OPTIMA POS - BASIC
2021 SUMMARY OF BENEFITS

City of Virginia Beach & Virginia Beach City Public Schools

Effective 1/1/21 – 12/31/21

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group Plan Document, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. There are two benefit columns. One column lists Your Copayment or the percent Coinsurance You will pay for In Network benefits from Plan Providers. The other column lists Your Copayment or the percent Coinsurance You will pay for Out of Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Plan Document carefully. This plan is a Qualified High Deductible plan compatible with a Health Savings Account.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT		
	Optima Network/PHCS Network	**Out-of-Network Benefits**
Deductibles per Calendar Year[3]	$2,000 per Person $4,000 per Family	$4,000 per Person $8,000 per Family
Maximum Out-of-Pocket Limit per Calendar Year	$4,000 per Person[4] $8,000 per Family[4]	$6,500 per Person[5] $13,000 per Family[5]

PHYSICIAN SERVICES

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery[6]**.

Physician Office Visits	**Optima Network/PHCS Network Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Primary Care Physician (PCP) Office Visit		After Deductible You Pay 50%
Sentara Quality Care Network (SQCN) SQCN providers are currently available in Hampton Roads, Charlottesville and Rockingham zip codes only. **Members who do not reside in those areas will pay the SQCN provider coinsurance.**	After Deductible You Pay 15%	
Non-Sentara Quality Care Network (SQCN) Members who reside in SQCN available zip codes and choose a Non-SQCN provider will pay the higher coinsurance.	After Deductible You Pay 25%	
MDLIVE Virtual Consults Must be furnished by approved Optima Health providers.	After Deductible Covered at 100%	Virtual Consults are not Covered Out-of-Network
Sentara Quality Care Network (SQCN) Specialist Office Visit SQCN providers are currently available in Hampton Roads, Charlottesville and Rockingham zip codes only. **Members who do not reside in those areas will pay the SQCN provider coinsurance.**	After Deductible You Pay 15%	After Deductible You Pay 50%
Non-Sentara Quality Care Network (SQCN) Specialist Office Visit Members who reside in SQCN available zip codes and choose a Non-SQCN provider will pay the higher coinsurance.	After Deductible You Pay 25%	

Preventive Care [10,11]	Optima Network/PHCS Network Copayments/Coinsurance[2]	Out-of-Network Benefits Copayments/Coinsurances[2]
Routine Annual Physical Exams **Well Baby Exams** **Annual GYN Exams and Pap Smears** [11] **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** ***(including 3-D mammograms)*** **Women's Preventive Services**	Covered at 100%	After Deductible You Pay 50%
OUTPATIENT THERAPY AND REHABILITATION SERVICES		
You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit.		
Short Term Therapy Services[7]	**Optima Network/PHCS Network Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Physical Therapy ***Rehabilitative/Habilitative Services*** **Pre-Authorization is required.[6]** Physical Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year combined for rehabilitative and habilitative services.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 50% per visit
Occupational Therapy ***Rehabilitative/Habilitative Services*** **Pre-Authorization is required.[6]** Occupational Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year combined for rehabilitative and habilitative services.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 50% per visit
Speech Therapy ***Rehabilitative/Habilitative Services*** **Pre-Authorization is required.[6]** Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year combined for rehabilitative and habilitative services.**[7]** Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 50% per visit
Short Term Rehabilitation Services[7]	**Optima Network/PHCS Network Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.[6]** Services are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.**[7]** Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 50% per visit

Other Outpatient Treatments	Optima Network/PHCS Network Copayments/Coinsurance[2]	Out-of-Network Benefits Copayments/Coinsurances[2]
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	After Deductible You Pay 25%	After Deductible You Pay 50% per visit
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.	After Deductible You Pay 25%	After Deductible You Pay 50%
OUTPATIENT DIALYSIS SERVICES		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Dialysis Services Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 50% per visit
OUTPATIENT SURGERY		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Outpatient Surgery **Pre-Authorization is required.[6]** Coinsurance or Copayment applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible You Pay 25%	After Deductible You Pay 50%
OUTPATIENT DIAGNOSTIC PROCEDURES		
Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Diagnostic Procedures	After Deductible You Pay 25%	After Deductible You Pay 50%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 25%	After Deductible You Pay 50%
Lab Work	After Deductible You Pay 25%	After Deductible You Pay 50%
OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Magnetic Resonance Imaging (MRI) **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)** **Sleep Studies** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Pre-Authorization is required for all procedures except MRS, SPECT and Nuclear Cardiology.[6]** Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 50%

