Nova Pathfinder Ltd

myNOVAHEALTHCARE

Summary of Benefits and Coverage

ABOUT US

Nova Pathfinder HealthCare's name translates as "New Beginnings in Healthcare." At Nova, we believe that every individual should have the ability to make their own healthcare decisions. Nova is a forward-thinking movement of health-conscious professionals committed to reclaiming and revolutionizing the healthcare system. With cutting-edge healthcare solutions, we aim to empower you to take control of your health and wellness. Our resolve to eliminate barriers that have historically held individuals back distinguishes us from other healthcare organizations.

We provide the conventional coverage you've come to expect and rely on, along with the option to access previously unapproved natural wellness services. Our open network allows you to select your own physician. Enrollment is available 365 days a year, so you can join whenever you want. Additionally, our innovative and adaptable plan includes an allowance for therapies such as vitamins and oils, health and wellbeing, physical therapy, and chiropractic care. You will not find

Our mission is to deliver the highest possible standard of care using the most effective healing approaches. Nova accomplishes this by broadening the scope of treatment and service offerings beyond the limited modalities covered by a standard health insurance policy.

OPEN ENROLLMENT

Do you worry that you will miss the open enrollment window? Nova Pathfinder Healthcare has done away with open enrollment periods. Our open enrollment policy means you can sign up for health insurance coverage at any time of the year.

With our open enrollment, you will never have to worry about:

- Missing Open Enrollment
- Losing your prior health coverage
- The hassle of short-term coverage plans

From the time you receive your quote, you could be covered in as little as two weeks. It is important to make sure you are protected, because you can be fined if you don't have health insurance. Penalties for not having health insurance, might go as high as $695 per individual or $2,100 per family. We believe that everyone deserves health insurance regardless of when they need it.

EASY ENROLLMENT ON YOUR SCHEDULE

Whether you believe you are paying too much for your health insurance of that you do not have adequate coverage for the services you require, you do not have to wait until an open enrollment period to make a change with Nova Pathfinder Healthcare. You can enroll at any moment or switch from a current plan if you feel you are paying too much for your health insurance. We are here to assist you.

WHAT HAPPENS IF I MISSED OPEN ENROLLMENT?

Individuals who missed open enrollment in the past have been forced to wait until the next enrollment period to receive benefits. When you don't have health insurance, even something as common as a cold or asthma might seem terrifying. It can be stressful to not know when, how, or if you will be able to afford the care you require. You can get coverage with Nova in as little as two weeks.

SHORT-TERM INSURANCE PLANS ARE NOT THE SOLUTION

For those who miss the open enrollment period, several healthcare facilities are pushing former patients into short-term health care plans. While short-term contracts are good for the entire year, they aren't always enough to protect you from unforeseen circumstances. Additionally, there are no limits on out-of-pocket maximums and pre-existing conditions are not covered. Short-term plans are just that, short term. They are not a good option for people who may need ongoing, extensive treatment. Remember that medical emergencies, surgeries and accidents can cost you thousands of dollars when you least expect them even if you are a healthy individual who doesn't visit the doctor all that often. For those who miss open enrollment, there is still a way to get health insurance. For your peace of mind, Nova Pathfinder HealthCare offers a 365-day registration period

HOLISTIC, ALTERNATIVE, AND CONVENTIONAL HEALTH CARE COVERAGE

Traditional treatment can be combined with holistic, naturopathic, homeopathic, and herbal therapies to provide more comprehensive wellness pathways for our members. Supplements and essential oils, medical marijuana, and holistic dental treatments are also covered by Nova. Yes, you can continue to utilize your current provider and receive the same care!

A FLEXIBLE HEALTHCARE PLAN

With Nova, you have the freedom to make your own healthcare decisions while still enjoying security and peace of mind. We're unique in that we offer a wide range of traditional and alternative healthcare alternatives that you won't find anyplace else. You make the decisions about how you manage your healthcare, so you can rest confident that no matter what life throws at you, you'll be protected.

Nova Healthcare is committed to offering a valuable and affordable plan to our members. In order to deliver the greatest healthcare plan and the best customer service, we work closely with our members. We think that by making holistic solutions more accessible, we can help you improve your overall health and give you the freedom to choose the best option for all your healthcare requirements.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

WHAT IS A HIGH DEDUCTIBLE PLAN?

Standard Coverage and Benefits, such as dental and vision, are included in our High Deductible Health Plan, as well as allowances that support Holistic/Naturopathic options to match your and your family's needs. Your plan also includes Virtual Doctor visits, an Online Member Portal, a Member Referral Program, and the option to use a Health Savings Account (HSA).

HOW IT WORKS

An HDHP can save you money in the form of lower premiums and the tax break you can get on your medical expenses through a Health Savings Account (HSA). **See below in Health Savings Accounts for more information.*

COVERAGE LIMITS

Deductible	$5000 Single $10,000 Couple/Family
HSA (Health Savings Account)	Available Yes
Annual Wellness Exam Covered	$300 per individual per year is covered toward an Annual Wellness Visit. Your yearly wellness visits will cover basic labs and screenings for preventive care (must be coded as preventative care) and reimbursed up to the $300 benefit amount. (You may be able to use a Chiropractor for your Annual Wellness Visit.) Any amount over the $300 benefit and any diagnostic testing will be applied to the Member's deductible. *Members must be active on the plan for three months to qualify.
Open Preferred Provider Network	Yes
Holistic and Naturopathic Providers	Yes
24/7 General Medicine Teladoc Membership	As a member, you have access to “Healthiest You” by Teledoc, providing 24/7 Telehealth services anywhere in the United States, any time you need it. *Please note that while Teladoc is provided as part of your membership, you must opt-in for the benefit. You may opt-in at any time during your membership. We encourage you to do this as soon as you sign up.
Traditional/Biological Dental Care	$1,000 per individual per year is covered toward Dental Care. Any cost after the benefit of $1000 is the Member's responsibility. *Members must be active on the plan for three months to qualify.
Vision Coverage	Our members receive up to $350, per individual, per year, toward Vision Care. Any cost after the benefit of $350 is the Member's responsibility. *Members must be active on the plan for three months to qualify.

Wellness Treatments & Services:	$2,000.00 Single* $4,000.00 Couple/Family* Acupuncture, Massage Therapy, Naturopathic, Homeopathy, Supplements & Essentials Oils*
Chiropractor	12 visits or $1,200.00 per person on policy
Physical Therapy	12 visits or $2,200.00 per person on policy
Gym Memberships and Health Clubs	Our members are eligible to be reimbursed for an annual gym membership and select health clubs, up to $200 maximum for an Individual plan, $300 for an Individual+1 $400 maximum for a Family Plan. Please remit your gym membership invoice for your annual reimbursement. You can only submit your receipts once a year to be reimbursed up to your maximum yearly benefit, regardless of the membership's annual cost. *Please note that your invoice must be a verifiable statement or receipt from the facility.
Personal Care Advocate	Yes
Membership Advisor	Yes

* See reimbursement policy on how to submit requests for reimbursement and product type restrictions.

MONTHLY RATES & FEES

Nova Pathfinder HealthCare member benefits start with a one-time membership and enrollment fee of $250 for each plan. The enrollment fee for Group Plans will be $350. Our enrollment fees are tax-deductible. **See the table below for our monthly rates.*

More than Traditional Healthcare, current health, habits, age, and your selected plan (Individual/Individual+1 or Economic Family Unit) will ultimately determine your monthly cost. The following prices are estimates; your exact cost will be determined following the completion of a standard health questionnaire.

Ages	Individual	Individuals +1 (Economic Unit, or Partners)	*Family (Economic Unit, or Partners)
Up to 34 Years Old	$ 280.50 - $ 428.22	$ 460.70 - $ 668.11	$ 681.70 - $ 919.45
Ages 35 - 44	$ 432.51 - $ 479.65	$ 674.79 - $ 748.34	$ 928.64 - $1015.64
Ages 45 - 54	$ 491.22 - $ 612.32	$ 766.40 - $ 955.33	$1040.16 - $1296.57
Ages 55 - 64	$ 630.69 - $ 797.43	$ 983.99 - $1244.14	$1322.50 - $1596.42
65 and up for Non-MediCare Clients	$ 897.43 - $2,347.43	$1334.14 - $2,794.14	$1696.42 - $4,146.42

Non-Medicare subscribers are usually subscribers who cannot qualify for Medicare. (NMQ)
*Family coverage includes up to 4 individuals; the rate is increased by $280 per additional dependent per month after that. Take care of your health by taking full advantage of your holistic coverage plan with Nova Pathfinder.

WHAT IS INCLUDED?

ACA ESSENTIAL HEALTH BENEFITS

The Affordable Care Act (ACA) requires that all Essential Health Benefits (EHB) be covered to ensure that everyone in the individual and small group health insurance markets has access to the same comprehensive coverage that includes the services they need. The Nova Pathfinder HealthCare plan meets all these requirements.

