



Pharmacy
Benefit
DimensionsSM
An Independent Health company



Jim Ellis Atlanta, Inc.

Member Enrollment Kit

Welcome



Your employer has chosen Nova Healthcare Administrators, Inc., an Independent Health company, to administer your health benefits. Here at Nova, we love what we do, and we strive to create an exceptional experience for members. That's why we put together this enrollment packet. It contains essential information regarding your health benefit plan and will help make sure you get the most out of your benefits.

Questions about your benefits?

Our Customer Service Department is available Monday through Friday from 8 a.m. to 8 p.m., ET. Call us using the number on your member ID card.

Enclosed you will find:

- **Plan Design Benefit Summary Details** – A quick glance at all the plan designs and health benefits available to you, as well as in- and out-of-network plan payment information.
- **A Key to Reading Your Member ID Card** – A sample of your ID card has been provided for you to become familiar with the way the information is presented on the card. Your actual card(s) will be mailed directly to your home once you enroll.
- **Information on Precertification** – Some of your benefits require precertification. Please be sure to read this overview carefully and consult your Summary Plan Description for a full list of precertification requirements.
- **Treatment Decision Support** – Information to help you make the right decision on when and where to seek care.
- **24-Hour Medical Help Line** – Available after you enroll, this helpful resource assists you with what to do when a medical problem arises and offers guidance on how to quickly seek treatment.
- **Online and Mobile Tools** – Our secure online and mobile resources allow you to track your claim information, access health support tools, obtain coverage details, locate providers, and view your ID card(s) anytime, anywhere.
- **HealthJoy** – Information on HealthJoy, whose app allows you to maintain an up-to-date benefits wallet with all your benefits cards, provides access to a health care concierge team, and take advantage of telemedicine services through Teladoc[®].
- **Pharmacy Benefit Information** – Important information regarding your pharmacy benefits through Pharmacy Benefit Dimensions, including materials on prescription drug formulary, national pharmacy network, specialty pharmacy, mail order and prior authorization.

Completing your enrollment

Please read the information in this kit carefully. Whether you're enrolling using our standard member enrollment form or utilizing another enrollment platform, please make sure you fill out all necessary fields. It's important to note that even if you choose to decline coverage at this time, we still ask that you go through the enrollment process.

Jim Ellis Atlanta, Inc.

PPO Plan

Benefits Summary	In-Network [^]	Out-of-Network ^{^^}	Additional Information
Calendar Year Deductible			
Individual	None	\$4,500.00	
Family	None	\$9,100.00	
Calendar Year Out-of-Pocket			
Individual	\$9,100.00	\$18,200.00	
Family	\$18,200.00	\$27,300.00	
<i>**Copay, Deductible and RX are included in Out of Pocket</i>			
Preventive			
Routine Physical - Adult	100%	60%*	Age 19+; one per plan year
Well Child Care	100%	60%*	Up to age 19
Routine Gyn Exam	100%	60%*	One per plan year
Pap Smear	100%	60%*	Age 18+ ; one per year
Laboratory - Routine	100%	60%*	
Diagnostic Testing - Routine	100%	60%*	
X-Ray - Routine	100%	60%*	
Mammogram	100%	60%*	
Immunization - Adult	100%	60%*	Age 19 +
Immunization - Child	100%	60%*	Up to age 19
Vision Exam	Not Covered	Not Covered	
Vision Benefits	Not Covered	Not Covered	
Inpatient			
IP Hospital Room & Board	100% after \$4500 copay	60%*	Pre-Certification Required
Outpatient			
Office Visit PCP	100% after \$25 copay	60%*	
Office Visit Specialist	100% after \$75 copay	60%*	
Allergy Injection	100% after \$75 copay	60%*	
Chiropractic	100% after \$75 copay	60%*	20 visits per calendar year
Outpatient Surgery Facility	100% after \$1,500 copay	60%*	Pre-Certification Required
Outpatient Surgery - Hospital	100% after \$2,500 copay	60%*	Pre-Certification Required
Surgery - Physician Outpatient	100%	60%*	
Physical Therapy (PT)	100% after \$75 copay	60%*	20 visits per calendar year
Occupational Therapy (OT)	100% after \$75 copay	60%*	20 visits per calendar year
Speech Therapy (ST)	100% after \$75 copay	60%*	20 visits per calendar year
Emergency Room	100% after \$750 copay	Payable at In Network	copay waived if admitted
Urgent Care	100% after \$75 copay	60%*	
Laboratory	100% after \$150 copay	60%*	
Diagnostic Testing	100% after \$150 copay	60%*	
Radiology	100% after \$150 copay	60%*	
Radiology; High Tech Imaging-Free Standing Facility	100% after \$450 copay	60%*	Pre-Certification Required
Radiology; High Tech Imaging-Hospital	100% after \$750 copay	60%*	Pre-Certification Required

**Subject to deductible.*

^In-Network: The plan pays based on the Preferred Provider Organization (PPO) allowed amount in accordance with the benefits outlined above.

^^Out-of-Network: The plan pays based on the Reasonable and Customary (R&C) allowed amount in accordance with the benefits outlined above. Plan participants may be responsible for billed charges in excess of the allowed amount.

This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Summary Plan Description.

Precertification Overview



What is Precertification?

Your benefits provide coverage for health care services that are medically necessary. To determine medical necessity, coverage for certain services, procedures, inpatient admissions and surgeries must be approved by Nova Healthcare Administrators, Inc. (Nova) in advance. This is called precertification and it's required for certain covered charges.

Precertification Includes

The request for precertification must be made at least 72 hours in advance of services being rendered, or within 48 hours of the first business day following emergency services and/or admission.

Precertification for non-emergency services must be obtained before medical and/or surgical services are provided (subject to the limitations set forth in the Scheduled of Benefits). Examples of medical or surgical services that often require precertification are noted below, however, your plan may vary. It is recommended that you call Nova in advance of a service or procedure to confirm coverage and precertification requirements.

- **Alcohol/Substance Abuse (including Inpatient Facility / Rehab Services, Hospitalizations, Intensive Outpatient and Residential Services)**
- **Chemotherapy**
- **Clinical Trials**
- **Dental (Accidental, Congenital Disease and Anomaly)**
- **Experimental/Investigational**
- **Genetic Testing**
- **High Tech Imaging (CT/PET/Bone Scan/MRI/MRA/Diagnostic Radiology)**
- **Home Birth**
- **Home Health Care**
- **Home Infusion (including Nursing Services/ Visits, Medication and Other Services)**
- **Hospitalizations (including Inpatient, Inpatient Medical Rehabilitation Facility)**
- **Infertility**
- **Injectable Medications**
- **Inter-facility Transport/Transfer**
- **Mental Health (including Inpatient Facility Services, Partial Hospitalization, Intensive Outpatient and Residential Services)**
- **Outpatient Surgical Procedures (excluding Office Based Settings)**
- **Physical, Occupational and Speech Therapies (if visits are limited additional visits require precertification)**
- **Prosthetics and Appliances**
- **Radiation Therapy**
- **Skilled Nursing Facility**
- **Temporomandibular Joint Disorder**
- **Transplants (excluding Corneal Transplants)**

Questions about the precertification list?

If you have questions about which services require precertification or before you receive care which requires precertification, contact Nova's Care Navigation team by calling the customer service number on your ID card or send a message through the member portal with the following information:

- **The name of the patient and relationship to the covered employee;**
- **The name, identification number and address of the covered employee;**
- **The name and telephone number of the treating physician/provider**
- **The name of the medical care facility, proposed date of admission and proposed length of stay**
- **The name of the employer**
and;
- **The diagnosis and/or type of surgery**

When a service requires precertification, both the member and provider will be advised in writing once a determination has been made for the requested service. In the event the covered member does not obtain precertification, a penalty may apply. The employee pays the balance, if any. Any penalty assessed does not apply towards the out-of-pocket maximum deductible or coinsurance limit.

Precertification is not a guarantee of benefits. Participant eligibility, plan requirements, including provisions and exclusions will determine available benefits. The Summary Plan Description should be reviewed for limitations relating to a specific type of service.

In addition to precertification services, the following may occur:

- Retrospective review of the listed services provided on an emergency basis to ensure whether they are medically necessary;
- Concurrent review, based on the admitting diagnosis, of the listed services requested by the physician/provider and;
- Certification of services and planning for discharge from a medical care facility or cessation of medical treatment.

If the attending physician/provider feels that it is medically necessary for the patient to receive additional services or to stay in the medical care facility for a greater length of time than has been precertified, the attending physician/provider must request the additional days.

Access Plan Information

Online

www.novahealthcare.com

Click on the *Member* button in the top-right corner, then click *Log In* to access your medical plan information.

App

The MyNova App is available for free in the Apple App and Google Play stores.

Help is One Call Away

Nova's Care Navigators can be reached Monday through Friday from 8 a.m. to 8 p.m. ET by calling the Customer Service number on your ID card.

Sample ID Card

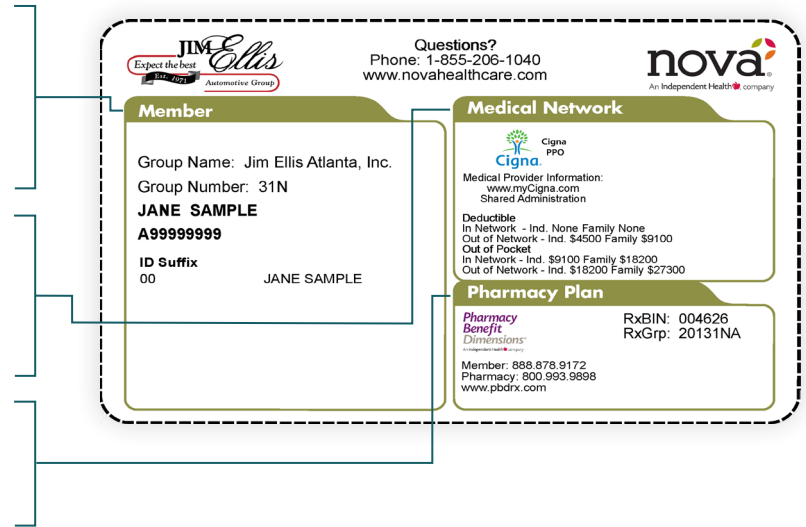
Be sure you and your dependents present this new ID card to providers when receiving service.