MATERNITY CARE		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Maternity Care [8, 10,11] **Pre-Authorization is required for prenatal services.**[6] Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.		After Deductible You Pay 50%
Sentara Quality Care Network (SQCN) SQCN providers are currently available in Hampton Roads, Charlottesville and Rockingham zip codes only. **Members who do not reside in those areas will pay the SQCN provider coinsurance.**	After Deductible You Pay 15%	
Non-Sentara Quality Care Network (SQCN) Members who reside in SQCN available zip codes and choose a Non-SQCN provider will pay the higher coinsurance.	After Deductible You Pay 25%	
INPATIENT SERVICES		
Inpatient Services	**Optima Network/PHCS Network Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Hospital Services **Pre-Authorization is required.**[6]	After Deductible You Pay 25%	After Deductible You Pay 50%
Transplants **Pre-Authorization is required.**[6]	After Deductible You Pay 25%	After Deductible You Pay 50%
Skilled Nursing Facilities/Services[7] **Pre-Authorization is required.**[6] Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined with In-Network and Out-of-Network benefits per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services.[7]	After Deductible You Pay 25%	After Deductible You Pay 50%
AMBULANCE SERVICES		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Ambulance Services[9] **Pre-Authorization is required for non-emergent transportation only.**[6] Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	After Deductible You Pay 25% *If transported by a Virginia Beach Volunteer Rescue Squad – Covered at 100%	After Deductible You Pay 25%
EMERGENCY SERVICES		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Emergency Services [2, 9] **Pre-Authorization is <u>not</u> required.** Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility. Coinsurance waived for facility charges if admitted. Inpatient copayment/coinsurance will apply if admitted.	After Deductible You Pay 25%	After Deductible You Pay 25%

URGENT CARE CENTER SERVICES		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Urgent Care Services[9] **Pre-Authorization is <u>not</u> required.** Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay an Emergency Services Copayment or Coinsurance.	After Deductible You Pay 25%	After Deductible You Pay 50%
MENTAL/BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. **Pre-Authorization is required for Inpatient Services**, **partial hospitalization services, intensive outpatient program (IOP), electro-convulsive therapy, and Transcranial Magnetic Stimulation (TMS).[6]**		
Mental/Behavioral Health/Substance Use Disorder	**Optima Network/PHCS Network Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Services **Pre-Authorization is required[6]** Residential treatment is not covered.	After Deductible You Pay 25%	After Deductible You Pay 50%
Outpatient Office Visits **Sentara Quality Care Network (SQCN)** SQCN providers are currently available in Hampton Roads, Charlottesville and Rockingham zip codes only. **Members who do not reside in those areas will pay the SQCN provider coinsurance.** **Non-Sentara Quality Care Network (SQCN)** Members who reside in SQCN available zip codes and choose a Non-SQCN provider will pay the higher coinsurance.	After Deductible You Pay 15% After Deductible You Pay 25%	After Deductible You Pay 50%
Other Outpatient Visits **(Includes Hospital Outpatient and Freestanding Outpatient Centers)**	After Deductible You Pay 25%	After Deductible You Pay 50%
DIABETES TREATMENT		
Coverage includes benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating EyeMed Provider at the applicable office visit Copayment or Coinsurance amount.		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Insulin Pumps **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 50%
Pump Infusion Sets and Supplies **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 50%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution.	After Deductible Covered at 100%	After Deductible You Pay 50%
Insulin, Needles, and Syringes	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit
Outpatient Self-Management Training and Education and Nutritional Therapy	After Deductible Covered at 100%	After Deductible You Pay 50%