THE NOVA PATHFINDER ESSENTIAL HEALTH EHB COVERAGES INCLUDE:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness visits and chronic disease management
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)

WE ALSO INCLUDE THE FOLLOWING COVERAGE:

- Birth control coverage

- Breastfeeding coverage

ADDITIONAL COVERED SERVICES AS BENEFITS:

- Dental coverage
- Vision coverage
- Gym Membership Reimbursement

DOES MY PLAN COVER A COVID-19 TEST OR VACCINE?

Nova Pathfinder does NOT cover the cost of COVID tests. COVID tests are free, as the Federal Government Emergency fund covers them.

IF YOU ARE EXPERIENCING SYMPTOMS AND WANT TO GET TESTED
You can get a free test; there are free testing sites near you. Check your local city website for information on locations by searching "Free Covid tests near me" in any search engine.

***THE MOST COMMON SYMPTOMS OF COVID-19 INCLUDE:**

- Fever
- Dry cough
- Tiredness

LESS COMMON SYMPTOMS:

- Aches and pains
- Sore throat
- Diarrhea
- Conjunctivitis

- Headache
- Loss of taste or smell, a rash on the skin, or discoloration of fingers or toes

SERIOUS SYMPTOMS:

- Difficulty breathing or shortness of breath
- Chest pain or pressure
- Loss of speech of movement

WHAT IF I'M NOT EXPERIENCING SYMPTOMS BUT STILL WANT TO GET A TEST?

There are many reasons you might want a test if you are asymptomatic. For example, you may want to get tested if you have been in contact with someone who has been exposed or tested positive or if you are going to be traveling. **Please Note**: If you are traveling or need a rapid test, there may be a cost associated with this test. However, we do not cover these tests as they are optional to you and not medically necessary.

WHEN TO GET A COVID-19 TEST:
Testing is currently recommended if you:

- If you have symptoms of COVID-19.
- Because of a contact tracing or outbreak investigation, your County Department requested a test from Public Health.
- You were in "close contact" with someone who has COVID-19 in the past two weeks.
- If you work- or live-in places such as skilled nursing facilities, group homes, residential care facilities, correctional facilities, or homeless shelters.
- If you are a person experiencing homelessness.
- If you are an essential worker with frequent contacts with the public in the following areas: health care, emergency, food and grocery services, factory workers in food and retail, public transportation, and education.
- If you don't have symptoms but believe you may be infected now because you were exposed to sick people, were around many people who were not wearing face coverings, and/or were not keeping a safe distance in the past two weeks.

IS DRIVE-THRU TESTING A SAFE OPTION FOR TESTING?

While there is still much, we don't know about the coronavirus, we know for sure that the virus is highly contagious. When you wait to have a test administered in a hospital or clinic, there is the possibility that you could be exposed to the virus. The idea behind drive-thru testing is simple. Keeping potentially sick individuals in their cars while administering tests outdoors drastically reduces the risk of spreading the infection to otherwise healthy individuals.

HOW LONG DOES IT TAKE TO GET RESULTS FROM DRIVE-THRU TESTING?

Most sites administering drive-thru testing only collect specimens for testing. The healthcare workers collect samples from you with a nasal or throat swab in a process that takes less than five minutes. Your samples will be sent to a laboratory for testing and getting the results back could take up to a week. Rapid testing is becoming more available, and you may be able to find drive-thru testing sites in your area that can provide results in as little as 15 minutes. Check with your state's health department to find out which locations in your area offer rapid testing.

HOW DO I PROTECT MYSELF FROM COVID-19?

Covid most commonly spreads between people in close contact through respiratory droplets or small particles produced when an infected person coughs, talks, or breathes. According to the CDC, growing evidence shows that droplets can remain suspended in the air and travel distances beyond six feet. Indoor environments with poor ventilation increase the risk of transmission.

TO PREVENT INFECTION AND TO SLOW TRANSMISSION OF COVID-19, DO THE FOLLOWING:

- Wash your hands regularly with soap and water or clean them with an alcohol-based hand rub.
- Cover your mouth and nose with a mask when in public settings or around others.
- Maintain at least six feet distance between you and people coughing or sneezing.
- Avoid touching your face.
- Cover your mouth and nose when coughing or sneezing.
- Stay home if you feel unwell.
- Refrain from smoking and other activities that weaken the lungs.
- Practice physical distancing by avoiding unnecessary travel and staying away from large groups of people.

AS VACCINES ARE NOW WIDELY AVAILABLE, IT IS IMPORTANT TO KEEP TAKING STEPS TO SLOW THE SPREAD OF COVID-19.

- Limit gatherings with others.

- Practice social distancing.
- Wash your hands frequently.
- Wear a mask in public.

NOW THAT THE COVID-19 VACCINE IS AVAILABLE TO YOU, HERE'S WHAT YOU SHOULD KNOW:

- Nova Pathfinder does not cover the cost of the COVD-19 Vaccine. The government will cover the cost of the Vaccine itself.
- Please use local resources and the internet to find out how and where to find the Vaccine in your area.
- You will need two doses of the COVID-19 Vaccine for it to be effective. When you receive your first dose, make sure to schedule your second dose.
- There will be no cost to you for the Vaccine itself, as the Federal Government Emergency fund covers it. Watch out for providers that may charge other fees within their office. Your insurance does not cover these fees, so arrange this before you visit your provider so they will not be charging you.

Visit CDC.gov for additional trustworthy information on the COVID-19 vaccines.

ALLOWANCES, BENEFITS, COVERAGE – THE ABC'S

Did you know that Allowances, Benefits, and Coverage all have different meanings? Let's look at them one by one.

ALLOWANCES

Allowances apply to any approved Wellness Treatment or Service. When referring to "Allowances," as they apply to your health insurance policy, we are talking about approved treatments and services that will count towards your deductible. The intent of Allowances is to incentivize you to utilize healthy, proactive, and preventive services such as chiropractic care, massage therapy, and more. Allowances can also help you meet your deductible by allowing you to use preventative and wellness services that you already use.

APPROVED WELLNESS TREATMENTS & SERVICES INCLUDE:

- Acupuncture
- Massage Therapy
- Chiropractic Care
- Naturopathic Care

- Holistic Care
- Homeopathic Services
- Physical Therapy
- Hearing Tests & Hearing Aids
- Supplements & Essential Oils, including Cannabis

BENEFITS

Benefits refer to "non-medically necessary" treatments or services also offered in the Nova HealthCare Plan. Benefits included are Dental, Vision, Wellness Visits, Gym Memberships, which are reimbursable up to the limits. **See Health & Wellness Treatments and Services for details*. Other notable benefits are the Member Referral Program, Personal Care Advocates, Open Enrollment, and our Open Network.

COVERAGE

Coverage refers to any healthcare services that a physician would provide to you, the patient. The service must evaluate, diagnose, or treat an illness, injury, disease, or its symptoms. Coverage is not intended to pay for elective, preventive, or Wellness Treatments & Services. Instead, your Coverage provides a safeguard against financial disaster should a significant health crisis arise. As stated above, the Nova Pathfinder Plan Coverage includes all (EHB's) Essential Health Benefits
**See above in ACA Essential Health Benefits for a list of EHB's*

HEALTH AND WELLNESS TREATMENTS AND SERVICES

Because we care strongly about providing you with solutions to improve your health and well-being naturally, Nova Pathfinder offers Holistic/Naturopathic healthcare allowances as well as traditional coverage alternatives to its members. Acupuncture, Massage Therapy, Chiropractic Care, Naturopathic and Homeopathy, Physical Therapy, Gym Membership, and authorized Supplements & Essential Oils are all available under our plan. These are products and services that our members value greatly. Because many of our members already use these services, applying these costs to their deductible makes sense, allowing them to satisfy their deductible sooner.

Why join an alternative healthcare plan, and what does that mean?

Do you consider yourself to be a bit of a rebel? Consider this alternative health plan in the same light. Nova Pathfinder does not conform; instead, we think outside the box to provide you with more options and flexibility than traditional insurance. It's not easy to get health insurance that covers everything you need at a reasonable price. Most health insurance companies will tell you that you're out of luck if you miss open enrollment, so you'd better hope you don't get hurt or sick in the meantime. This flawed approach, which is used by most health insurance carriers, is unacceptable. Nova Pathfinder is an alternative insurance plan that could be exactly what you're looking for.

How it works:

Nova Pathfinder is here to assist you in discovering natural pathways to well-being. Keep and submit your receipts for products, and wellness services like vitamins, essential oils, chiropractic care, massage therapy, and acupuncture. These receipts must be sent to the Claims department, where they will be applied as an allowance to your annual deductible. Money spent on these kinds of health and wellness services will count toward your deductible.. You will be reimbursed for future wellness checkups and supplements up to the maximum benefit amount once your deductible has been satisfied. All receipts for health and wellness services, including visits and purchases of supplements, essential oils, and other similar items, must be provided within 30 days after the service or purchase. It is your responsibility to ensure that the receipts have been received. By emailing claims@mynovahealthcare.org, you can obtain confirmation. Please keep in mind that you will not be reimbursed for services in this category until your deductible has been reached. * Please read "Coverage Limits" for the maximum benefit limits. These can be used in combination with any of the services listed in the limits section below.

