimahealth.com.
- **Vision Services.** Cole Vision Services Inc., offers up to a 15 percent discount off the cost of LASIK surgery (or 5 percent 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 is available through a mail order program. Call Contacts Direct at 1-800-987-5367. A discount schedule from Cole is also 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 757-766-2658 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 1-800-736-8272.
- **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 *Optima's Healthy, Wealthy & Wise*™ 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 what *Services Require Our Prior Approval* on page 11.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals (see Section 3) or emergencies (see Emergency Benefits section 5(d));
- 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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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 services you receive outside of the Plan's service area -- 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	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Optima Health Plan, Appeals Department, P.O. Box 62876, Virginia Beach VA 23466-2876; (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial—go to step 4; or (c) Ask 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	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3620

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 more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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.

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 may 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 or a covered family member have coverage 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.

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 then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 757-552-7550 or 1-800-206-1060.

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 coinsurances and coordinate benefits with the primary payer.

Coordinating benefits with other coverage, continued 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, or	✓	
b) Are an active employee, or		✓
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

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from 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 and CHAMPVA

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

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

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.

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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 12.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

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. Custodial care that lasts 90 days or more is sometimes known as long term care.

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:

- 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 your FEHB coverage. These materials tell you:

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

Children's Equity Act

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

FEHB Facts, continued on next page.

administrative order requiring you to provide health benefits for your child(ren).

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

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

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

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.

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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB

FEHB Facts, continued on next page.

coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

• Temporary Continuation of Coverage (TCC)

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

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 Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, you premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care," long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But …

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request on through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by **calling 1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

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

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Summary of benefits for Optima Health Plan - 2003

- **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; $20 specialist	14
Services provided by a hospital: • Inpatient..... • Outpatient.....	 $250 per admission $100 per admission	 29 30
Emergency benefits: • In-area ..... • Out-of-area	$100 per Emergency Room visit or $20 per Urgent Care visit	33 33
Mental health and substance abuse treatment	Regular benefits	34
Prescription drugs.....	$10 per Preferred Tier Drug $20 per Standard Tier Drug $40 per Premium Tier Drug	37 37 37
Dental Care.....	No benefit.	40
Vision Care.....	$15 per exam once every 12 months.	20
Special features: After Hours 24 Hour Nurse Line, High Risk Pregnancy Case Manager		39
Protection against catastrophic costs (your catastrophic protection 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	12

2003 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 a special FEHB guide is published 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.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Peninsula/Southside Hampton Roads							
Self Only	9R1	$109.30	$52.60	$236.82	$113.96	$129.03	$32.87
Self and Family	9R2	$249.62	$133.46	$540.84	$289.17	$294.70	$88.38