OTHER COVERED SERVICES		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Allergy Care Includes allergy testing, injections, serum and RAST testing.	After Deductible You Pay 25%	After Deductible You Pay 50%
Prosthetics and Components **Pre-Authorization is required.[6]** Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components. "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. "Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.	After Deductible You Pay 25%	After Deductible You Pay 50%
Autism Spectrum Disorder **Pre-Authorization is required.[6]** Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder. "Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of Autism Spectrum Disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder. "Treatment for Autism Spectrum Disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) **Applied Behavioral Analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.** "Applied Behavioral Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. **Coverage for Applied Behavioral Analysis under this benefit is limited to an annual maximum benefit of $35,000.[6]**	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.

OTHER COVERED SERVICES		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Clinical Trials **Pre-Authorization is required.[6]** Coverage of routine patient costs for phase I, II and III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.
Chiropractic Care Rider [7] **Pre-Authorization is required by ASH for all Chiropractic services.** Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit. Pre-Authorization is required by ASH for all chiropractic care services To use this benefit call ASH's Member Services at 1-800-678-9133. Representatives are available 8:00 AM to 9:00 PM Monday-Friday. Coverage is limited to a combined maximum benefit with In-and Out-of-Network benefits of 30 per person visits per calendar year. This benefit also includes coverage of Chiropractic appliances up to a combined maximum benefit with In-and Out-of-Network benefits of 1 appliance per Person per calendar year when medically necessary. For providers not in the ASH network the Member will be responsible for payment of all charges in excess of ASH's allowable charge in addition to any Coinsurance amount. Allowable charge is the lesser of the provider's actual charge or ASH's In-Network fee schedule for the same services.	After Deductible You Pay 25% of ASH's fee schedule	After Deductible You Pay 50% of ASH's fee schedule
Durable Medical Equipment (DME) and Supplies Orthopedic Devices and Prosthetic Appliances **Pre-Authorization is required for single items over $750.[6]** **Pre-Authorization is required for all rental items.[6]** **Pre-Authorization is required for repair and replacement.[6]** Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.	After Deductible You Pay 25%	After Deductible You Pay 50%
Early Intervention Services **Pre-Authorization is required.[6]** Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.

OTHER COVERED SERVICES		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Family Planning Depo-Provera Injection: Lunelle Injection: Tubal Ligation: Pre-authorization required Vasectomy:	 Covered at 100% Covered at 100% Covered at 100% After Deductible Covered at 100% Subject to any applicable outpatient/inpatient surgery copayment	 After Deductible You Pay 50% After Deductible You Pay 50% After Deductible You Pay 50% After Deductible You Pay 50% Subject to any applicable outpatient/inpatient surgery copayment/coinsurance.
Hearing Aid Rider **Pre-Authorization is required.[6]** The following services are covered up to the annual maximum benefit of $2,000 per ear: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 36 months from date of acquisition. Batteries are not covered. Supplies are not covered.	After Deductible You Pay 25%	After Deductible You Pay 50%
Home Health Care Skilled Services[7] **Pre-Authorization is required.[6]** Services are covered up to a maximum combined benefit with In-Network and Out-of-Network benefits of 100 visits per calendar year for Members who are home bound, and in the Plan's judgment require Home Health Skilled Services.[7] You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.	After Deductible You Pay 25%	After Deductible You Pay 50%
Hospice Care **Pre-Authorization is required.[6]**	After Deductible You Pay 25%	After Deductible You Pay 50%