Health and Wellness Treatments and Services: Acupuncture, Massage Therapy, Physical Therapy, Chiropractic Care, Naturopathic Care, Holistic Care, Homeopathic Services, Hearing Tests & Aids, Supplements & Essential Oils, Reimbursement for Gym Membership Fees, Wellness Visits, Dental, and Vision.

Health and Wellness Limits

- $ 2000.00 max benefit for Individual
- $ 4000.00 max benefit for Individual +1
- $ 4000.00 max benefit for Family

What's Included in Health & Wellness Services and Treatments?

Acupuncture: This service can be combined with any other Service in the wellness treatments & services benefit package until the maximum limit has been met. If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the total amount.

Massage Therapy: This service can be combined with any other service in the wellness treatments & services benefit package until the maximum limit has been met. If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the total amount.

Primary Care Annual Wellness Visit

Members are reimbursed up to $150 for two yearly visits, starting after three months of membership, up to $150.00 for each visit or one combined visit for a total of $300 annually. Any additional cost over the $300 is applied toward the deductible and paid by Member.

Chiropractor Annual Wellness Visit

If your Chiropractor is your Primary Care Provider and performs an Annual Wellness Exam, you can substitute these services to be included in your basic coverage, and not as an allowance. You are covered for Annual Wellness Exams up to $300 per individual per year. $150 for two yearly visits, starting after three months of membership, up to $150.00 for each visit or one combined visit for a total of $300 annually. See Coverage Limits for details.

Chiropractic Care: 12 visits or $2000 per person on the policy. Any health and wellness service or product can be combined with any Service in the Health and Wellness Treatments & Services benefit package *until the maximum limit has been met*.

$100 per three visits are covered starting after three months of membership up to $100 for each visit or one combined visit for a total of $300 annually. Additional costs over the $300 area are applied toward the deductible and paid by the Member.

Your chiropractic provider can refer you to see a specialist, including holistic/naturopathic providers with a referral. If the specialist needs to provide additional services, those services will require pre-authorization.

If your provider includes holistic/naturopathic providers, their orders and referrals may consist of "over-the-counter" supplements and essential oils may be covered as an allowed benefit if the wellness treatments and services guidelines are followed for coverage limits.

You can use your wellness treatments and services benefits to see your Chiropractor without a Pre-authorization. However, it is suggested that you speak with the Nova Benefit Claims department. They can help you combine visit limits per injury and your Health & Wellness Treatments & Services to increase visit limits.

If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the total amount.

Naturopathic Providers: If your provider includes other holistic/naturopathic providers, their orders and referrals may include "over-the-counter" supplements and essential oils. These may be covered as an allowed benefit if the wellness treatments & services guidelines are followed for coverage limits.

This service can be combined with any other service in the Health & Wellness Treatments & Services benefit package until the maximum limit has been met. If the reimbursement for submitting receipts is not followed, the Member might be responsible for paying the total amount.

Holistic Providers: If your provider includes holistic/naturopathic providers, their orders and referrals may include "over-the-counter" supplements and essential oils. These may be covered as an allowed benefit if the wellness treatments & services guidelines are followed for coverage limits.

This service can be combined with any other service in the Health & Wellness Treatments & Services benefit package until the maximum limit has been met. If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the total amount.

Homeopathy Providers: This service can be combined with any other service in the Health & Wellness Treatments & Services benefit package until the maximum limit has been met. If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the total amount.

Hearing Tests & Aids: This service can be combined with any other service in the Health & Wellness Treatments & Services benefit package until the maximum limit has been met. If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the total amount.

Supplements & Essential Oils: This service can be combined with any other service in the wellness treatments & services benefit package until the maximum limit has been met.

These are the plan limitations for this benefit category:

- Each month, not more than (3) three bottles of a 30-day supply of supplements from an approved supplements manufacturer.
- No more than (2) two bottles of essential oils per month per person
- Exceptions can be considered with a Pre-authorization

**It is important to note that not all supplements and essential oils are equal, nor will all of them be accepted. The supplements purchased should contain a USP dietary supplement verification program seal or mark. We have two approved manufacturers to purchase from as they follow good manufacturing practices (CGMPs) for essential oils. dōTERRA Essential Oils and or Young Living Essential Oils. Some essential oils will be considered one bottle per plan due to the nature of the oil. Please contact benefits to review a specific essential oil. The Member will need to follow all reimbursement guidelines posted on our website to ensure the cost is credited to the deductible or, if the deductible is met, reimbursed directly to the Member.*

What are essential oils?

Essential oils are concentrated compounds from plants that have a unique scent and flavor. Throughout history, essential oils have been used for medicinal, ritual, and beauty purposes. Recently they have come back as an alternative form of medicine because of their versatility and innocuous nature.

Examples of the Health Benefits of Essential Oils

- *Trouble Sleeping:* Do you have a hard time sleeping? Essential oils can support healthy relaxation. Lavender and chamomile are two essential oils that can create a sense of calm in the body. By putting these oils on your chest and feet before you go to bed, you can help the body slow down and fall asleep faster.
- *Relaxation:* Along with supporting sleep, lavender can aid in relaxation during the day. When feeling tense, put a drop of lavender under your nose or on your chest. Stop, be present and focus on your breath as you inhale.
- *Stay Focused and Motivated:* Are you feeling a drop in your energy levels? Essential oils can also help with that. For a natural boost, reach essential oils with citrus or peppermint instead of that caffeine or a fourth cup of coffee.
- *Reduce Inflammation:* Not only can essential oils help with your mood, but they can also help your body physically. Many essential oils are anti-inflammatory can support healthy muscle function by soothing sore muscles and diminishing blemishes.

Nova Pathfinder Encourages the use of Essential Oils

Nova Pathfinder HealthCare believes that combining both alternative and traditional medicine gets the best result. That's why purchasing essential oils is approved in our health care plan. Please speak with your Personal Care Advocate to find out more about our Essential Oil Policy and Allowances.

Extra Benefits and Additions Reimbursable to the Member *(*Up to the limits before the deductible has been met.*)

Vision & Routine Eye Care

As a part of our Health and Wellness care, we have added Vision and Eye Care benefits; this includes adult/child screenings and eye refraction for vision correction purposes. Your Vision benefits start 90 days (three months) after your initial enrollment date. As a member, you will receive up to $350, per individual, per year, toward Vision Care. Any cost after the limit of $350 is the Member's responsibility. These maximum limits do not roll over and are reset each year. *You can be reimbursed for these services annually up to the limit below*

Vision Benefits:
Single: $350
Individual plus one: $700
Family: $1,100

(Children's Eye Exam & Children's Glasses are included and provide $350 toward any Vision service per 12-month benefit period per child on the plan.)

Biological/Holistic Dental Care: As a part of our Health and Wellness care, we have added benefits for conventional and biological dental procedures. Your Dental coverage starts 90 days (three months) after your initial enrollment date. As a member, you are given a maximum annual allowance of $1,000 per individual, per year, reimbursable to you. These maximum allowances do not roll over and are reset each year. *You can be reimbursed for these services annually up to the limit below*.

Dental Benefits:
Single: $1,000
Individual plus one: $2,000
Family: $3,000

The billing process is as follows: Vision and Dental services do not go toward the deductible. They are reimbursed to the Member after receiving care and have submitted their receipts for services to our Claims Department.

There are two options for sending billing for Dental and Vision services.

1. Members can submit the receipt for services they have received by sending them to our claims department for reimbursement.
2. Members can have their Dentist or Eye Care Professional send a bill directly to our claims office so they can be billed to Nova. (*If they need assistance, please send them to our Personal Care Advocates who can assist in this.*)

Members should send all receipts to claims@mynovahealthcare.org, or they can be faxed to 805-375-6090.
* ***Please note that all receipts must be submitted no later than 30 days from the date of service within your benefit period or plan end date.***

Gym Membership Benefit

At Nova Pathfinder HealthCare, we appreciate Members taking care of their health. We want to encourage Members to keep pursuing a healthy lifestyle. After one year on the Nova HealthCare plan, our members are eligible to be reimbursed for an annual gym membership, up to $200 maximum for an Individual plan, and $400 maximum for an Individual +1 or Family Plan. Members will need to remit their gym membership invoice for their annual reimbursement. Members can only submit receipts once a year to be reimbursed up to the maximum yearly benefit, regardless of the membership's annual cost. **Please note that all invoices must be a verifiable statement or receipt from the facility and in the form of a PDF*. Members should contact Claims at claims@mynovahealthcare.org or call (888)-266-4462, Ext. 1016

Member Referral Program

Nova Members can earn dividends every time they refer a friend or family member to us. At Nova Pathfinder, much of our growth has come from satisfied members who referred our company to their family and friends. Members can refer a friend or family member at https://mynovahealthcare.org/individuals-families/ To share the plan with a friend or family member, submit their information in the member portal. By clicking on the rewards tab, you will see "Refer a friend." Just type in their information, and press submit. Loyalty benefits (dividends) begin at 12 months of enrollment, disbursements are dispensed annually.