Front of Sample Card

Member Information – Your group name, medical/pharmacy group number, member ID number and name are located here on the front of your ID card. This information is used to identify benefits for you and your covered dependents.

Medical Network – To receive the in-network level of benefits, your provider must participate in this network. To identify participating providers, please visit the Consumer Information Center online.

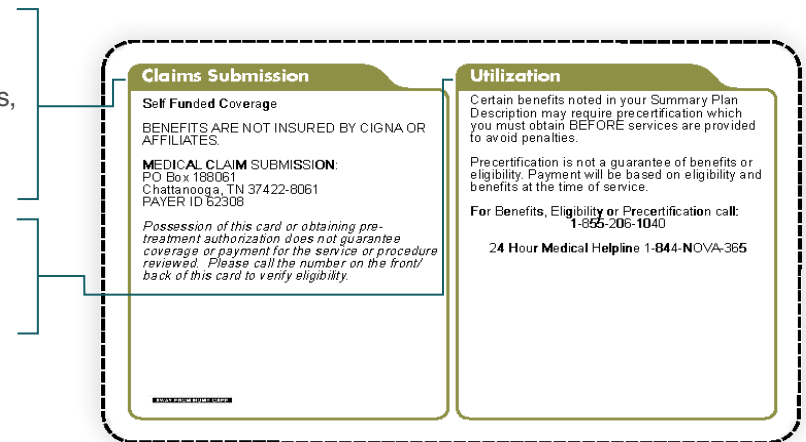
Pharmacy Plan – Your Pharmacy Benefits Manager is Pharmacy Benefit Dimensions. Maximize your savings by utilizing participating pharmacies.



Back of Sample Card

Claims Submission – All claims should be submitted to the address located on the back of your ID card. If you have any questions about claims, please contact our Customer Service department using the number on the front of your ID card.

Utilization – Please contact our medical management department at the number listed in the Utilization section for precertification.



Questions?

If you have questions related to your benefit plan, please contact Nova's Customer Service department using the number on the front of your ID card, **Monday – Friday 8 a.m. – 8 p.m. ET.** We thank you for your participation and look forward to providing you with the exceptional service you deserve.



\$0 Preventive Care Services

Staying up to date with medical care is key to maintain and improve your health and well-being. Not only do preventive services help you stay healthy, they also make sure that if you do get sick, you can start recovering as soon as possible. In fact, for many health conditions, early detection can lead to better outcomes and quicker recovery.

As part of our commitment to help you stay healthy, we want you to know all of the \$0 care services offered to keep you healthy. Even those enrolled in a deductible plan can enjoy FREE preventive services from the start!

Top 10 List of FREE Preventive Services

- Annual Routine Adult Doctor Visit Checkup*
- Screening for Risk of Heart Disease
- Colon Cancer Screening
- Diabetes Screening
- High Blood Pressure Screening
- Breast Cancer Screening
- Annual Women's Well Visit
- Pap Smear and Cancer Screening
- Flu, Pneumonia, and other Preventive Shots/ Vaccinations
- Annual Doctor Visit for Children*

Additional FREE Preventive Services

- Abusive Relationship – Domestic Violence Screening
- Abdominal Ultrasound Screening for Abnormal Aorta Changes
- Aspirin Use for Prevention of Heart Disease**
- Aspirin Use for Prevention of Preeclampsia**
- Birth Control Methods and Advice
- Breast Cancer Preventive Medications
- Breast, Ovarian, Tubal, or Peritoneal Cancer Risk Test and Genetic Counseling/Testing***
- Breast Feeding Supplies
- Breast Feeding Support and Advice
- Bone Density (Osteoporosis) Screening
- Counseling and Treatment to Stop Smoking
- Depression Screening – Children, Adults, and Pregnant Women
- Diabetes Testing During Pregnancy
- Falls Risk Prevention in Older Adults
- Folic Acid for Women During Pregnancy
- Fluoride Treatment in Preschool Children
- General Health Blood Work
- Healthy Diet and Physical Activity Advice
- Healthy Weight Counseling During Pregnancy
- Hepatitis B Virus Infection Screening
- Hepatitis C Screening

- HIV Counseling
- HIV Screening
- HPV Screening
- Lung Cancer Screening
- Obesity Screening – Adults and Children
- Oral Birth Control
- Preeclampsia Screening
- Prevention of Tobacco Use in Children and Adolescents
- Pre-Pregnancy Visit* and One (1) Post-Delivery Visit*
- Rh(D) Incompatibility Screening in Pregnant Women
- Sexually Transmitted Disease Testing
- Sexually Transmitted Infections Counseling
- Skin Cancer Behavior Change
- Syphilis Screening
- TB (Tuberculosis) Infection Screening
- Thyroid Screening for Newborns
- Treatment to Prevent Pinkeye in Newborns
- Unhealthy Alcohol Use Screening and Treatment
- Unhealthy Drug Use Screening and Treatment
- Urine Test to Check for Infection in Pregnant Women
- Vision Loss Screening (for Children Younger than 5 Years Old)

Additional Preventive Services Information

These services are covered in full one time per plan year when given by an in-network/participating provider. Some preventive services need to meet specific criteria.

Please keep in mind, a routine checkup/well visit or preventive service can turn into a “sick visit.” When other services are provided, a “sick visit” can result in added charges where you will be responsible for paying an office visit copay. If you are enrolled in a deductible plan, you will be responsible for all charges until your deductible level is met. Those services are subject to any applicable liability as described in your contract.

* Does not include procedures, injections, diagnostic services, laboratory and X-ray services, or any other services not billed as an Evaluations and Management (E&M) code.

** Please discuss with your doctor before starting any new medications.

*** Please note: BRCA mutation screening requires prior authorization to review for medical necessity based on product. Reference the following policy for additional information: Breast Cancer Susceptibility 1 and 2 (BRCA 1 and BRCA 2) Sequence Testing for Susceptibility to Hereditary Breast Cancer and BRCA Analysis® Rearrangement Test (BART).

Preventive Care Services are: Items or services with an “A” or “B” rating from the United States Preventive Services Task Force; immunizations pursuant to the Advisory Committee on Immunization Practices (“ACIP”) recommendations; and preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”). For additional information, [click here](#).

Questions?

If you have questions or would like additional information, please call Nova’s Customer Service Department using the number on your ID card.

Know Your Health Care Options



When your family needs care, it's a comfort to know you have options. Knowing which one to choose can be a challenge. Helping you understand their differences is just one of the ways we can help you get and stay healthy, ensuring that your family gets the right care at the right time, and in the right setting. It can also make a big impact on your health care savings, since the average American family spends \$5,177* annually on health care. Below are options for you to consider and their average related costs.

	24-Hour Medical Help Line	Telemedicine **	Primary Care Physician (PCP)	Urgent Care Center	Emergency Room
Average Cost	No Cost	No Cost	\$\$	\$\$\$	\$\$\$\$
Care Provider	Registered Nurse (RN)	Board-certified, state-licensed physician	Primary Care Physician (PCP)	Physician, Physician Assistant, Nurse Practitioner, RN and LPN	Physician, Physician Assistant, Nurse Practitioner, RN and LPN and other hospital personnel
Average Wait Time	Immediate	16–20 minutes	Varies by Office	1–2 hours	3–5 hours
Care Setting	Virtual Visit (eVisit) via 24-hour phone line	Virtual Visit (eVisit) via phone, online or app.	In-Person or Virtual Visit (eVisit) via phone, online or app (varies by office)	In-Person	In-Person
	<p>When you can't reach your doctor, our 24-Hour Medical Help Line is available 24 hours a day, 7 days a week to:</p> <ul style="list-style-type: none"> Recognize symptoms; Choose appropriate care Find doctors or hospitals Manage health conditions Explore treatment options Identify medication side effects and interactions Discuss what health screenings you need 	<p>When you can't reach your primary care physician, our telemedicine benefit provided through Teladoc® allows you to talk with a doctor by phone 24/7 for common illnesses, such as:</p> <ul style="list-style-type: none"> Allergies Bronchitis Cough and flu symptoms Nasal congestion Pink eye Sinus problems Urinary tract infection <p>You may receive prescriptions for short-term antihistamines, antibiotics, cough suppressants or anti-bacterial agents.</p>	<p>Your PCP is responsible for taking care of your health and, when necessary, coordinating care for you with other health care providers. Call your PCP for:</p> <ul style="list-style-type: none"> Influenza Rashes Fevers Regular and preventive care Chronic conditions such as diabetes and high blood pressure Immunization and screening General questions about your health 	<p>An urgent medical service provider can provide care for:</p> <ul style="list-style-type: none"> Sprains and strains Minor broken bones Mild asthma attacks Ear infections Small cuts Minor burns and injuries Other minor infections 	<p>Go to the hospital emergency room for:</p> <ul style="list-style-type: none"> Chest pain Heavy or uncontrollable bleeding Large open wounds Trouble breathing Major burns Spinal injuries Severe head injury Loss of consciousness Severe abdominal pain

* Source: U.S. Bureau of Labor Statistics Consumer Expenditure Surveys – 2020

**Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written.

At Nova, we care about you. That's why we offer a variety of tools and resources to help you lead a healthier life. For more information, talk with your doctor and visit us online at novahealthcare.com.