OTHER COVERED SERVICES		
	Optima Network/PHCS Network Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Vision Care and Materials[7] Optima Health contracts with EyeMed Vision Care to administer this benefit. Medical conditions related to the eye, such as glaucoma, are covered under the medical plan. Coverage includes one examination every 12 months when done by a participating EyeMed Provider. To locate a participating EyeMed provider, please call 1-888-610-2268 or visit www.optimahealth.com.	Spectacle Exam: You Pay $20 ***OR*** Contact Lens Exam: You Pay $40 Limited to one exam every 12 months (from the date of last exam) by a participating EyeMed Provider. Materials – By a participating EyeMed Provider: Lenses (single vision, bifocal, trifocal) covered in full. Frames: Covered in full up to $150 retail Contact Lenses (in lieu of glasses) covered in full up to $150 retail. If you choose contact lenses when they are not medically indicated, you will receive an allowance of $150 toward the purchase price. (Contact lenses are deemed medically necessary following cataract surgery, to correct extreme visual acuity problems not correctable with spectacle lenses, or if you have certain conditions of anisometropia or keratoconus). If contact lenses are obtained, they are in lieu of spectacles.	For eye examinations from Out-of-Network providers, Members will be reimbursed up to $40 for an eye examination (once every 12 months from date of last exam). No coverage for eyeglasses/ contacts out-of-network.
Telemedicine Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.	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.	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.

NOTES

All benefits are subject to the terms and conditions in the *Plan Document.* Words that are capitalized are defined terms listed in the Definitions section of the Plan Document.

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 Plan Document 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 Plan Document 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 the Plan determines will be paid to a Provider for a Covered Service. When You receive Covered Services from an In-Network Physician the Allowable Charge is the lesser of: (1) the Physician's contracted rate with the Plan or its third party administrator or (2) the Physician's actual charge for the Covered Service. When You receive Covered Services from an In-Network facility the Allowable Charge will be the facility's contracted rate with Plan. In-Network Providers will accept our Allowable Charge as payment in full. You will be responsible for any applicable In-network Deductible, Copayment or Coinsurance amounts. When You use Out-of-Network benefits from Non-Plan Providers the Allowable Charge may be a negotiated rate; or if there is no negotiated rate the Allowable Charge is Optima's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less.

   Medically Necessary Covered Services provided by a Non-Plan Provider during an authorized Admission to a Plan Facility, will be covered under In-Network Benefits. Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket amounts. However, you may have to pay the difference between what the Non-Plan Provider charges and the Plan's Allowable Charge in addition to your in-network copayment, coinsurance and deductible amounts. Participants should notify Optima immediately if a balance bill is received.

   All other Covered Services You receive from Non-Plan Providers will be Covered under Out of Network Benefits. However, You may have to pay the difference between what the Non-Plan Provider charges and the Plan's Allowable Charge in addition to Your Out-of-Network Copayment, Coinsurance and Deductible amounts. When You use an Out-of-Network Provider, the Allowable Charge is the lesser of the usual and customary rate for the service as determined by the Plan. Amounts You pay as a result of balance billing will not accumulate toward any Deductible and Maximum Out-of-Pocket amounts.

3. **Deductible** means the dollar amount You must pay out-of-pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. If You have individual coverage You must satisfy the individual member Deductible before Coverage begins. If You have family coverage You must satisfy the family coverage Deductible. **Your Plan has a non-embedded individual deductible. Non-embedded means if one covered family member meets the individual member deductible his or her benefits will not begin until the entire family deductible is satisfied. Once the total family coverage deductible is met benefits are available for all covered family members.** A Plan may have separate individual and family Deductibles for In-Network Covered Services and for Out-of-Network Services. Deductibles will not be reimbursed under the Plan. The Deductible does not apply to Preventive Care Visits and Screenings, Preventive Drugs, or Preventive Vision Services and You are required to pay Your office visit Copayment or Coinsurance only. Amounts applied to Your In-Network Deductible will apply toward Your Plan's In-Network Maximum Out-of-Pocket Limit. Amounts applied to Your Out-of-Network Deductible will apply toward Your Out-of-Network Maximum Limit. Should the Federal Government adjust the deductible for high deductible health plans as defined by the Internal Revenue Service, the deductible amount in the Policy will be adjusted accordingly.

