

OTHER COVERED SERVICES

Other Services	In-Network Benefits Copayments/%Coinsurance ²
<p>Preventive Vision Services⁶ Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 24 months when done by a participating EyeMed Provider. To contact EyeMed about participating Providers call 1-888-610-2268.</p>	<p>Covered at 100% Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost. For eye examinations from Out-of-Network Providers, Members will be reimbursed up to \$30 for an eye examination only.</p>
<p>Telemedicine Services</p> <p>Telemedicine means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket deductible, copayment, or coinsurance amounts will not exceed the deductible, copayment or coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.</p>

NOTES

All benefits are subject to the terms and conditions in the *Evidence of Coverage (EOC)*. Words that are capitalized are defined terms listed in the Definitions section of the EOC.

Children are covered up to the end of the month in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your benefits. This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your EOC for details about how to file a complaint or an appeal.

Under certain circumstances Your coverage can be terminated. However, Your Coverage can only be rescinded for fraud or intentional misrepresentation of material fact. Please look in Your EOC in the section on When Your Coverage will end.

For Optima Health plans that require that You choose a primary care provider (PCP) You have the right to choose any PCP who participates in our network and who is available to accept You or Your family members. For children, You may choose a pediatrician as the PCP.

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.
2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

Allowable Charge is the amount Optima Health determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers Allowable Charge is the Provider's contracted rate with Optima Health or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.

Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be covered under Your In-Network benefits. All other services You receive from Non-Plan Providers will not be Covered; and You will be responsible for payment of all charges to the Non-Plan Provider.

Emergency Care You get Out of Network from a Non-Plan Provider will be covered as an In-Network benefit. However, You may have to pay the difference between what the Non-Plan Provider's charges and the Plan's maximum allowable amount or Allowable Charge in addition to Your Emergency Care Copayment, Coinsurance and Deductible amounts.