Nova's 24-Hour Medical Help Line



When you can't reach your doctor or your health care center is closed, you can speak to an experienced registered nurse 24 hours a day, 7 days a week for non-emergency medical issues and advice. **Call 1-844-NOVA-365 to reach Nova's 24-Hour Medical Help Line***

What Kind of Help Can I Get From Calling the Medical Help Line?

- Help with medical needs (non-emergency)
- Information about heart disease, asthma or diabetes
- Details about common surgeries
- Advice on how to treat a child's fever or minor injury
- Help understanding symptoms and choosing the right care
- Medicine interactions and side effects
- Health and wellness information
- Advice on choosing foods that are good for you
- Information on how to quit smoking
- Vaccinations

Choosing the Right Care

Helping you get and stay healthy is our top priority. Our nurses will answer your questions and help you learn more about the treatment and procedure options available to you for different health problems and diseases. The nurse may suggest you contact your doctor so you can be seen the following day. Remember, it's important to keep your primary care physician up to date on all matters of your health.

As always, if your situation is a medical emergency, please go to the closest emergency room.

Nova's Treatment Decision Support is Available 24/7 to Discuss:

MUSCULOSKELETAL

(Bone, muscle, ligament, tendon and nerve pain)

- Back pain
- Hip replacement
- Knee replacement
- Shoulder pain

OTHER

- Tubes in ears
- Weight loss surgery

MEN'S HEALTH

- Prostate disease

WOMEN'S HEALTH

- Breast cancer
- Possible infections
- Heavy bleeding
- Surgical removal of the uterus
- Noncancerous uterine conditions

HEART DISEASE

- Heart bypass

GENERAL

- Coaching on healthy lifestyle changes
- Treatment options
- Finding community resources
- Understanding and reviewing health plan information

A Registered Nurse in Your Corner



Did you know you can call our Customer Service department and ask to speak with a Registered Nurse? We are here to help guide you with your health care needs, understand your benefits and help you take better care of yourself and your family.

We understand health care can be confusing. That's why we are here to support you and provide another resource in addition to your primary care physician. By helping you navigate the health care system and get organized, we can make your health care experience less overwhelming.

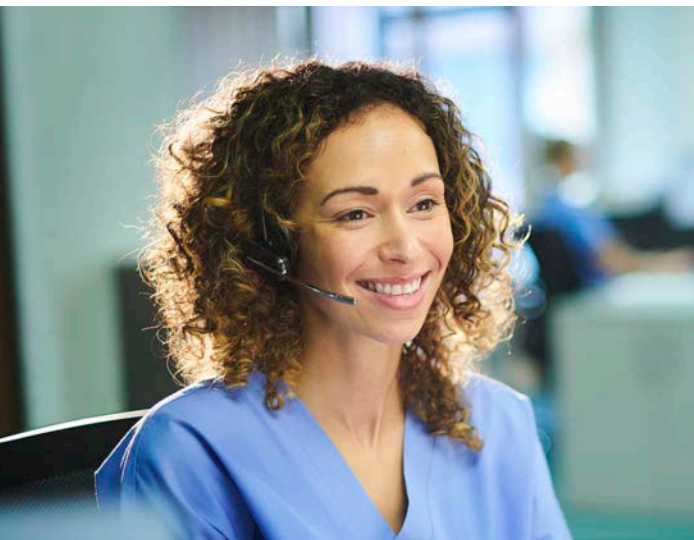
What Can You Call About?

- **If you have recently been diagnosed with a condition or illness:**
Registered Nurses are available to serve as a resource for information and help manage your condition.
- **If you have an upcoming procedure:**
We can help you understand what to expect so that you are prepared.
- **If you had a hospitalization:**
A Registered Nurse is available to provide guidance and support to assist you in navigating the complex health care system to reduce your risk of complications and optimize your recovery after discharge.
- **If you are taking a new medication:**
Our team works with you to understand your medications, side effects and possible interactions.
- **If you are managing an illness or multiple conditions:**
Our Registered Nurses can help coordinate your care and help answer your questions.

Guidance and Education

Our Registered Nurses are available to provide education on these topics, and more:

- Asthma
- Cancer
- Chronic Back Pain
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Disease
- High Blood Pressure
- Multiple Sclerosis
- Rheumatoid Arthritis
- Stroke



How Nova Can Help

With the support and guidance from our team, we can help you:

- Outline your strengths and develop strategies to help you achieve your desired outcomes.
- Set short- and long-term goals to help you manage your health.
- Create action plans and help you keep track of your progress.

Questions About Your Benefits?

Call the Customer Service number on your ID card, Monday – Friday, and ask to speak with one of our nurses today.



Find a Provider or Facility



Nova's online Find a Provider tool is designed to assist you in finding an in-network doctor, hospital, pharmacy, urgent care or other service. You will increase your opportunity for savings on services by visiting a participating hospital or physician in your network.

How to Search Online

1

Visit www.novahealthcare.com and click the **Members** button located in the top-right corner of the screen.

2

On the next page, select **Find a Provider**. Then select the type of provider you are searching for by navigating between the **Medical, Vision, Dental, and Prescription Providers** tabs.

3

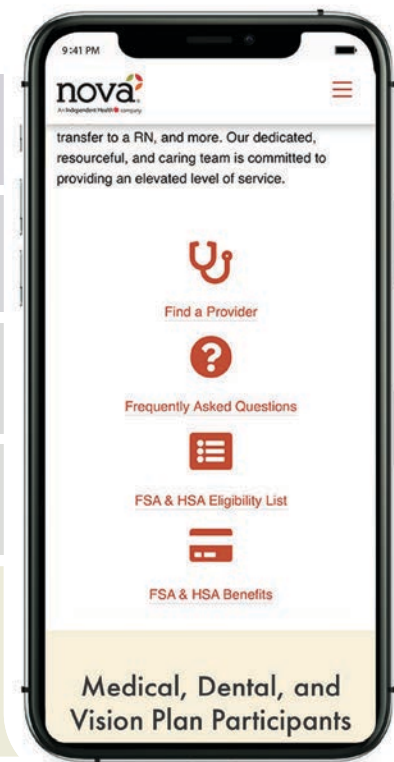
Select your provider network by **matching the logo found on your ID card** to the list of networks that appear on the webpage.

4

Upon selecting one of the directory links, you will be able to find **participating providers and/or facilities**.

5

Additionally, you may contact the network directly using the toll-free number listed with each directory link on this page to speak to a representative from their customer service department to verify participating providers.



Book Your Appointment

Online provider directories are updated regularly. It is your responsibility to confirm your providers' continued participation in the network and accessibility under your benefit plan. Please be sure to follow any preauthorization or precertification procedures required by your plan.

Questions?

Call the Customer Service phone number found on your ID card.

Information at Your Finger Tips

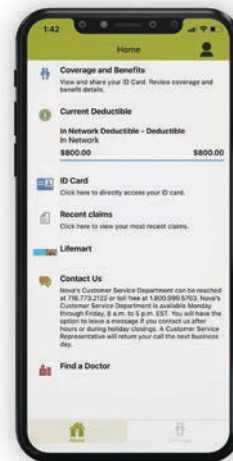
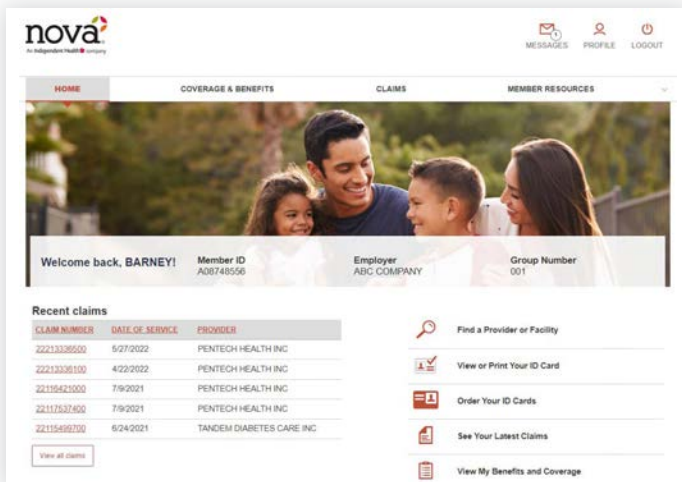
Nova offers a variety of tools and information designed to empower you to increase your health awareness, reduce your personal health risks and get the most from your benefits.

Consumer Information Center

Nova's secure online Consumer Information Center offers immediate access to individual coverage, plan and claims information. You can view your benefit structure, access recent claims, order an ID card, find a provider, search a collection of information on a variety of wellness topics, enroll in LifeMart for discounts on health and wellness products and contact Customer Service.

Register Today!

1. Visit novahealthcare.com and click **Member** in the top-right corner of the page.
2. Click on the **Log In** button for Medical Plan Participants then click **Create account** to get started.



MyNova App

The MyNova App lets you take your benefits with you wherever you go. With MyNova you can access plan details, review recent claims, find a provider, shop LifeMart discounts and view the front and back of your ID card. You can even email your card information right to your provider.

User Information

Only members with benefits administered by Nova can log in and use the app. Your personal information cannot be accessed without your username and password. You must register on the Consumer Information Center before using MyNova.

MyNova App

With the MyNova App, we're putting the benefit information you need right at your fingertips! We're helping you put tools and resources in your pocket, so you have everything you need whenever you need it.

Through the app you'll find:

My ID Card

View the front and back of your ID card whenever you need to, with the option to email your card information directly to your provider's office.

Show Your ID Card to Providers

On the landing page there is an option to view your ID card, without logging in, helping users save time and access information more conveniently.

My Benefits

Reference a quick snapshot of your benefits.

My Claims

See your most recent claims and get a detailed view of each one.

Claim Forms

Medical, dental, vision, and super bills can be submitted through the app. Snap a picture and submit a claim right from your mobile device!

LifeMart

Access a wide variety of health and wellness discounts, and much more!

News and Views

Up-to-date and easy-to-read deductible and out-of-pocket information.