WOMEN'S HEALTH SERVICES

Most Women's Health Services are covered by Nova Pathfinder, including birth control, prenatal, neonatal, and postpartum care. Your healthcare plan includes well-visits, licensed birthing centers, and delivery. You have complete control over the course you take on your path to parenting. To make the birthing process go more smoothly, Nova requires Pre-Authorization and planning, so you'll need to coordinate with one of our Care Advocates to create a personalized pregnancy protocol for you and your newborn.

Please Note: All copayments and coinsurance charges for the services listed below are calculated before your deductible if one applies. This means you must pay all provider fees up to the deductible amount before this plan begins to cover the following expenses.

Birth Control Members pay 0% coinsurance or $0 copay after the deductible has been met.

All conventional methods of birth control outlined in the Affordable Care Act (ACA), including all Food and Drug Administration (FDA)-approved contraceptive methods prescribed by a woman's healthcare provider, including:

- Intrauterine devices (IUDs), including insertion and/or Removal.
- Barrier Methods including female condoms and sponges
- Implantable contraceptives.
- Injectable contraceptives when administered by a Physician.
- Voluntary sterilization (tubal ligation)
- Diaphragm fitting procedure.

Note: No benefits are provided for IUDs when used for non-contraceptive reasons.

See reimbursement policy on our website for submitting receipts for Birth Control.

Prenatal and Newborn Care Benefits

Pregnancy and Delivery Facilities

Nova Pathfinder Healthcare provides coverage based on our pregnancy protocol for delivery, pre- and post-natal services, and facilities that pose the least risk to the expectant mother and baby among the options listed. A certified hospital or birthing facility, OBGYN/hospital delivery, and a c-section are all included.

Prenatal Office Visits

You may have to pay for services that aren't preventive or part of your delivery if you have not met your deductible and/or if the services fall outside of your pregnancy protocol. Some services, such as Wellness visits, are covered before your deductible is met. If you have already met your deductible, there is no copay or coinsurance. However, you should ask your provider if the services needed are preventive or part of your delivery. Then, using the pregnancy protocol as a reference, see what your insurance will cover. Because your OBGYN might be an annual wellness visit, a pediatric annual wellness visit, and a pediatric vision/hearing annual wellness visit, please call us to discuss combining primary care annual wellness visit types.

Benefits provided for Pre-Natal Services include:

- Prenatal care
- Prenatal diagnosis of genetic disorders of the fetus utilizing diagnostic procedures in case of high-risk pregnancy
- Outpatient Maternity Services
- Involuntary complications of pregnancy,
- Inpatient Hospital maternity care including labor, delivery, and post-delivery care

Involuntary complications of pregnancy include:

- Puerperal infection
- Eclampsia
- Cesarean section delivery
- Ectopic pregnancy
- Toxemia

Diagnostic Prenatal Testing Includes:
Standard Prenatal testing for the diagnosis of genetic disorders of the fetus in case of high-risk pregnancy is covered. See below for other standard diagnostic testing information.

- **Standard Diagnostic Tests:** If you are unsure if the test or screening will be covered, please get a pre-authorization. If your provider orders an EKG or other needed x-rays (i.e., chest x-ray), these are covered as part of your annual wellness visit. For more complex tests over $75.00, it is a good idea to request a pre-authorization to know your cost.
- **Annual Wellness Visit Laboratory Tests: (**This list contains examples of standard annual wellness Visit lab tests that may be ordered) Complete Blood Count (CBC), lipid, Comprehensive Metabolic Panel (CMP), Cholesterol Panel, Urinalysis, Glucose Blood Sugar, Hemoglobin A1c, Prothrombin time with INR, C-Reactive Protein (CRP) (HS-CRP), and Thyroid Function. There are additional lab tests we will cover. If you are unsure if we would cover a lab test as part of an annual wellness visit, please ask us.
- **Lab tests** are covered up to $50.00 for each test. Testing facilities are paid directly, not applied to the deductible, starting after three.

Pre-planned C Section births require a pre-authorization, a provider's order, and planning with our Care Advocates as part of your Pregnancy Protocol Plan. All preadmission testing for planned C Sections must be performed and included in the surgical procedure when possible. All surgeries must meet the definition of **medically necessary** based on our guidelines. All Professional, Facility, and Other Charges that will be billed as part of the surgery should be included in the pre-authorization.

Note: Emergency C Sections do not require pre-authorization and fall under standard emergency surgery protocols.

The Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a standard vaginal delivery and 96 hours after a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate. If the hospital stay is less than 48 hours after a standard vaginal delivery or less than 96 hours after a C-section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating Physician. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. In consultation with the mother, the treating physician shall determine whether this visit shall occur at home, the contracted facility, or the Physician's office.

Newborn Care:
Newborns must be added to the plan within 30 days after birth under the family plan. The newborn's immediate medically necessary needs will be covered within the 30-day grace period under the mother's plan up to the limits. If a member is on an individual +1 plan, they must upgrade to a family plan. Children will then be covered under standard coverage as a member.

Routine newborn circumcisions performed within 18 months of birth for this benefit are referred to as outpatient routine newborn circumcisions.

All DME requires a pre-authorization and a provider's order. See the pre-authorization form for details on how to submit a complete request for pre-authorization for a Breast Pump. All DME must meet the definition of medically necessary based on Medicare and our guidelines.

Breastfeeding and Breast Pumps DME (Durable Medical Equipment) Breast Pumps fall under DME (Durable Medical Equipment) and are limited to a maximum of $500.00 each calendar year.

Excluded Services & Other Covered Services:

- Infertility services
- Cosmetic surgery

Other Covered Services (Limitations may apply to these services). Abortion services are covered only in medically necessary lifesaving situations.

CHOOSING YOUR PRIMARY CARE PROVIDER & ACCESSING A SPECIALIST

Nova Pathfinder gives you the freedom to choose your primary care provider, which can include a chiropractor.

Will you pay less if you use a preferred provider?

Yes. This plan uses a Preferred Provider network defined as a health care provider or group of providers who have contracted to deliver specified covered services. Nova Pathfinder has contracted with a network of Preferred Providers to arrange at a lower rate in return for prompt payment. Our network or (Preferred Providers) accept the Allowed Fee schedule amount as payment in full and will not balance-bill our insured members. This contract allows Preferred Providers to offer you lower-cost services than providers not in our network. If the provider does balance-bill, it is an agreed-upon rate that the Member is made aware of before services are rendered because there is a Pre-authorization or a Single-case Agreement in place. Nova always suggests that Members work with our Claims department and Pre-authorization teams to shop for the best price for the service to be provided. Be aware; your Preferred Provider network might use a Non-Preferred Provider for services such as lab tests.

**Check with the Nova Benefits department before you get services.*

If your provider is not on our Preferred Providers' list, we are happy to work with them to get them into our Providers' list. Any licensed health care provider in good standing and in a class approved by the health care corporation can become a Preferred Provider with us. According to the National Conference of State Legislatures, more than half of the states in the U.S. operate under "Any Willing Provider" statutes, also known as "Any Authorized Provider," which require health insurance carriers to allow health care providers to become members of the carriers' network of providers if certain conditions are met. These laws prohibit insurance companies from limiting the membership of network providers based on geography or other characteristics. Still, the health care provider must meet specific requirements for network membership made by the insurance company. Of course, these laws vary by state and scope. For a summary of Any Willing Provider statutes by state, visit the NCSL website.

Nova Pathfinder invites all Naturopathic, Complementary, Integrative, Holistic Dentists, Functional Medicine Practitioners, and all Conventional Practitioners to apply for membership to become a Preferred Provider in our network. Please review our Preferred Providers terms before filling out an application.

Non-Preferred Providers (*Also part of the open network*) Any Provider that is not a Preferred Provider is considered a provider who doesn't have a contract or will not accept a single case agreement or accept the Nova fee schedule included in a Pre-authorization provide services. The plan covers Non-Preferred Providers; however, you'll usually pay more to see a Non-Preferred Provider than with a Preferred Provider. Nova also refers to these providers as "non-participating."

When a provider bills you for the balance remaining on the bill that your plan doesn't cover, this amount is the difference between the actual billed amount and the allowed amount. For example, if the provider charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see a NON-Preferred Provider. You will pay the most if you use a non-preferred provider's open network. You may receive a bill from a provider to differentiate between the provider's charge and what your plan pays. This is called balance-billing.