4. **Maximum Out of Pocket Limit for In-Network Benefits** means the total dollar amount You and Your family pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's Out-of-Network Benefits. Copayments and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out-of-Pocket Limit. Amounts applied to Your In-Network Deductible will apply to Your In-Network Maximum Out-of-Pocket Limit. Copayments or Coinsurance for Outpatient Prescription Drug Coverage will count toward Your In-Network Maximum Out-of-Pocket Limit. **If a service does not count toward**

Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayments or Coinsurances or any other charges for the following will not count toward Your In-Network Maximum Out of Pocket Limit:

1. Amounts You pay for services not covered under Your Plan;
2. Amounts You pay for Out-of-Network Benefits;
3. Amounts You pay for Vision care;
4. Amounts You pay for any benefits covered under a plan rider;
5. Amounts You pay for Reduction Mammoplasty benefits, except for procedures associated with reconstructive breast surgery following mastectomy;
6. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available. Ancillary charges are not Covered Services;
7. Amounts You pay for any services after a benefit limit has been reached;
8. Amounts You pay as a penalty for failure to comply with the Plan's Pre-authorization procedures;
9. Amounts applied to Your Out-of-Network Deductible

5. **Maximum Out-of-Pocket Limit for Out-of-Network Benefits** means the total dollar amount You will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Out-of-Pocket limit for Covered Services You receive under the Plan's In-Network Benefits. Copayments and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out-of-Pocket Limit. Amounts applied to Your Out-of-Network Deductible will apply to Your Out-of-Network Maximum Out-of-Pocket Limit. **If a service does not count toward Your Maximum Out-of-Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out-of-Pocket Limit has been met. Copayments, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out-of-Pocket Limit:**

   1. Amounts You pay for services not covered under Your Plan;
   2. Amounts You pay for In- Network Benefits;
   3. Amounts You pay for Vision care;
   4. Amounts You pay for any benefits covered under a plan rider;
   5. Amounts You pay for Reduction Mammoplasty benefits, except for procedures associated with reconstructive breast surgery following mastectomy;
   6. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available. Ancillary charges are not Covered Services;
   7. Amounts You pay for any services after a benefit limit has been reached;
   8. Amounts You pay as a penalty for failure to comply with the Plan's Pre-authorization procedures;
   9. Amounts applied to Your In-Network Deductible;
   10. Amounts that exceed the Plan's Allowable Charge for a Covered Service.

6. This benefit requires Pre-Authorization before You receive services. We have instructions and procedures in place for providers to obtain Pre-Authorization through Case Management/Clinical Care Services. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.

7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. Unless otherwise noted benefit limits are combined for services received both In-Network and Out-of-Network and for all places of service. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your In-Network or Out-of-Network Maximum Out of Pocket Maximum Limit.

8. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.

9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical

Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had You received care from a Plan Provider

10. Preventive Care includes the services listed below. You may be responsible for an office visit Copayment or Coinsurance when You receive preventive care. Some services may be administered under Your prescription drug benefit under the Plan. Where no frequency or limits are indicated the Plan will use it's normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Services covered under the Plan's outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

    1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;

    2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

    3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

    4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:

    - **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
    - **Contraceptive Methods and Counseling including:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
    - **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
    - **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
    - **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
    - **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
    - **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
    - **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.

11. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your Plan Document in the Utilization Management Section for more information on Pre-Authorization.

Optima POS - Basic
Outpatient Prescription Drug Summary of Benefits

This Summary of Benefits describes Your outpatient prescription drug coverage. All drugs must be United States Food and Drug Administration (FDA) approved and you must have a prescription. You will need to pay Your Copayment or Coinsurance when you fill your prescription at the pharmacy. If Your Plan has a Deductible you must meet that amount before your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. Your drug coverage has specific Exclusions and Limitations listed in Your coverage documents. Optima Health's Pharmacy and Therapeutics Committee places covered drugs into the following Tiers. You will pay Your Copayment or Coinsurance depending on which Tier Your Drug is in.