Download the MyNova App Today!

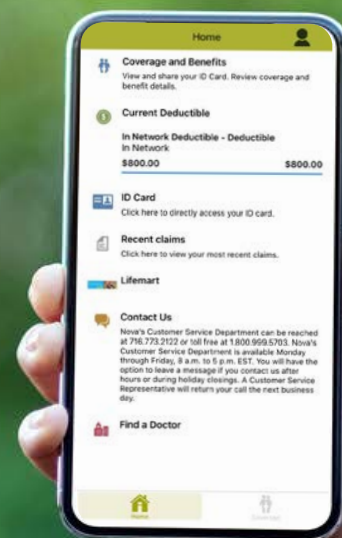
User Information

Only members with benefits administered by Nova can log in and use the app. Your personal information cannot be accessed without your username and password. First, register through the Consumer Information Center online and download the app on any iOS or Android device.

Get Started With MyNova in Minutes.

Download the MyNova App for your chosen device from the Apple App Store or Google Play and log in using the password you use to access the MyNova Consumer Information Center.

Questions? Just contact the Nova Customer Service team using the phone number on your ID card.



How to Read Your Explanation Of Benefits



An Explanation of Benefits (EOB) provides you with an overview of how recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts you may owe to the provider(s) of service. An EOB is not a bill, but you can use it to make sure any bill you do receive from the provider(s) is accurate.

To help you better understand, we included a sample EOB that further breaks down each section.

 Nova Healthcare Administrators, Inc.
PO BOX 408
BUFFALO NY 14231-0408

Forwarding Service Requested

TAMARA R. SAMPLE
123 MAIN ST
ANYWHERE NY 12345

Explanation of Benefits

KEEP THIS STATEMENT FOR YOUR RECORDS

THIS IS NOT A BILL

Customer Service

If you have any questions, please call
Nova Healthcare Administrators, Inc.
an Independent Health company at
1-844-235-1391
or visit us online at www.novahealthcare.com

Group Name: ABC Company
Group #: ###-###
Employee: TAMARA R. SAMPLE
Member #: A99999999
Date: 8/11/2021

Claim #: 9999999999
 Patient: TAMARA R. SAMPLE

Provider: ACME HEALTH

Patient Acct: #####

1 Dates of Service	2 Service Code	3 Procedure Code	4 Total Charge	5 Ineligible Amount	6 Reason Code	7 Discount Amount	8 Covered By Plan	9 Deductible Amount	10 Co-pay Amount	11 Balance Amount	12 Paid At	13 Payment Amount
08/03-08/03/2021	201	99213	\$90.00	\$0.00		\$0.00	\$72.00	\$0.00	\$0.00	\$72.00	80%	\$72.00
08/03-08/03/2021	250	99386	\$180.00	\$0.00	NW	\$5.46	\$174.54	\$0.00	\$0.00	\$174.54	100%	\$174.54
08/03-08/03/2021	558	93000	\$30.00	\$0.00	NW	\$14.16	\$15.84	\$0.00	\$0.00	\$15.84	100%	\$15.84
08/03-08/03/2021	550	36415	\$5.00	\$0.00	NW	\$1.51	\$3.49	\$0.00	\$0.00	\$3.49	100%	\$3.49
08/03-08/03/2021	RDT	96160	\$5.00	\$0.00	NW	\$2.08	\$2.92	\$0.00	\$0.00	\$2.92	100%	\$2.92
Column Totals			\$310.00	\$0.00		\$23.21	\$268.79	\$0.00	\$0.00	\$268.79		\$268.79
Patient's Responsibility: 9 \$18.00										10 Other Credits or Adjustments		11 \$0.00
										Total Net Payment		\$268.79

12 Service Code / Description	13 Reason Code / Description
201 OFFICE VISIT	NW MEDICAL NETWORK DISCOUNT
250 ROUTINE PHYSICAL EXAM	
558 DIAGNOSTIC TESTING	
550 LABORATORY OP	
RDT ROUTINE DIAG TESTING	

Accumulators	Payment Details
\$400.00 of \$400.00 of the Individual Deductible has been met for 2021	Paid To
\$478.96 of \$2500.00 of the Individual Out-of-Pocket has been met for 2021	Check No.
\$400.00 of \$800.00 of the Family Deductible has been met for 2021	ACME Health
\$478.96 of \$5000.00 of the Family Out-of-Pocket has been met for 2021	Amount
	#####
	\$268.79

Definition of terms on your Explanation of Benefits (EOB)

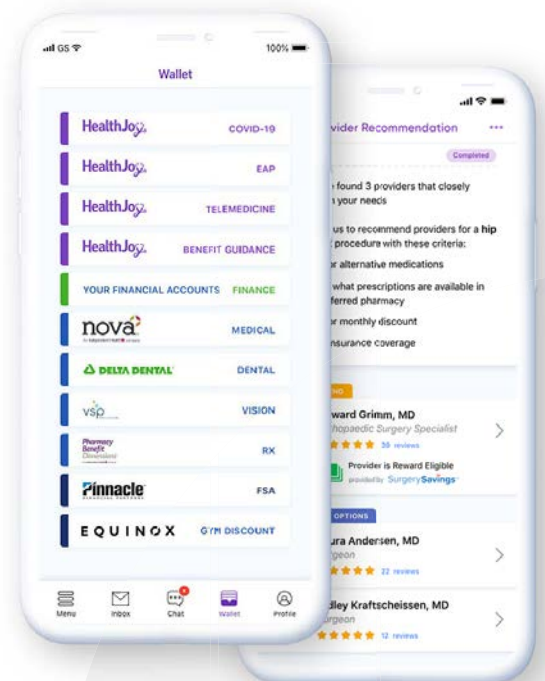
- Dates of Service** – The actual date/or timeframe when you received medical services.
- Total Charge** – The actual amount charged by the provider.
- Ineligible Amount** – Any portion of the submitted charges that are not covered by your benefit plan. Your provider may bill you for these charges.
- Reason Code** – Used to call your attention to a specific message about the service charged. (See #13.)
- Discount Amount** – The amount of a claim determined to be neither the responsibility of the plan nor the member. Most often this is the difference between the provider's billed charge and the contracted or discounted rate ("Network allowed amount").
- Deductible Amount** – The initial out-of-pocket amount you are responsible for when receiving covered services. Once you reach your deductible amount, co-pay and/or coinsurance may apply. (Note: The amount remaining until you meet your plan year annual deductible is determined as of the date(s) claims are processed by Nova, not the date that services were provided.)
- Co-pay Amount** – The amount you are responsible for paying the provider once you meet your plan year annual deductible amount.
- Payment Amount** – The amount paid by your plan to your physician or provider.
- Patient's Responsibility** – The amount you owe this provider for services rendered. (Note: This is not a bill; your provider will send you a bill if you owe anything.)
- Other Credits or Adjustments** – Amount paid by another insurance carrier. Only applies if patient has health coverage in addition to this plan.
- Total Net Payment** – The total amount paid by your plan for all the services incurred for each claim.
- Service Code Description** – The type of service(s) you received.
- Reason Code** – Specific message about the service charged.



Benefits are Complicated. HealthJoy Makes it Simple

HealthJoy is the first stop for all your healthcare and employee benefits needs. We're provided for free by your employer and personalized for you. You'll have instant access to an up-to-date benefits wallet with all your benefits cards and our healthcare concierge is always available to help you.

You can use the HealthJoy app throughout the year to identify prescription savings, request a review of your medical bills for errors, and chat with our concierge team about upcoming procedures and services. We'll save you time, money, and a ton of aggravation.



Core Platform



Benefits
Wallet



Healthcare
Concierge



RX Saving
Review



Appointment
Booking



Provider
Recommendations



Broadcaster



Medical
Bill Review



Virtual Care Suite

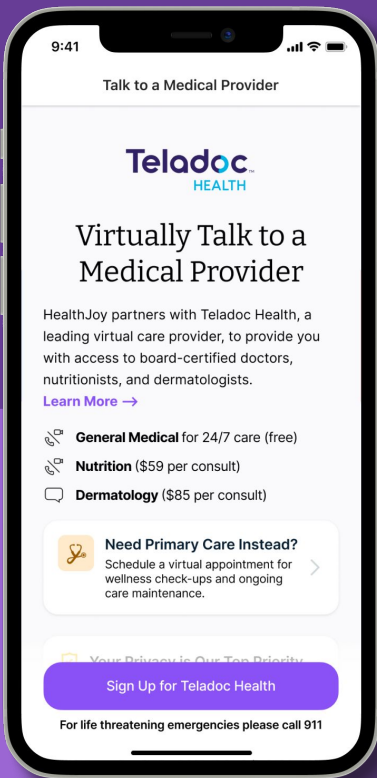
Included:

- Virtual Exercise Therapy
- General Medical

Additional Cost (provided upon request)

- Primary Care
- Chronic Care
- Mental Health
- Employee Assistance Program (EAP)

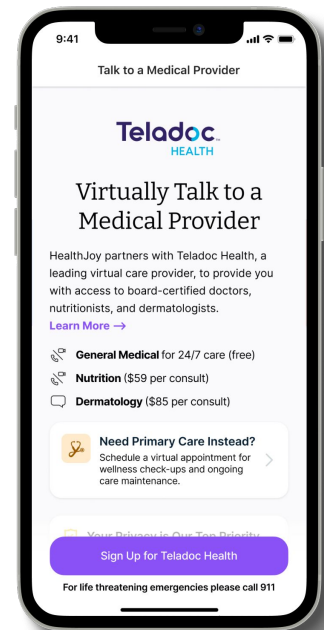




General Medical

General Medical

General Medical provides critical care 24/7 for non-emergency conditions like cold and flu, sinus infections, and allergies, as well as care for specialty needs such as dermatology and nutrition consultations.