Please note:

- To avoid balance-billing, be sure to obtain a Pre-authorization first, especially for amounts totaling more than $300.
- If your provider includes holistic/naturopathic providers, their orders and referrals may consist of "over-the-counter" supplements and essential oils. These may be covered as an allowed benefit if the Wellness treatments & Services guidelines are followed for coverage limits.

Do you need a Referral/Pre-authorization to see a specialist?
Yes, a Referral and Pre-authorization are required from your primary care provider to see a specialist. (This includes holistic/naturopathic providers.) If the specialist needs to provide additional services, those services will also need Pre-authorization.

EMERGENCIES

If you are experiencing an emergency, call 911 or go to the nearest emergency room to be treated. All "**Medically Necessary*" emergencies and admissions are covered in your plan. Again, be sure to present your Nova Membership ID card when you check-in. Nova HealthCare prefers that the providers bill Nova directly. Any bills you may receive should be sent to claims@mynovahealthcare.org or faxed to 1(805)-375-6090 or mail to Nova Pathfinder HealthCare5739 Kanan Road, Suite 336Agoura Hills, CA 91301

For non-emergency care, contact Teladoc first. Pre-authorizations should be filled out for all optional inpatient and outpatient surgical and diagnostic procedures. Nova will cover any reasonable and customary amounts. To avoid balance billing, be sure to obtain a Pre-authorization first, especially for amounts totaling more than $300. If you have any questions or concerns, please contact the Nova HealthCare Claims Department by email at claims@mynovahealthcare.org, or call 1(888)-266-4462, Ext. 1016

* *"Medically Necessary" or "Medical Necessity"* means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. The service must be: To evaluate, diagnose, or treat an illness, injury, disease, or its symptoms.

MEMBER SERVICES

Personal Care Advocates

Your Nova Personal Care Advocate is happy to answer your questions, review your plan, discuss your options or listen to your wellness needs at any time. We are here to assist you by being your bridge between the various departments at Nova. Our advocates will speak to medical providers on the members' behalf to explain the benefits and how the deductible works and will also verify benefits for members when required. We can even walk you through the process of how and when to submit your receipts to claims. If you would like more information, please contact a Personal Care Advocate at advocates@mynovahealthcare.org or by calling (888) 266-4462, Ext. 1003.

ACCESSING THE MEMBER PORTAL

Members have access to our Member Portal, where they can update their personal information and log into their billing portal to manage their billing and more. To access your online Member Portal, visit Mynova.health to log in. Please note that there is a $15 a month processing fee if you use a credit card for your automatic billing. However, there is no fee if you set up your billing with a bank account.

As always, we strive to deliver the best customer service and are working to ensure that you are up to date in all of your coverage information at all times. Moving into 2022, we request that all members log into their new member portal to update personal information in their member profiles. We are required by law to provide you with an IRS Tax Document, so we must ensure we have the most current information from our members. We are working hard to provide this vital document in a timely fashion.

Information we need will be asking for, and it will include the following:

- Your SSN and your dependents (for tax purposes).
- Any changes in contact information, address, phone number, etc.
- Any changes in your family or plan, births, deaths, etc.
- Any changes to your banking information.
- Any changes to your email(s).

Member Portal Update Instructions:

1. Sign into your portal at Mynova.health.

2. When the portal opens, you will see a warning message that says, *"Please Update Your Tax Information **HERE.**"*

3. Next, verify that the site is secure by ensuring you can see the Security Seals of Norton and Digicert below the dialogue box before you enter your Social Security Number(s).

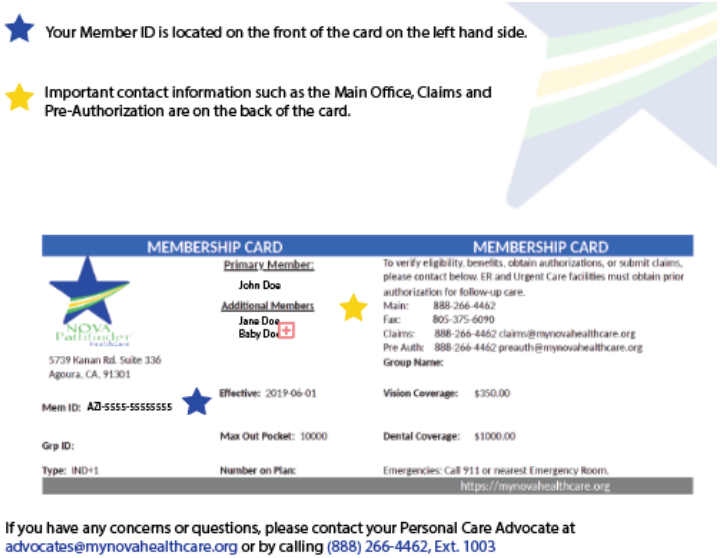
Once you confirm that the site is secure, enter your Social Security Number(s) and click on "***Submit Tax Information***."

4. Refresh the page to make sure the warning message is gone.

You can update your personal information in the Member Portal, or you can call our Care Advocate, who can help you add your information; call us at (888) 266-4462 ext. 1003 or (833) 444-Nova (6682). Or via email at advocates@mynovahealthcare.org.

MEMBERSHIP CARD INFORMATION

Your Membership Card/ID contains important information about your health insurance account. Your Membership ID number, as well as key claim information and contacts, can be found here. Save your Membership card in a secure location. If you misplace your membership card, you can request a replacement from your Personal Care advocate.



If you have any concerns or questions, please contact your Personal Care Advocate at advocates@mynovahealthcare.org or by calling (888) 266-4462, Ext. 1003

HEALTH SAVINGS ACCOUNT (HSA)

Great news! You can use your existing HSA account with our HDHP (High Deductible Health Plan) to pay for eligible services with pre-tax dollars from your HSA funds. If you don't currently have an HSA but want one, we can assist you at the link below. If you have an HSA, you may use it with our HDHP to lower tax costs on your healthcare and pay for treatments. Individuals who establish an HSA will be pleased to learn that dental and vision expenses are also eligible to be paid with your HSA funds. For more detailed information about how to enroll in an HSA (Health Savings Account), visit mynovahealthcare.org/health/what-is-a-health-savings-account/.

2021 HSA Limits Rise Modestly, IRS Announced

Health savings account (HSA) contribution limits for 2021 are going up to $50 for self-only coverage and $100 for family coverage, the IRS announced May 21, giving employers that sponsor high-deductible health plans (HDHPs) plenty of time to prepare for open enrollment season later this year.

The annual limit on HSA contributions will be $3,600 for self-only and $7,200 for family coverage. That's about a 1.5 percent increase from this year. In Revenue Procedure 2020-32, the IRS confirmed HSA contribution limits effective for the calendar year 2021, along with minimum deductible and maximum out-of-pocket expenses for the HDHPs with which HSAs are paired.

What is a Health Savings Account?

A Health Savings Account (HSA) is personal savings account for health care expenses that allow you to set aside money on a pre-tax basis. An HSA can be used immediately next year or can be saved for retirement. HSA Benefits Health Savings Accounts (HSA) offered by banks are a win-win with a Nova Pathfinder HealthCare High Deductible Healthcare Plan. Setting up an HSA can take less than 10 minutes, but the benefits are long-lasting.

- An HSA allows you to make tax-free deposits each year.
- You can withdraw funds from your HSA at any time to pay for medical expenses not paid by your High Deductible Healthcare Plan.
- You can use the account to pay for a spouse or other family member's medical expenses—anyone that is part of your tax household.
- Your funds are never lost; instead, they continue to roll over year to year.
- As long as you are using your HSA funds for medical expenses, there are no fees associated with withdrawal. If you use funds for non-medical expenses before the age of 65, you will have to pay a 20 percent penalty and income tax. After 65, you can withdraw your HSA funds for non-medical expenses without incurring a liability; however, you will still owe income tax on the withdrawal. As long as you use your HSA funds for medical expenses, the leaves are tax-free.

A health savings account (HSA) can provide those with a High Deductible Healthcare Plan a nest egg for future medical expenses, or it can help pay for immediate, unexpected health issues. The most significant benefit of an HSA is the tax advantage. The money that goes into your HSA can be deducted pre-tax by your employer's payroll, or it can be deducted from your income tax on your tax return. While your employer chooses the bank where your HSA will be housed, you are free to transfer your funds to another HSA institution at any time. If an HSA is not an option with your employer, you can still sign up for one on your own through either a bank, credit union, or brokerage firm of your choosing. If you are interested in opening an HSA, talk to your Nova Personal Care Advocate for more information. If you have an Individual High Deductible Healthcare Plan, you can contribute up to $3,600 to your HSA each year (this amount is specific to 2020 and fluctuates each year). If you have a family plan, the contribution maximum is $7,200. Also, if you are over the age of 55, you can contribute an extra $1,000 a year as a "catch-up contribution." As stated above, you can withdraw money from your HSA for medical expenses at any time.