This Plan uses a closed prescription drug formulary. That means Your Plan includes coverage for a specific list of drugs and medications determined by our Pharmacy and Therapeutics Committee. Drugs that are not included on the Standard formulary will not be covered under Your plan. Please use the following link to see a list of drugs on the Standard formulary: https://www.optimahealth.com.

- **Selected Generic (Tier 1)** includes commonly prescribed generic drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.

- **Selected Brand & Other Generic (Tier 2)** includes brand-name drugs, and some generic drugs with higher costs than Tier 1 generics, that are considered by the Plan to be standard therapy.

- **Non-Selected Brand (Tier 3)** includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a generic equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers.

- **Specialty Drugs (Tier 4)** includes those drugs classified by the Plan as Specialty Drugs. Tier 4 also includes covered compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or on-going medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional. Specialty Drugs include the following:
  - Medications that treat certain patient populations including those with rare diseases;
  - Medications that require close medical and pharmacy management and monitoring;
  - Medications that require special handling and/or storage;
  - Medications derived from biotechnology and/or blood derived drugs or small molecules; and
  - Medications that can be delivered via injection, infusion, inhalation, or oral administration.

  Specialty Drugs are only available through the Optima Health specialty mail order pharmacy. Proprium Pharmacy at 1-855-553-3568. Specialty Drugs will be delivered to Your home address from Our Specialty mail order pharmacy. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Pharmacy Member Services at the number on Your Optima Health ID Card. You can also log onto optimahealth.com for a list of Specialty Drugs.

  A compound prescription medication is used to meet the needs of a specific individual and must have at least one ingredient requiring a Physician's authorization by State or Federal Law. Compound prescriptions can usually be filled at Your local pharmacy.

Your Copayment, Coinsurance, and Deductible amounts for each Tier are listed on the following page. Your Maximum Out-of-Pocket Limit is also listed on the following page. If You need help please call Member Services or log on to optimahealth.com to find out which of the following Tiers Your drug is in.

Administered by Sentara Health Plans, Inc.

Standard Formulary

Deductibles and Maximum Out-of-Pocket Limit	
Deductibles	You must meet the medical Deductible listed on the Your Plan's Summary of Benefits.
Maximum Out-of-Pocket Limit	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Maximum Medical Out-of-Pocket Limit Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are not Covered, do not count toward the Plan's Maximum Out-of-Pocket Limit and must continue to be paid after the Maximum Out-of-Pocket Limit has been met
Insulin, syringes, and needles	Covered at the cost sharing listed below for the applicable Tier.

Copayments and Coinsurances.

For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge. 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 prescribing Physician requests 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 the Copayment charge (not to exceed $150 per each 31-day supply prescription).

PREFERRED NETWORK – You will pay a lower Copayment if you fill your prescriptions at a Walgreens, Walmart or Sam's Club Preferred Pharmacy. **You may purchase up to a 90-day supply for 3 Copayments or Coinsurance amounts.**	
Selected Generic (Tier 1)	After Deductible $10 Copayment (or the plan's negotiated cost of the drug, if less)
Selected Brand & Other Generic (Tier 2)	After Deductible $25 Copayment (or the plan's negotiated cost of the drug, if less)
Non-Selected Brand (Tier 3)	After Deductible You Pay 25% (maximum $50)

Non-Preferred Pharmacy (all retail other than Walgreens, Walmart or Sam's Club). **You may purchase up to a 30-day supply.**	
Selected Generic (Tier 1)	After Deductible $25 Copayment (or the plan's negotiated cost of the drug, if less)
Selected Brand & Other Generic (Tier 2)	After Deductible $45 Copayment (or the plan's negotiated cost of the drug, if less)
Non-Selected Brand (Tier 3)	After Deductible You Pay 25% (maximum $75)

Specialty Drugs (Tier 4)	After Deductible You Pay 25% (maximum $200)

PLEASE NOTE: Prescription medications used to prevent any of the following medical conditions are not subject to the deductible including medications for Hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency.