Request an on-demand visit or schedule a visit at your preferred time

Secure a telemedicine visit available in several language options via interpreter, including American Sign Language (ASL)



Connect with U.S. board-certified physicians with an average of 20 years' experience

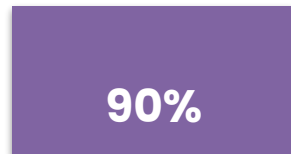
Avoid trips to the doctor's office and costly visits to the emergency room

General Medical

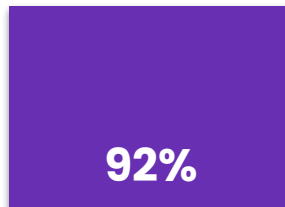
How It Works

- Access the service through the HealthJoy home screen and quickly connect with a licensed care provider via phone or video for a broad range of everyday healthcare issues, from cold and flu to a rash or sunburn, as well as dermatology and nutrition consultations
- Request an on-demand visit or schedule a visit at your preferred time. Receive a diagnosis as well as treatment, and prescriptions when necessary
- Receive a visit summary to your file and send a prescription to your local pharmacy if necessary

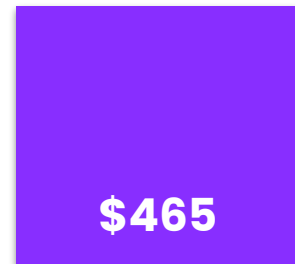
Outcomes



**Member
satisfaction**



**Resolution rate on
first visits**



**Average claims
savings per visit**

With five kids at home you can imagine the amount of time spent at doctors' offices as they spread the flu to each other. I can set up an appointment and never leave home. This service is a lifesaver."

- Misty, General Medical User



General Medical FAQs

When should I use General Medical services?

You should choose General Medical any time you want to talk to a doctor in minutes about non-emergency health issues like sinus problems, respiratory infections, allergies, flu symptoms, rashes and many other illnesses. Doctors are available 24/7 within the HealthJoy app. Your doctor will diagnose your symptoms and provide a treatment plan, which may or may not include a prescription.

Can Teladoc Health handle emergency situations?

You should not use Teladoc Health if you are experiencing a medical or mental health emergency. In the event of a medical emergency, please call 911.

Will I talk with a real doctor?

The providers in our General Medical care offering are board-certified internists, family doctors, psychiatrists, dermatologists and pediatricians licensed to practice medicine in the U.S. When you request a visit, Teladoc Health will connect you with a doctor licensed in your state or province.

All providers can diagnose, treat and prescribe medications for common, non-emergency health issues by phone or video.

Does the doctor review my medical history before a visit?

You will complete a brief medical history prior to requesting your first visit. This is similar to filling out forms before an in-person doctor visit. You can update your medical history at any time within the HealthJoy app.

Your medical history is stored on Teladoc Health's HIPAA-compliant, encrypted central server. Before each visit, the doctor will review your medical history with a specific focus on chronic illnesses, current medications, allergies and changes in your medical condition.

Can I request a specific doctor?

Depending on the plan your employer is on, you may be able to select a specific doctor for your visit. All Teladoc Health doctors are board-certified, and state licensed. To become an official Teladoc Health doctor, they go through a credentialing process. All Teladoc Health doctors are thoroughly trained on how to provide the best virtual care experience.

Your Pharmacy Benefits



Welcome to Pharmacy Benefit Dimensions®!

Dear Valued Member:

Pharmacy Benefit Dimensions is a national pharmacy benefit administrator managing benefits for over 400,000 members. Our members enjoy access to more than 64,000 pharmacies across the country, including major pharmacy chains so you will be covered no matter where you work, live or travel.

Pharmacy Benefit Dimensions is pleased to be serving your pharmacy needs. We have worked closely with your employer to create a pharmacy benefit designed to meet your needs now and in the future. Our promise to you is that we will do everything we can to ensure you are getting the most of your prescription drug benefit. Please keep in mind that your prescription drug benefit is unique and plan options may vary.

This handbook is intended to provide basic information to help get you started. If you have questions about your prescription drug benefit, please call Pharmacy Benefit Dimensions Member Services Department, Monday through Friday between 8 a.m. and 11 p.m. ET at (716) 635-7880 or toll free at 1-888-878-9172. TTY/TDD users may call 711. For urgent requests outside normal business hours, an on-call representative is available.

Again, welcome to Pharmacy Benefit Dimensions.

Sincerely,



Lynne Reilly,
President

About Pharmacy Benefit Dimensions

Pharmacy Benefit Dimensions (PBD) stands alone from typical pharmacy managers because we give you more.

As a wholly owned subsidiary of Independent Health, Pharmacy Benefit Dimensions has been helping customers and members gain greater control over their prescription drug benefits since 1998. Our years of expertise managing over 400,000 insured lives provides us a greater understanding over clinical and economic decisions that influence your pharmacy benefits.

PBD is focused on you. Every one of our members gets the same commitment to service excellence – from helping a member with questions about their benefits to collaborating with pharmacists at the point of sale, we cover all the details.

As a member, you can log in online to view claims history, view the prescription drug formulary, look up your drug copayment for a specific medication or just pick up the phone and call us with a question about your pharmacy benefit.

Your Prescription Drug Formulary

Pharmacy Benefit Dimensions has worked to develop a list of prescription drugs to ensure that you and your family receive the best pharmaceutical care and service to meet your needs.

A drug formulary is simply an approved list of the most appropriate and cost-effective medications from which providers prescribe. Certain drugs on the formulary may have restrictions that require your provider to submit a "Prior Authorization form." Your provider will already have a supply of these, but one is included in this booklet as well. The provider simply faxes this request to Pharmacy Benefit Dimensions where it will be reviewed. A response is provided within 24 hours for urgent requests and generally in 3-5 business days for standard requests.

Please refer to your employer's Summary Plan Description for specific tier placement of drugs (tier placement may vary by plan), copayment/coinsurance information and other details regarding your specific pharmacy drug benefit. For a complete formulary listing, visit our website at www.pbdrx.com.

Drug Formulary Facts:

- Generic drugs appear in lowercase. Brand name drugs are capitalized.
- Preferred generic drugs and a few select brand name drugs are assigned to Tier 1. In most instances, once a generic product is available for which there are no bioequivalence concerns, the brand product is removed from the formulary (not covered), and the generic product is assigned to Tier 1. Certain generic drugs may also be covered in a non-preferred tier when efficacy, safety, or cost factors suggest that better alternatives exist on the formulary.
- Pharmacy Benefit Dimensions reserves the right to modify drug tiers as necessary.
- Some medications are considered non-formulary (not covered). To obtain a medication that is non-formulary, your health care provider is encouraged to submit a Prior Authorization request for coverage through the exception process. If the request is approved, you will be responsible for the cost share associated with a nonpreferred drug tier.
- Certain self-funded employer groups may not follow this base formulary and certain exclusions may apply. Members in these pharmacy benefit management groups should refer to their summary plan description and/or their benefit administrator.
- Some drugs in the formulary are listed with a two-letter indicator which applies to that specific drug. Below is our Drug Formulary Key:

AL – Age Limit
DF – Dental Formulary
LA – Limited Access
MO – 90-day supply

PA – Prior Authorization Required
QL – Quantity Limits Apply
SP – Specialty Medication
ST – Step Therapy

For a complete formulary listing, visit our website at www.pbdrx.com. For specific questions about your prescription drug coverage, please call Member Services at (716) 635-7880 or 1-888-878-9172, Monday – Friday between 8 a.m. and 11 p.m. ET. TTY/TDD users may call 711.

Prescription Drug Benefit Summary

The following section provides a description of all the various benefit components of your prescription drug plan. Not all drugs and/or edits listed are covered by all pharmacy benefit programs. Tier placement may vary by plan.

Copayments: In most cases you will be required to pay for some portion of the prescriptions you need. Note: there may be changes, exclusions and/or prior authorizations in the prescription drug formulary unique for your plan that impacts your copayment.

If you would like a printed copy of your drug formulary or if you have any questions, please call Member Services, Monday through Friday between 8 a.m. and 11 p.m. ET at (716) 635-7880 or 1-888-878-9172. TTY users may call 711.

Exclusions: Certain prescription drugs are excluded from your formulary based on your plan (e.g., drugs used solely for cosmetic purposes). An exception request may be submitted by your physician for such drugs for a determination of medical necessity. PBD will facilitate a coverage determination with authorized representatives for the plan.

For details on medically necessary exceptions please call Member Services at (716) 635-7880 or toll free at 1-888-878-9172, Monday through Friday between 8 a.m. and 11 p.m. ET. TTY users may call 711.

Prior Authorizations: Some prescription drugs may require pre-approval before your prescription can be filled. These medications are noted in your formulary. Your provider will need to send a Prior Authorization Request form to PBD for review. Your provider may already have a supply of these forms, but one is included in this member kit as well. The provider simply faxes this request to PBD where it will be reviewed. Typical response times for urgent requests are within 24 hours and within 3-5 business days for standard requests. If additional information is required from your provider to make a coverage determination – such as lab work, prior therapy, etc. – additional time to decide may be necessary.

Age Restriction: Some prescription drugs are restricted by age due to safety reasons or Food and Drug Administration (FDA) recommended labeling.

Step Therapy: Step therapy is a way to help you get the best quality and value from your prescription drug benefit. This usually means that an equally effective generic drug is prescribed before a more expensive brand name drug. Step therapy may also ensure that two medications are used together if they are more effective.

Quantity Limits: Quantity limits may apply to certain medications. Some medications are covered up to a specific quantity per 30 or 90 days. Some examples of medications with a quantity limitation are: sumatriptan (generic Imitrex®) and zolpidem tartrate (generic Ambien®).

Maximum Daily Dose (MDD): Certain drugs are dose limited by a maximum daily dose (MDD) as recommended by the Food and Drug Administration (FDA) for safety reasons. Limits may be set by the number of tablets/capsules per day or the total daily dose.