Expenses can include deductibles, copayments, coinsurance, vision and dental care, and other out-of-pocket medical costs. Many holistic services also qualify as approved medical expenses (see IRS Publication 502 for details). They say sharing is caring. Your HSA allows you to share the wealth with a spouse or other family member, which means you can use your funds to pay for the medical expenses of anyone who is a part of your "economic family unit" or tax household. While there is no penalty or additional tax incurred if you withdraw funds from your HSA for medical expenses, there is a 20 percent penalty. The funds are subject to income tax if they are used for anything other than medical needs. After the age of 65, that penalty is waived, but you will still have to pay income tax on those funds if they are not used for health reasons. You can also use HSA funds to pay Medicare premiums for Part B, D, and C (Medicare Advantage) after the age of 65. Check out the Bank of America HSA user guide for more information.

Download Bank of America Brochures

- MyHealth HSA Mobile APP
- BOFA the Power of Two HSA and 401(k)
- Health Savings Account BOFA Investment Option
- Health Savings Account for Life, How it works

***HSA Limits Rise Modestly, IRS Announced**

On May 21, the IRS announced that Health Savings Account (HSA) contribution limits for 2021 are going up to $50 for self-only coverage and $100 for family coverage, giving employers that sponsor high-deductible health plans (HDHPs) plenty of time to prepare for the open enrollment season later this year. The annual limit on HSA contributions will be $3,600 for self-only and $7,200 for family coverage. That's about a 1.5% increase from this year. In Revenue Procedure 2020-32, the IRS confirmed HSA contribution limits effective for the calendar year 2021, along with minimum deductible and maximum out-of-pocket expenses for the HDHPs with which HSAs are paired.

What Benefits an HSA Offer?

If you are browsing various health care coverage plans trying to find the best option for you, you will probably see some terms that you aren't too familiar with. But, to choose the plan that best suits your lifestyle and needs, it's essential to understand what each plan entails. You may see one term throughout health care, and insurance sites are "Health Savings Account" or "HSA."

So, what is an HSA? And what are the benefits associated with having one?

An HSA is a savings account with funds allocated specifically for health care expenses and eligible for certain tax advantages. HSA accounts are only available for high-deductible health insurance plans, including Nova Pathfinder Limited HealthCare High Deductible Healthcare Plans. If you're wondering whether such an account would be right for you and your family, consider the following Health Savings Account benefits.

Not Subject to Taxation

Funds that you deposit into your HSA are deductible on your federal income taxes. Nothing is better than getting a bigger refund or paying a smaller amount to the IRS, and it's ideal when this benefit accompanies the security offered by an HSA. Unlike other specialized savings accounts that impose tax penalties for withdrawals,

you will not be taxed for taking funds out of your HSA—as long as the withdrawal is used to cover eligible medical expenses. Medical expenses are an inevitability, so stowing away funds in an HSA is a great way to minimize your tax bill while also planning your health care.

HSA Growth is Also Tax-Free

The interest rates on a Health Savings Accounts vary based on the institution with which you open it and the amount you initially deposit. Some accounts range in interest from .1 to .45% APY. The interest earnings of traditional savings accounts are subject to taxation if they surpass $10 a year, but HSA interest earnings are not. Like your initial deposit, the sum that you earn in interest will remain untaxed by the IRS. This is great news if you can deposit a substantial amount and find a bank that offers a high-interest rate on your funds.

Avoid the Headache of Unexpected Expenses

Many people hope that they can survive without seeing a doctor and avoid health care emergencies, but there are a million ways that an unexpected medical expense can happen. Car accidents, physical injuries, and serious diagnoses don't discriminate. They can happen to anybody, and if you haven't planned for the possibility of one, such an event can be financially devastating. Some of the expenses you may incur if you haven't properly planned include the following:

- Collection Fees
- Interest on Account Balance
- Late Penalties
- Credit Card Interest
- Cost of Time Off Work

A health savings account makes it simple to prevent the additional expenses associated with medical emergencies.

Wait to Use Funds if Necessary

When people ask, "what is a health savings account?" they often have several questions beyond a simple definition. How long does it last? How is it taxed? When can I use it? An important feature of an HSA is that you can keep funds in the account for as long as you'd like without penalty.

You do not need to have a minimum quota of activity to maintain the account, so you don't need to use or withdraw the funds within a certain period. This is good since medical emergencies are not planned—so you never know when you will need to use funds. It may be six months after establishing your account, but it may also be six years.

Reimburse Expenses Incurred After Establishment

Many HSA account holders may worry about the timeframe for medical expenses incurred. Some accounts only cover expenses that occur within a certain period after establishment or enrollment. Still, with an HSA, any expenses incurred after establishing your account are eligible for coverage. This means that even if you have not claimed reimbursement for an expense a year after it occurred, so long as it happened after you established and funded your HSA, it may be eligible for coverage. There is no probationary or trial period that delays potential reimbursement from your account. This makes it simple to deal with any health care expenses that happen after establishing your account.

Maintain Savings Regardless of Insurance Status

With traditional insurance, one of the most stressful factors is the uncertainty of insurance coverage. Your policy could change at any moment, your premiums could go up, or it could be discontinued. Luckily, Nova Pathfinder Limited HealthCare™ offers the benefits of an HSA without the constant worry that your costs will go up. Our premiums haven't changed since 2014!

One of the best advantages of an HSA is that it is not affected by changes like this. So long as your initial coverage is an eligible high deductible plan, any future changes in your coverage will not threaten your HSA savings. Suppose you incur a medical expense while covered by a plan that would be HSA ineligible. In that case, it is still eligible for coverage because you established your HSA with an eligible plan.

Cover Dental and Vision Expenses

Lastly, individuals who establish an HSA will be pleased to learn that dental and vision expenses are also eligible for reimbursement through their HSA. If you need to get new glasses or have a cavity filled, routine health care costs like these may not be covered by traditional insurance, but you can fund them through your HSA. Many health insurance policies do not extend vision and dental coverage, so an HSA provides a great way to ensure that these healthcare needs are met without the burden of paying them out of pocket. With Nova Pathfinder Limited HealthCare™, you don't have to worry about these expenses, ever. Along with an HSA, you also get coverage for holistic dental care. This includes initial and routine checkups, cleanings, comprehensive dental examinations, dental trans-illumination, thermography, panoramic X-ray, and more!

Get the Benefits of an HSA with Nova Pathfinder HealthCare

Whether you've missed your open enrollment period or are looking for a healthcare coverage plan that better suits your lifestyle, signing up for Nova Pathfinder Limited HealthCare is a simple and straightforward process.

SUBMITTING RECEIPTS

Reimbursement Policy and How it Works

If you are an active person who uses wellness services and takes supplements to stay healthy, don't forget to keep your receipts for these services and items. You can send the expenses to Nova Pathfinder's Claim Department, and they can be applied to your annual deductible. Before your deductible has been met, money spent on services such as massages and acupuncture and items like essential oils will count toward your deductible. Once your deductible has been met, you will be reimbursed for future wellness visits and supplements up to the maximum benefit allowance.

Remember that health and wellness service receipts, including visits and the purchase of supplements, essential oils, etc., must be submitted within 30 days of service or purchase. It is the Member's responsibility to validate that Nova's Claim Department has received those expense receipts. We will confirm via fax or email upon request. Member must request confirmation via email by contacting claims@mynovahealthcare.org.

Physicians/Providers or Hospital Claims Types

- We do not want the Member to pay before the Nova Claims Department calculating the allowed reimbursement. This is so the Member does not overpay.
- If the Member does pay the claim, they must request a claim form for the encounter. The Claims Department will not reimburse the Member based on only a payment receipt with supporting claim forms.

Any service that requires a Pre-authorization will not be paid without an approved Pre-authorization number. All Pre-authorization is for allowed amounts applied to the deductible allowance $5000/$10,000 deductibles or reimbursed once the deductibles have been met.

Claims must be submitted directly to Nova.

Claim Forms:

- CMS-1500
- UB40
- Other specialties

Receipts (not Claims)

Please follow our policy for submitting receipts, or the amount on the receipt will not be applied to deductible allowance ($5000/$10,000) or once the deductible has been met for reimbursed.

How does the reimbursement qualify?
Non-traditional healing treatments and medicines provided by any professional may be eligible if prescribed to treat a specific medical condition; we look at these very closely.

The treatments must be legal or pre-approved and may not qualify if the remedy is a food or a substitute for food that the Member would typically consume to meet nutritional requirements. On-itemized [bulk or bundled] bills will be **Rejected** as **Incomplete**.

**See lists of approved products or services that are covered under receipt submission.*

All Health and Wellness Services fall under the provider's supervision.
Suppose any non-provider receipt is over $100. In that case, a provider will need to be prescribed if it is not in the Approved Products List, even though it is available without a prescription or letter of medical necessity. Receipts for Health and Wellness, Supplements, Oils, etc., will only be accepted if the receipts are within 30 days from the purchase date. Any receipts received after the 30-day purchase will not be considered.