Mail Order Pharmacy Benefit Copayments and Coinsurances	
Some Outpatient prescription drugs are available through the Plan's Mail Order Provider. This does not include Tier 4 Specialty Drugs. You may call OptumRx Home Delivery at 866-244-9113 to find out if a drug is available. If Your drug is available, You may purchase up to a 90-day supply for the Copayment or Coinsurance amount.	
Selected Generic (Tier 1)	After Deductible $25 Copayment (or the plan's negotiated cost of the drug, if less)
Selected Brand & Other Generic (Tier 2)	After Deductible $60 Copayment (or the plan's negotiated cost of the drug, if less)
Non-Selected Brand (Tier 3)	After Deductible You Pay 25% (maximum $125)
Specialty Drugs (Tier 4)	No 90 day mail order benefits are available for Tier 4 Specialty Drugs.

Non-formulary requests. You have the right to request a non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of covered drugs (formulary), or You have been receiving a specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your physician must complete a medical necessity form and deliver it to the Optima Health pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, Optima Health will make a determination. Optima Health will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.

Synchronization of Medication. For prescription drugs Covered under the Plan We will permit and apply a prorated daily cost sharing rate to prescriptions that are dispensed by an In-Network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the Member, and the Member requests or agrees to a partial supply for the purpose of synchronizing the Member's medications. Proration will not occur more frequently than annually.

The Plan will not deny Coverage for the dispensing of a medication by an In-Network pharmacy on the basis that the dispensing is for a partial supply if the prescribing provider or the pharmacist determines the fill or refill is in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the Member's medications.

Optima Health Alternative Language Options for Notices and other Written Information

Amharic:
ማሳሰቢያ፡
አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260 (TTY: 711) ።

Arabic:
تنبيه: إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجانًا. اتصل بالرقم 1-855-687-6260 (TTY: 711).

Bengali/Bangla:
লক্ষ্য করবেনঃ যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন– 1-855-687-6260 (TTY: 711) ।

Chinese (Mandarin):
注意：如果您讲中文普通话，可以免费获得语言协助服务。请拨打电话 1-855-687-6260 (TTY: 711)。

French:
ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260 (TTY: 711).

German:
ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 (TTY: 711) zur Verfügung.

Gujarati:
ધ્યાન આપો : જો તમે ગુજરાતી બોલી છો તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 (TTY: 711) પર કૉલ કરો.

Hindi:
ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 (TTY: 711) पर कॉल करें।

Hmong:
CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260 (TTY: 711).

Igbo:
GEE NT Ị: ọbụrụ na ị na-asụ Igbo, ị ga-enweta enyemaka n'efu site n'aka ndị ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260 (TTY: 711)

Japanese:
重要：日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260 (TTY: 711) までお電話ください。

Korean:
주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260 (TTY: 711) 번으로 전화해 주십시오.

Kru/Bassa:
YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha I nyuu hola we. Sebel: 1-855- 687-6260 (TTY: 711).

Laotian:
ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນໍາໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260 (TTY: 711).

Mon-Khmer, Cambodian:
កំណត់សំគាល់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260 (TTY: 711) ។

Navajo:
SHOOH: Diné Bizaad bee yáníłti'go doo bą́ą́h ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'á. Kojį' hólne' 1-855-687-6260 (TTY: 711).

Persian/Farsi:

توجه:
اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 (TTY: 711) تماس بگیرید.

Portuguese:
ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260 (TTY: 711).

Russian:
ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260 (TTY: 711), и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:
ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260 (TTY: 711).

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260 (TTY: 711).

Turkish:
DİKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz. 1-855-687-6260 (TTY: 711) numaralı telefonu arayın.

Urdu:

توجہ دیں:
اگر آپ اُردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 (TTY: 711) کال کریں۔

Vietnamese:
CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260 (TTY: 711).

Yoruba:
KÉÉRE:
Ti o bá ń sọ èdè Yorùbá, iṣẹ́ ìrànlọ́wọ́ èdè wà fún ọ lọ́fẹ̀ẹ́. Pe 1-855-687-6260 (TTY: 711)