Mail Order

Mail order is a cost-effective and convenient way to receive maintenance medications. Please follow the instructions below to enroll in a mail order program today.

Please note: PBD offers two (2) mail order vendor options - Wegmans or ProAct. Regardless of which option you choose for mail order, please be advised you will need to contact your physician and request a three-month prescription.

Wegmans Mail Order

Members can enroll through three easy methods:

1) By PHONE (1-888-205-8573 or TTY/TDD: 1-877-409-8711)

- a. Members can call Wegmans Member Services to speak with a representative to enroll in mail order. Members should have their ID cards available to do so.

2) Provider sends a prescription to Wegmans mail order

- a. When members want to start using mail order – they can direct their provider to send the prescription to Wegmans mail order.
 - I. If the member is already enrolled, Wegmans will process the prescription and send out as necessary.
 - II. If the member is NOT enrolled, a representative from Wegmans will call the member once the prescription is received to get the member's information to enroll in mail order.

3) ONLINE at www.wegmans.com/pharmacy

- a. After enrolling by phone, members can go online to create a web account
 - I. A prescription number is not required to create an account.
 - II. To manage/order your prescriptions, you must first link a Wegmans prescription number to your web account. You can do this by using a prescription shipped by Wegmans, or by calling Wegmans Mail Order Pharmacy.

Providers can submit prescriptions to Wegmans mail order:

- 1) ELECTRONICALLY: Providers can e-scribe to Wegmans RX Home Shipping #199, 2873 Broadway, Suite 100, Cheektowaga, NY 14227
- 2) By FAX: Providers can fax prescriptions to 1-866-242-7239.
This is a secure fax that is only used for prescriptions.
- 3) By PHONE: Providers can call the customer service numbers listed below and be transferred to the automated prescription line.

Wegmans Member Services: 1-888-205-8573 or TTY/TDD: 1-877-409-8711

ProAct Mail Order

Members can enroll through two easy methods:

1) By PHONE

a. Members can call ProAct Member Services to speak with a representative and advise they would like to set up a mail order account. Members will need their Member ID card to do so.

I. Once an account is set up, they can go to the website www.proactpharmacyservicespbd.com and refill a script using the Quick Rx Refill option.

2) Enrollment into ProAct's mail order program cannot be completed online; however, if a ProAct mail order account is already established, members can go online at www.proactpharmacyservicespbd.com to order refills from the Quick Rx Refill option.

Please note: Members will not be able to login to view claims, credit card info, shipping info, etc. Members can reach out to ProAct's member services team to get that additional information at any time.

Providers can submit prescriptions to ProAct mail order:

1) ELECTRONICALLY: Providers can e-scribe to ProAct. They may need to search for the pharmacy by address: 1226 U.S Highway 11 Gouverneur, NY 13642.

2) By FAX: Providers can fax prescriptions to 315-287-3330. This is a secure fax that is only used for prescriptions.

3) By PHONE: Providers can call the customer service numbers listed below and be transferred to the automated prescription line.

Please note: If the medication is a controlled substance, it can only be sent in via mail to the address above or electronically.

ProAct Member Services: 1-888-425-3301, 1-877-635-9545 or TTY/TDD users can call 711.

If you have questions about your coverage and benefits, please call Pharmacy Benefit Dimensions Member Services Department at (716) 635-7880 or 1-888-878-9172, Monday through Friday from 8 a.m. to 11 p.m. ET. TTY/TDD users may call 711.

Prescription Drug Plan Frequently Asked Questions

Am I able to get any prescription medication that I want as long as I have a prescription?

Pharmacy Benefit Dimensions has developed a list of covered prescription drugs (prescription drug formulary) to ensure that you and your family receive the best pharmaceutical care and service to meet your needs. Prescriptions must be filled in accordance with the prescription drug formulary. To obtain a copy of the formulary, please visit our website at www.pbdrx.com, or contact Member Services to have a copy sent to you.

Who determines what drugs are included on the formulary?

Independent Health's Pharmacy and Therapeutics Committee which is comprised of practicing Providers and practicing pharmacists meets quarterly to develop and maintain the most effective formulary for Pharmacy Benefit Dimensions.

Why use a formulary?

Use of a drug formulary ensures that health care dollars are used wisely. The cost of each drug on the formulary is balanced with its effectiveness, which means that drugs are not included on the formulary just because they are inexpensive – effectiveness is more important than the price of the drug. If a drug is not capable of achieving the desired effect, then the price of treating an illness or condition increases because other therapies must be used. Likewise, there are expensive medications that have not been proven to be more effective than less costly alternatives. Plan participants benefit when their Providers use the formulary because all drugs included are selected due to their effectiveness and safety.

What if I am taking a prescription medication now and it is not listed on formulary?

Because there are thousands of drugs available in the market, not all drugs can be listed on the formulary. Most drugs that are not listed may be obtained, and you will be responsible for your copayment amount based on the tier the drug is in on the formulary. Some drugs require that your Provider obtain prior authorization before the prescription is filled. If your current medications are not listed on the formulary, please contact Member Services to see if your medications can be obtained.

How can I be sure that my Provider prescribes drugs on the formulary that will be the least costly to me but be consistent with the Providers proposed therapy?

If your Provider is recommending a prescription drug as part of your treatment, please ask them to review the Pharmacy Benefit Dimensions formulary and prescribe a medication that will be the best clinically and the most cost effective for you.

What should I do if I get to the pharmacy and my claim is rejected?

Please have the pharmacist contact our Pharmacy Help Desk at 1-800-993-9898. Our Pharmacy Help Desk is open Monday through Sunday from 7 a.m. to 11 p.m. ET. Most often these problems can be resolved while you are at the pharmacy. If the problem is not resolved at the pharmacy, please call Member Services.

Have questions about your benefits? Contact Pharmacy Benefit Dimensions Member Services Department at (716) 635-7880 or 1-888-878-9172, Monday through Friday between the hours of 8 a.m. and 11 p.m. ET. TTY/TDD users may call 711.

Pharmacy Claim Form

This form is for members with prescription drug coverage through Pharmacy Benefit Dimensions. Use this claim form to submit prescription drug receipts to Pharmacy Benefit Dimensions for reimbursement. **A separate claim form and itemized bill must be submitted for each patient/member for services rendered.**

Please complete questions 1-4 on this claim form. Sign, date and return this form to Pharmacy Benefit Dimensions along with your itemized prescription drug receipt (not your cash register receipt) from your pharmacy. Mail to:

**Pharmacy Benefit Dimensions
Attn: Pharmacy Department
P.O. Box 1642
Buffalo, NY 14231**

PHARMACY RECEIPTS MUST INCLUDE:

- Pharmacy Name
- Name of the doctor who ordered the prescription
- Name and quantity of drug dispensed
- Member paid expense
- Date prescription was dispensed

Claim(s) will be returned if the member/subscriber's signature is not present.

If you have any questions or need additional copies of this form, please call our Member Services Department at (716) 635-7880 or toll free at 1-888-878-9172. TTY users should call 711. Service hours are Monday – Friday between the hours of 8 a.m. and 11 p.m. ET.

1. PATIENT'S NAME (Last Name, First Name, MI)

2. PHONE NUMBER

3. PATIENT'S MEMBER ID NUMBER (11 Digits)

4. DATE OF BIRTH

_____/_____/____

Coordination of Benefits

If your primary insurance has already paid for the attached prescription, please complete this section.

Primary Health Plan/Insurance Company Name

(please turn to page 2)

Primary Member/Subscriber's Name (Last Name, First Name, MI)

Primary Member/Subscriber's ID

I certify that the patient for whom this claim is made is a covered person in this prescription drug program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

X _____ MEMBER'S NAME _____ DATE

REQUEST FOR A NON-FORMULARY PRIOR AUTHORIZED DRUG EXCEPTION OR STEP THERAPY

Member Name: _____

DOB: _____

Member ID number: _____

Date: _____

Diagnosis: (ICD-10) _____ Is this an appeal to a previously denied request? YES or NO

(A separate request must be completed for each patient for whom the following drug is prescribed. This form does not constitute a request for addition of this drug to the drug formulary.)

Drug Requested: _____

****Required: Dose Prescribed, Dosage Form, Frequency, Quantity, and Duration of Therapy:**

Reason(s) Drug is Requested: _____

Other Formulary Drugs Tried, and Results of Treatment:

I understand the above drug may not be on the current *Pharmacy Benefit Dimensions Formulary*. Further, I understand that if this request is not approved, the patient will be responsible for paying the entire cost of the medication if it is prescribed.

Requestor Signature _____ Date: _____ NPI Number: _____

Print Name: _____ FAX #: _____ Phone Number: _____

Contact Person (if additional information is necessary) _____

Approval does not guarantee payment; Approval is subject to the terms of the member's contract.

For questions regarding non-formulary/prior authorization requests or if the treating physician would like to discuss this case with a physician reviewer, please call the Pharmacy Department at (716) 631-2934 or 1-800-247-1466 between 8 a.m. and 6 p.m. ET, Monday – Friday.

If you disagree with this decision you have the right to file an expedited or standard appeal by contacting the Pharmacy Department at (716) 631-2934 or 1-800-247-1466. The member may also appeal to member services at:

**Pharmacy Benefit Dimensions
(716) 635-7880 or (888) 878-9172**

Form may be mailed to:
Pharmacy Benefit Dimensions
Attn: Pharmacy Department
PO 1642
Buffalo, NY 14231

Or faxed to:
(716) 250-7139 or 1-800-273-7397

Fax: _____
Phone: _____
Mail: _____

Confirmation to MD (Date/Time):

This is a CONFIDENTIAL transmission, as it may contain information which is privileged and protected from disclosure by laws of confidentiality. The transmission is intended for the designated addressee only. If you are not the intended recipient, please contact us immediately, and REFRAIN FROM DISCLOSING OR USING THE ENCLOSED INFORMATION IN ANY WAY. Failure to comply with this direction may result in a claim that you have violated the law and are liable for money damages. Thank you for your attention to this message.