Please note that all receipts must be submitted no later than 30 days from the date of service within your benefit period or plan end date. It is the members' responsibility to validate that we have received your receipts. We will confirm via fax or email upon request. Member must request confirmation via email to claims@mynovahealthcare.org.

Appeals must be filed 30 days from the decision date.
For more information, please refer to our appeals policy or dispute a provider charge policy.

The Member will be reimbursed based on the allowed amount and only after the deductible for their policy has been met.

- All receipts that are submitted must be verifiable by the claims department

- Handwritten receipts will **not be accepted**
- To be reimbursed or amount applies to deductible allowance, the Member must provide contact numbers for the store, vendor, or provider to receive healthcare services or goods.
- Bank or credit card statements will **not** be accepted
- An original Paid receipt is required
- All receipts must be clear and legible
- Shipping or taxes will not be applied to the allowance or reimbursed
- We will not apply for allowance or reimburse for receipts that were paid by points or certificates
- The ticket must include the Member's/dependent's name on the account/receipts to which the allowance is applied
- If the item was paid using an HSA account
- It will be considered a non-reimbursable item.

Example Items to be Included on Receipts:

- Name of store and or provider's name, address, and phone
- Member/Spouse/Dependent address and ID number
- Member/Spouse/Dependent name as it appears on our membership roles
- Any Procedure description and CPT code amount charged per item, if available
- And the related Diagnosis & ICD-10 code for the condition being treated, if available
- Total charges
- Amount paid by Member and how it was paid: cash, check, or credit

DISPUTE PROCESS FOR CHARGES FROM YOUR PROVIDER

Please review the following scenarios to determine how to dispute the Point of Service charges.

- **Emergency Care:** If you believe your care was due to an emergency, you may file a claim appeal. Please review the Nova Pathfinder HealthCare definition of emergency care to determine if an appeal is appropriate.

- **You contacted your Primary Care Doctor (PCD) after the service**, you did not know a referral was needed, the service was a follow-up to preventive care, or you did not realize the referral had expired. As a Nova Pathfinder HealthCare member, it is your responsibility to be aware of the referral requirements. Point of Service charges cannot be waived if you did not follow the referral requirements. Your PCD/hospital or clinic cannot submit a retroactive referral for these circumstances.

- **Your PCD/hospital or clinic appointment line/referral manager failed to submit the referral to Nova Pathfinder Limited HealthCare or gave you misinformation**. Nova Pathfinder advises its members to contact the hospital's or clinic's patient advocate to determine if he/she will submit a referral for

services already rendered. If the referral is approved, members can then contact Nova for a claim adjustment. Nova does not have review rights for this circumstance, and the local hospital or clinic determination is final.

- **Your PCD failed to submit the referral to Nova, or the referral was submitted and rejected**. If your PCD gave you a written referral but did not submit a referral to Nova, you may submit a copy of the written referral. If the referral was verbal, you might submit a written statement from the provider indicating when the verbal referral was given.
  Submit the documentation with a copy of the Explanation of Benefits (EOB) to:
  Nova Pathfinder Healthcare Claims Correspondence
  5739 Kanan Rd., Suite 336, Agoura, CA 91301

- **Misinformation from a Nova Pathfinder Limited HealthCare customer service representative** If our customer service records indicate misinformation or incomplete information was provided, the Point of Service charges may be adjusted. You may submit a request for review online or via U.S. mail.
  Email via secure Encryption I to appeals@mynovahealthcare.org**.**
  U.S. mail: Nova Pathfinder Healthcare Claims Correspondence
  5739 Kanan Road Suite 336, Agoura, CA 91301

- **Other reasons not listed above** You may submit a request for review online or via U.S. mail.
  Email via secure Encryption I to appeals@mynovahealthcare.org
  U.S. mail: 5739 Kanan Rd., Suite #336, Agoura, CA 91301

FILING A GRIEVANCE

A grievance is a written complaint or concern about a medical provider, or the Nova Pathfinder Healthcare program in general. Authorization appeals, claims appeals, and claim review issues are separate from grievances. The following are examples of grievances:

- Quality of services provided by a provider (inadequate service, ineffective care, inaccurate results)
- Providers' conduct or actions and their Inaccurate personnel information
- Delays or mistakes in the processing of authorizations
- Patient protection issues at a hospital or doctor's office
- Privacy issues

Note: Disputing charges for services should not be submitted as a grievance.

Who can file a grievance?

A grievance is a written complaint or concern about a medical provider, or the Nova Pathfinder Healthcare program in general. Authorization appeals, claims appeals, and claim review issues are separate from grievances.

The following are examples of grievances:

What is the grievance process?
Nova Pathfinder HealthCare takes complaints seriously. We will conduct a thorough investigation of the concerns and take actions as necessary to improve services. If necessary, we will contact the involved provider(s) and various Nova Pathfinder departments to gather additional information. Generally, we do not contact the Member unless the information in the grievance is unclear. The person who submitted the grievance will receive a written response, usually within 60 days.

How is a grievance submitted?
Print a **Nova Pathfinder Healthcare Grievance Form** or send a letter with the following:

- Name, address, and telephone number of the person submitting the grievance
- The Member's name, address, and telephone number if different from the submitter
- The Member's Social Security number or the beneficiary's Social Security number
- A description of the issue(s), including the day, time, and details
- The name of the involved provider(s) or Nova associates
- The provider's address if the complaint is about a provider
- Any appropriate supporting documents
- If necessary, an Authorization for Disclosure of Medical or Dental Information form

Fax to 1-805-375-6090
Mail to: Nova Pathfinder HealthCare Healthcare Grievances 5739 Kanan Rd., Suite 336 Agoura, CA 91301

NOVA CANCELLATION POLICY

How to Cancel Your Insurance:

Contact Nova Pathfinder directly to cancel your health insurance.

Plan cancellation Policy: * 30-day waiting period—in order to provide you with the best service possible, we have kept the waiting period as short as possible. *

Written Notification: To protect both yourself and us, we require that the insured provide us with written notice. It is sufficient to send an email with a documented explanation and requested date. This ensures that both parties are aware of your intentions. Your name, address, and policy number should all be included. Please email your written request for cancellation to accounts@mynovahealthcare.org.

Because our members currently use holistic/naturopathic therapies, they see this as an advantage in that they may apply those amounts to their deductible, allowing them to meet their deductible sooner. **Please keep in mind that all receipts must be presented within 30 days of the date of service, regardless of whether your benefit period or plan has ended.**

SWITCHING TO NOVA AND WANT TO CANCEL YOUR OLD PLAN?

A Guide to Canceling Your Old Health Insurance

Medical care companies want you to think your contract is guaranteed in perpetuity. Some insurers play games to make it as difficult as possible for their members to cancel their policy. But the truth is that canceling your existing policy is always an option.

Can You Cancel Your Current Health Insurance Policy at Any Time?

If you've ever tried to cancel your health insurance, you've probably been faced with fees and horror stories about what could happen if you don't have coverage. This strategy is employed to keep members loyal to even the most ineffective insurance policies. It is, nevertheless, possible to cancel your coverage. If you have a marketplace plan, you can cancel it depending on how many individuals are on the insurance. In most cases, your termination will take effect within 14 days after your cancellation. You may be charged a fee for any months you go without coverage, although there are some exceptions, and you can enroll in Nova Pathfinder Healthcare as soon as your other coverage expires.

Firing Your Old Insurance

Traditional insurers charge exorbitant monthly premiums in addition to providing inadequate benefits or nonexistent services. If this sounds familiar it's time to start considering other solutions. Fortunately, there are numerous options available. Find a health care company that puts health and care back into health care today!

Discover the Alternatives

You might think that enrolling in a new health care plan or applying for a special exception will require you to wait until open enrollment in November. Nova Pathfinder Healthcare is aiming to cut through the red tape and provide direct care to patients. Our organizational foundation, in addition to enabling 365-day enrollment, puts control in your hands and strives to keep our healthcare accessible and affordable. Choose from programs that include standard medical, as well as holistic and naturopathic treatments.

Manage Your Health on Your Terms

Health care is not "one-size-fits-all," but many providers treat it that way. We believe you should be able to manage your health on your terms and enroll in a plan that provides the exact treatment you need. Our plans reach beyond traditional health care to include naturopathic and therapeutic approaches. If your health requires therapies such as homeopathy, chiropractic, acupuncture, you should consider a plan that includes non-traditional solutions. You know your body better than anyone else, so choose a company and a plan that's right for you.

Break Away from The System

Don't allow yourself to be shackled to a health care company that doesn't value you. You are more than a number. You don't need to buy into a costly health care program that offers a limited range of options. We care for you the way you would care for yourself. We welcome families, individuals, and companies and give our members the tools and incentives to get healthy and stay healthy. See and experience the difference at Nova Pathfinder HealthCare.