Authorization to Disclose Protected Health Information (PHI)

Under Federal and State privacy laws, Nova Healthcare Administrators, Inc., Independent Health and/or Pharmacy Benefit Dimensions, LLC (individually or collectively herein "Company") is authorized to use or disclose your health information for payment, treatment and health care operations and as required by law. For uses and disclosures other than these purposes, your written authorization is required before sharing your health information. This includes sharing your health information with your spouse, relatives, employer, etc. This form allows you to authorize the Company to use or disclose your health information including HIV-related information to those individuals or entities you specify.

Please read before completing this form

- Incomplete authorizations will be considered invalid and will not be accepted. Incomplete authorizations will be returned. **An asterisk (*) is used to denote the required fields in this form.**
- Completion of this authorization form is voluntary. You may refuse to sign this form, but then Company will not be able to release your information.
- A copy of this authorization will be available to you, but you should retain a copy for your records.
- Signing or not signing this form will not affect any payment, enrollment or eligibility for benefit decisions made by Company.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described in this authorization may be disclosed to other individuals or institutions and no longer protected by these regulations.
- You may revoke this authorization in writing at any time by sending a letter to the address listed below. Your revocation notice will not apply to actions taken by the requesting person/entity prior to the date we received your written request to revoke this authorization.

Send completed and signed authorization to:

Nova Healthcare Administrators
P.O. Box 408
Buffalo, NY 14231
Fax: (716) 250-7193
memberservice@novahealthcare.com

**If you need assistance completing this form, please contact Nova
using the number listed on your ID card or email
memberservice@novahealthcare.com.**

Authorization to Disclose Protected Health Information (PHI)

Section A: Member Information*		
Name*:	Date of Birth*: / /	Member ID*: _____ - _____

Section B: Authorized Individuals* (at least one individual is required)			
Please list the individuals and/or entities that you are authorizing to view or receive your health information. If more space is required to list individuals or entities, please attach an additional page.			
1.	Name*:	Relationship*:	Telephone Number*: ()
2.	Name:	Relationship:	Telephone Number: ()
3.	Name:	Relationship:	Telephone Number: ()

Section C: Information That Can Be Released (Select C-1 or C-2 and if applicable, C-3)*							
If more space is needed to describe the information that can be released, please attach an additional page.							
<input type="checkbox"/>	<p>C-1: I would like you to disclose any of my health information requested by the individuals and/or entities named in Section B. This does <u>not</u> include information in Part C-3 (below) unless I have placed my initials next to the condition. If I do not place my initials in C-3, information related to those conditions will not be disclosed.</p> <p style="text-align: center;">- OR -</p>						
<input type="checkbox"/>	<p>C-2: Only the following specific health information (such as claims submitted by a specific provider or information related to one of the protected diagnoses listed below):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p style="text-align: center;">- AND, IF APPLICABLE -</p>						
<p>C-3: Unless specifically initialed below, I understand my health information will <u>not</u> be disclosed related to the following conditions. By placing my initials next to one or more of these conditions, I am authorizing Company to disclose information related to the condition(s) (see page 4 for additional information):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">_____ Alcohol and/or Substance Abuse</td> <td style="width: 50%;">_____ HIV-Related</td> </tr> <tr> <td>_____ Pregnancy/Reproductive</td> <td>_____ Mental Health</td> </tr> <tr> <td>_____ Sexually Transmitted Diseases</td> <td>_____ Genetic Testing</td> </tr> </table>		_____ Alcohol and/or Substance Abuse	_____ HIV-Related	_____ Pregnancy/Reproductive	_____ Mental Health	_____ Sexually Transmitted Diseases	_____ Genetic Testing
_____ Alcohol and/or Substance Abuse	_____ HIV-Related						
_____ Pregnancy/Reproductive	_____ Mental Health						
_____ Sexually Transmitted Diseases	_____ Genetic Testing						

Section D: Purpose and Time Period

Unless noted below, the authorized parties in Section B can obtain your health information upon their request and from the start date of your plan coverage.

- Purpose: _____
- Time Period: Only release health information concerning dates of service from *(insert date)* _____ to *(insert date)* _____.

Section E: Expiration

This authorization will automatically expire one (1) year after termination of your enrollment, upon your death, in the case of a minor, when the named minor reaches the age of eighteen (18) years, or if Company receives a letter from you revoking this authorization.

For dates or events not described in the preceding paragraph, you may specify an expiration date or event for this authorization below:

This authorization will expire:

- On the following date *(insert date)*: _____
- On the following event: *(please specify)* _____

Section F: Personal Representative Information

Complete this section if you are a personal representative that is acting on behalf of a member. You must include a copy of one of the following documents as proof of your legal representation and authority:

- Valid health care proxy
- Certificate of guardianship issued by a Court of appropriate jurisdiction
- Surrogate decision maker appointed pursuant to Family Health Care Decisions Act (FHCDA)

If the member is deceased, please submit a copy of one of the following:

- Letters of Administration or Letters Testamentary

Name:	Relationship:	Telephone Number: ()
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Section G: Signature/Date*

Please read the following carefully before you sign, and refer to page 4 for additional information.

By signing this form, I understand the following: (1) if the entity authorized to receive my health information is not a health plan, health care provider or other covered entity as described by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the released information may no longer be protected by federal privacy laws, rules and regulations; (2) the information disclosed will only include mental health, alcohol and substance abuse, HIV-related information, sexually transmitted disease, pregnancy and reproductive and/or genetic testing information if I specifically direct Company to release that information; (3) I am not required to sign this form, but if I do not sign this form, it will not be considered valid, it will be returned to me and no information will be released by Company; (4) I may revoke this authorization at any time by notifying Company in writing; (5) if I do revoke this authorization, my revocation will have no effect on any actions Company took according to this authorization before Company received my revocation; and (6) it is my choice whether I sign this form and signing or not signing this authorization will not affect any payment, enrollment, or eligibility for benefit decisions made by Company.

- By checking this box, this form replaces any HIPAA authorization forms previously sent to Company.

I sign this authorization under penalty of perjury and attest that the information contained in this authorization is true and correct and may be relied upon by Company.

_____ **Date:** _____

Signature of Member or Personal Representative

Sensitive Information

- **Alcohol and Substance Abuse Information**

By initialing the appropriate box on this form, alcohol and substance abuse information can be provided to the individuals listed by you on this form. If information is disclosed from alcohol or substance abuse records protected by federal confidentiality rules (42 CFR Part 2), these rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by these rules.

- **HIV-Related Information**

By initialing the appropriate box on this form, HIV-related information can be provided to the individuals listed by you on this form. HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

For example, under New York state law, HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; authorized agencies involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; special court order; attorney assigned to represent a minor or by an executor or administrator of an estate (Public Health Law §2782). Under state law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

- **Pregnancy and Reproductive Information**

By initialing the appropriate box on this form, information relating to pregnancy and reproductive health can be provided to the individuals listed by you on this form. Information regarding pregnancy and reproductive health cannot be disclosed, even to a parent or guardian of a minor patient, without the specific authorization of the patient (Public Health Law §17).

- **Mental Health Information**

By initialing the appropriate box on this form, mental health information can be provided to the individuals listed by you on this form. Mental health information, including a patient's clinical records and information can be released, with your consent or the consent of someone authorized to act on your behalf, to those authorized agencies listed by you on this form who have a demonstrable need for such information provided such disclosure will not reasonably be expected to be detrimental to you or others (Mental Hygiene §33.13).

- **Sexually Transmitted Diseases**

By initialing the appropriate box on this form, information regarding sexually transmitted disease can be provided to the individuals listed by you on this form. Parents may access most of their child's medical records until the child turns 18, with the exception of information relating to the diagnosis and treatment of sexually transmitted disease (Public Health Law §17). Such information cannot be released to any party, including the child's parent or guardian, without the child's specific authorization.

- **Genetic Testing**

By initialing the appropriate box on this form, genetic testing information can be provided to the individuals listed by you on this form. Genetic testing information includes any information relating to laboratory tests of human DNA, chromosomes, genes or gene products to diagnose a predisposition to a genetic disease of disability in the individual or offspring (Civil Rights Law §79-l). Genetic testing information shall not be released without your specific consent with the exception of information released to a health insurer or health maintenance organization for the purpose of claims administration.

Instructions for Completion of Authorization to Disclose Protected Health Information (PHI)

Section A: Enter your name, date of birth, and your member ID number including your suffix

Section B: List the name, relationship, and telephone number for the individuals and/or entities that you are authorizing to view or receive your health information.

Section C: Choose either Box C-1 OR box C-2 AND initial C-3 if applicable.

- **Box C-1:** Select this box to permit all of your health information to be disclosed. Please note, checking this box alone does NOT include the sensitive conditions listed in C-3, which you must separately initial in C-3.
- **Box C-2:** Select this box to limit the health information that you wish to be disclosed. You should write in the specific information you are authorizing to be disclosed and be as detailed as possible. Please note, checking this box alone does NOT include the sensitive conditions listed in C-3, which you must separately initial in C-3 or manually write in here.
- **Box C-3:** If you wish for any of these sensitive conditions to be disclosed, you must initial them individually here.

Section D: You may leave this section blank to default to the purpose and time period rules as indicated on the form, or you may specify a different purpose and/or time period.

- **Purpose:** The circumstances in which you are authorizing the information to be disclosed. For instance, you may choose to list a narrow purpose such as litigation or claim payment resolution. If left blank, your representatives may obtain your information upon their request.
- **Time Period:** The scope of the information to be released. For instance, you may choose to list a specific time frame such as 1/01/2021-12/31/2021. If left blank, your representatives may obtain your information from the start date of your plan coverage.

Section E: This form will expire automatically upon the events noted on the form, but you may specify additional dates or events that would trigger the form to expire, such as upon your death or listing a specific date.

Section F: If you are a personal representative that is acting on behalf of a member in signing this authorization, please check which authority you hold and include a copy of the relevant document(s) as proof of your legal representation and authority. Please list your name and telephone number as well as relationship to the member.

Section G: Please sign and date the form in this section, whether you are filling it out for yourself or on behalf of the member. As a reminder, if you are signing on behalf of the member, please include a copy of the relevant document(s) as proof of your legal representation and authority. If you wish this form to replace previous HIPAA Authorization forms on file with Company, please check the box in this section.

No Surprises Act

Sections 102, 104, & 105

What is the No Surprises Act?	
<p>The No Surprises Act (NSA) establishes new protections and industry guidance against surprise medical bills and other services, beginning on or after January 1, 2022. The following provisions are currently effective:</p>	
<p>Surprise Medical Bills</p>	<p>Also known as balance bills, arise when care is received by an out-of-network (OON) provider (hospital, doctors, etc.), when emergent or out-of-control (ground ambulance transportation does not apply).</p>
<p>The No Surprises Act — Sections 102 & 104: Applicable Services</p>	<p>Any emergent service or services rendered by an OON provider which are performed at an in-network (IN) facility (such as an anesthesiologist or attending physician) will not be subject to surprise billing. These services will be covered at the IN cost-sharing and apply toward any applicable IN deductible and out-of-pocket maximum.</p> <p>Example situation: You schedule a routine colonoscopy at an IN facility. For the procedure, you see an OON anesthesiologist. The anesthesiologist cannot balance bill the difference between billed-charges and the plan/member cost-sharing.</p> <p style="text-align: center;">**See the below exception to this rule**</p>
<p>Are OON Providers Still Permitted to Balance Bill?</p>	<p>Yes! Providers must give members advanced notice that services are OON and obtain consent. If the member gives consent, the OON provider may balance bill. Services will be covered at the OON cost-sharing and apply toward any applicable OON deductible and out-of-pocket maximum.</p> <p>The advance notice must include an estimate of charges at least 72 hours prior to services (if non-emergent) or immediately upon notice of a service.</p> <p>Using the Example Situation from above: If the OON anesthesiologist provided you with advanced notice and you provided consent, you could be subject to balance billing. Consent should accompany the claim and a copy should be kept for your records.</p> <p>If you decline, the colonoscopy may be cancelled or delayed until an IN anesthesiologist can be scheduled.</p>
Air Ambulance	
<p>The No Surprises Act — Section 105: Air Ambulance Services</p>	<p>Members are held harmless from surprise air ambulance bills and will only be required to pay the IN cost-sharing. Providers are barred from balance billing.</p> <p>Advanced notice and consent will not apply.</p>

No Surprises Act

Section 113: Continuity of Care

What is Continuity of Care?	
<p>Continuity of care occurs when a member is undergoing treatment for a serious or complex condition (for example, cancer, pregnancy, terminal illness, scheduled non-elective surgery) and their provider is no longer in-network (IN). This can occur if:</p> <ul style="list-style-type: none">• the provider terminates with the plan’s current network; or• the plan begins accessing a new provider network	
How Long Can A Member Continue to Receive Care?	<p>The member may continue to utilize services through their (now) out-of-network (OON) provider for up to 90 days. The 90-day clock starts upon the “event” date — either provider termination or new plan effective date when member’s network changes.</p> <p>Claims should continue to be processed as IN.</p>
What Happens After the 90 Days?	<p>The member will need to find a new IN provider.</p> <p>After 90 days, if the member chooses to see the OON provider, the member will be responsible for the OON cost-sharing and may be balance billed the difference.</p>
How to Notify Nova of a Potential Continuity of Care Situation	<p>A Continuity of Care Form (found in the Knowledge Center: Member Resources tab on www.novahealthcare.com) must be completed by you and your provider, to identify a potential Continuity of Care situation. Once both pages are completed, the form should be sent to Nova for review, as indicated on the bottom of the form.</p>
What if the Member Has Not Been Seen Recently?	<p>If the member moves from one network to another and hasn’t visited their (now) OON provider within 90 days, those visits will be processed as OON, the plan’s applicable OON cost-sharing will apply, and the member may be balance-billed.</p>

Questions: If you have any questions or if you believe you are receiving care for a serious or complex condition and your provider is now considered OON, please email UMRequests@novahealthcare.com with the subject “No Surprises Act Continuity of Care” or call Nova’s Customer Service number on your ID card.



No Surprises Act Continuity of Care Form

Please clearly PRINT all information

Options to return this two-page form
 Mail: Nova Healthcare Administrators
 PO Box 1543, Buffalo, NY 14231
 Fax: (716) 250-7170, Attn: Medical Management
 Email: UMRequests@novahealthcare.com,
 Subject: No Surprises Act Continuity of Care

THIS SECTION TO BE COMPLETED BY MEMBER

1	Name:	Member ID number:	Date of birth:
2	Address:	City:	State/ZIP:
3	Home phone:	Cell phone:	Work phone:
4	Employer name:	Employer plan enrollment:	
5	Member's relationship to employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	Is the member currently covered by other health insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, carrier name:	
6	Previous health insurance company and plan name:	Date coverage ended:	Was previous health plan still offered? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical condition for which you are completing this application: (complete one form for each condition/provider)			
7	<input type="checkbox"/> I am pregnant or am receiving post-partum care. <input type="checkbox"/> I am receiving outpatient care on a long-term basis for conditions such as, but not limited to, cancer or dialysis. <input type="checkbox"/> I am receiving home care or hospice services. <input type="checkbox"/> I am seeing a physician regularly (once per month) to actively manage a condition that is not stable. <input type="checkbox"/> I am a transplant candidate or recipient in need of ongoing care due to complications associated with the transplant. <input type="checkbox"/> I have an upcoming (non-elective) surgery scheduled and authorized. <input type="checkbox"/> I am being treated inpatient (hospital, skilled nursing, or rehabilitation facility). <input type="checkbox"/> I have durable medical equipment (DME) in the home (such as oxygen, wheelchair, etc.) paid for by my medical plan. <input type="checkbox"/> Other		
8	Condition, services, or treatment receiving, or type of DME:		
9	Physician, surgeon, or OB/GYN	Name:	Address: Phone:
10	Hospital, agency, facility, or DME supplier	Name:	Address: Phone:
11	Date of surgery, transplant, admission, or delivery (if applicable):		
Member certification and authorization to release records: I certify that all statements on this and all accompanying documents are true, correct, and complete to the best of my knowledge and belief. I authorize all physicians and other health care professionals, facilities, or medical service providers to provide Nova Healthcare Administrators, Inc., or its agents or employees, all information concerning medical care, advice, treatment or supplies for the member names above. This information will be used to determine the member's eligibility for the No Surprises Act - Continuity of Care benefits under the plan. I also authorize Nova Healthcare Administrators, Inc. to leave confidential information on my voicemail at the number(s) listed above. Please indicate all that apply: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Do NOT leave confidential information on my voicemail.			
Printed name of person responding:			
Member's signature/parent or guardian's signature if member is a minor:			Date of signature:

Continuity of Care/Transition of Care Application

THIS SECTION TO BE COMPLETED BY HEALTHCARE PROVIDER

12	Name:	National Provider Identifier (NPI) or TIN:	Phone:
13	Address:	City:	State/ZIP:
14	Hospital name:		Hospital phone number:
15	Date of last appointment:	Date of next appointment:	Frequency of visits:
16	Diagnosis:	Expected length of treatment:	If maternity: Expected date of delivery:
17	Is the treatment for an exacerbation of a previous injury or chronic condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have a terminal condition? <input type="checkbox"/> Yes <input type="checkbox"/> No ICD-10:		
18	Current treatments and comments (include all relevant CPT codes) associated with condition on this application: Please attach: Initial consult report from the treating provider(s), current treatment plan, and last three progress notes.		
19	What is the current in-network rate you receive for these services?		
The above-named patient is a Nova Healthcare Administrators, Inc. member. We understand you are not, or soon will not be, a participating provider under the member's Network. The member has asked that for a defined period of time, we treat claims for the condition defined on Page 1 as In-Network under the member's benefit plan for the covered services you provide as a non-participating provider. This is because of a qualifying condition. If we approve this request, you agree (1) to provide the covered service for the defined period of time, including any follow-up care covered under the member's plan, and (2) if applicable, the terms and condition of your participation will continue to apply to the covered service, including any follow-up care covered under the member's plan. Please note the following: <ul style="list-style-type: none"> If applicable, payment under your participation agreement, together with any copayment or deductible for which the member is responsible under the plan, is payment in full for the covered service and you will not seek to recover, and will not accept any payment from, the member, Nova Healthcare Administrators, Inc., or any payer or anyone acting on their behalf, in excess of payment in full, regardless of whether such amount is less than your billed or customary charge. Upon request and approval of the patient, you will share information regarding the member's treatment with Nova Healthcare Administrators, Inc. If applicable, you will make referrals for services including laboratory services to network providers in accordance with the terms of your participation agreement. For any questions on providers within network, please contact Provider Services on your patient's ID card. 			
Signature of Health Care Professional:			Date of signature:

Return this 2-page form through one of the following:

Mail	Email	Fax
Nova Healthcare Administrators, Inc. Attn: Medical Management Department PO Box 1543 Buffalo NY 14231	UMRequests@novahealthcare.com Subject: No Surprises Act Continuity of Care Application	716-250-7170 Attn: Medical Management Department

CONFIDENTIALITY NOTICE:

This information you have received may contain protected and privileged, highly confidential medical information, Personal and Health Information (PHI), and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate, or otherwise distribute it. If you have received this information in error, please notify the sender immediately and confidentially destroy the information that was sent in error.