Nova Pathfinder ® promotes holistic health and wellness coverage for all members. Get a quote today and be covered in as little as two weeks.

Nova Pathfinder Ltd
myNOVAHEALTHCARE

Summary of Benefits and Coverage: What services are covered by my NOVA Pathfinder HealthCare plan and how much will I have to pay out of pocket for covered and non-covered services.
Coverage Period: 01/01/2021-12/31/2021
NOVA Pathfinder Limited a HealthCare Company: HDHP with HSA option
Coverage for: All Covered Members
Plan Type: HSA

The summary of benefits and coverage document will assist you in selecting a health plan. The document outlines how you and the plan will share the cost of covered health care services. **NOTE:** Information about the cost of this plan (referred to as the premium) will be provided separately.

This is only an overview. For more information about your coverage, call toll free 1-833-444-NOVA (6682). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, providers, or other underlined terms see the Glossary.

You can view the glossary at https://mynovahealthcare.org/ or call toll free at 1-833-444-NOVA (6682) to request a PDF copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible? *(See Footnote 1)*	$ 5,000 per person / $ 10,000 per family through the preferred provider open network; ***(See Footnote 2)*** for non-preferred providers open network ***(See Footnote 3)*** the maximum cost per individual/family is unavailable per calendar year.	In general, before this plan will begin to pay, you must pay all provider costs up to the deductible amount. ***(See Footnote 4).***

[1] An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have a separate deductible that applies to specific services or groups of services. In addition, a plan may have only separate deductible. (For example, if your deductible is $ 5,000, your plan won't pay anything until you've met your $ 5,000 deductible for covered health care services subject to the deductible.) The exception is health and wellness.
[2] Using an open-network preferred provider means the member will potentially pay the least amount when the provider accepts the fee schedule allowed amount and the not allowed amount. One example of a preferred provider is a provider who accepts the fee schedule rates Nova pays as the allowed amount for the service and normally will not balance bill the member. If the provider does balance bill it is an agreed-upon rate that the member is notified about prior to services because there is a preauthorization or a single case agreement in place for the services. A preferred provider needs a single case agreement to keep the members' costs to a minimum. Nova always suggests that the member works with our claims and preauthorization teams shop the best price for the service to be provided. Be aware, your preferred provider network. might use a non-preferred provider's open network for services such as lab tests. Check with Nova benefits department before you get services.
[3] Non-Preferred Providers are also considered part of the open network, considered a provider who doesn't have a contract or will not accept a single case agreement or not accept the Nova fee schedule that is included in a preauthorization to provide services. If your plan covers non-preferred providers, you'll usually pay more to see a non-preferred provider than a preferred provider. Nova also refers to these providers as "non-participating".
[4] Members may request temporary assistance due to a hardship and need to reduce deductible requirement. This is granted on a case-by-case basis.

Important Questions	Answers		Why This Matters:
What is the **deductible** for this **plan**?	$ 5,000 per person / $ 10,000 per family through the preferred provider. Please see definition of provider ***(See Footnote 5)***	Non-preferred provider (non-participating) the maximum cost per individual/family is unavailable per calendar year. Please see definition of Non-preferred provider ***(See Footnote 6)***	The deductible is the maximum you would pay in a year for covered services. If you have additional family members on this plan, the combination of their allowance and yours, reduces the family deductible until the total family deductible is satisfied .On the Family and Individual Plus 1 plan, all Members contribute to the deductible.
What is not included in the **deductible**?	**Premiums**, balance billing ***(See Footnote 7)*** charges, penalties for non-certification and healthcare services this plan doesn't cover.		Even though you pay these expenses**,** they do not count toward your deductible.
Will you pay less if you use a **preferred provider**?	Yes. For a list of preferred providers call (888) 266-4462. If your provider is not in our preferred providers list, we are happy to work with them to get them into our preferred providers list.list.		This plan uses a preferred provider network. If you choose a preferred provider you will save money. You will pay the most money if you utilize an open network from a non-preferred provider . You may receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). ***(See Footnote 7***)
Do you need a **referral / preauthorization to see a specialist?**	Yes, a referral/preauthorization is required from your primary **care provider to see a specialist**. (This includes **holistic/naturopathic providers.)**		Your provider can refer you to see a specialist with a referral. (This includes holistic/naturopathic providers.) Please note, if the specialist needs to provide additional services, those services will also need a preauthorization. **Note:** If your provider includes holistic / naturopathic providers, their orders and referral may include "over-the-counter" supplements and essential oils. These may be covered as an allowed benefit if the Wellness treatments & Services guidelines for coverage limitations are followed.

[5] Using an open-network preferred provider means the member will potentially pay the least amount. The Provider accepts the fee schedule allowed amount and the not the allowed amount. One example of a preferred provider is a provider who accepts the fee schedule rates Nova pays as the allowed amount for the service and normally will not balance bill the Member. If the provider does balance bill, it is an agreed-upon rate, that the Member is notified about prior to services because there is a preauthorization or a single case agreement in place for the services. With a preferred provider that needs a single case agreement to keep the Members cost to a minimum. Nova always suggests that the Member works with our claims and preauthorization teams shop for the best price for the service to be provided. Be aware, your preferred provider network. might use a non-preferred providers open network for services such as lab tests. Check with Nova benefits department before you get services.

[6] Non-Preferred Providers are also considered as part of the open network, considered a provider who doesn't have a contract or will not accept a single case agreement or not accept the Nova fee schedule that is included in a preauthorization provide services. If your plan covers non-preferred providers, you'll usually pay more to see a non-preferred providers than a preferred provider. Nova also refers to these providers as "non-participating".

[7] When a provider bills you for the balance remaining on the bill that your plan doesn't cover, this amount is the difference between the actual billed amount and the allowed amount. For example, if the provider charge is $ 200.00 and the allowed amount is $ 110.00, the provider may bill you for the remaining $ 90.00. This happens most often when you see a NON-preferred provider. An open network provider (preferred provider) might not bill the not allowed amount for the service.

Important Questions	Answers	Why This Matters:
Are there services covered before you meet your deductible?	Yes. Preventive care & annual wellness visits are covered ***(See Footnote 8)*** before you meet your deductible. **Primary Care Annual Wellness Visit** $ 150.00 for two yearly visits are covered starting after three months of membership up to $ 150.00 for each visit or one combined visit for a total of $ 300.00 annually. ***(See Footnote 9 & 10)*** Additional cost over the $ 300.00 is applied toward the deductible and paid by Member. ***(See Footnote 11)***	This plan covers some items and services even if you haven't yet met the deductible amount. However, a copayment or coinsurance may apply. For example, this plan covers certain preventative services before you meet your deductible. See a list of examples in the section to the left for an annual wellness visit. For more information about your coverage, call 833-444-NOVA (6682)
	Chiropractor Annual Wellness Visit If your chiropractor is your primary care provider and they perform a health and wellness visit, you can substitute these services for your benefit ***(See Footnote 8 & 10)*** $ 100.00 per three visits are covered starting after three months of membership up to $ 100.00 for each visit or one combined visit for a total of $ 300.00 annually ***(See Footnote 8 & 10)*** The additional cost over the $ 300.00 is applied toward the deductible and paid by the Member.	This plan covers some items and services even if you haven't yet met the deductible amount. However, a copayment or coinsurance may apply. For example, this plan covers certain preventative services before you meet your deductible. See a list of examples in the section to the left for an annual wellness visit. For more information about your coverage, call 833-444-NOVA (6682)
Are there services covered before you meet your deductible?	**Standard Diagnostic Tests:** If you are not sure if the test or screening will be covered, please get a preauthorization. If your provider orders an EKG or other needed imaging (i.e., chest x-ray), these are covered as part of your annual wellness visit. For more complex tests that are over $ 75.00, it is a good idea to request a preauthorization, so you know your cost. ***(See Footnote 12) (See Footnote 13)***	This plan covers some items and services even if you haven't yet met the deductible amount. However, a copayment or coinsurance may apply. For example, this plan covers certain preventive services before you meet your deductible. In the section on the left, you will find a list of examples for yearly wellness visits..For more information about your coverage, call 833-444-NOVA (6682).
Are there services covered before you meet your deductible?	**Annual Wellness Visit Laboratory Tests:** This list contains examples of standard annual wellness visit lab tests that may be ordered: Complete Blood Count (CBC), Lipid, Comprehensive Metabolic Panel (CMP), Cholesterol panel,	This plan covers some items and services even if you haven't yet met the deductible amount, However a copayment or coinsurance may apply. For example, this plan covers certain preventative services without

[8] All services must be billed directly to the claims department on CMS-1500 or UB-04 or other approved claim form types for the services performed. Members are not to pay the provider at time of service and submit receipts unless approved in advance.
[9] Paid to the provider of services after receiving an approved claim form.
[10] All paid fees are based on the allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid.
[11] The Member must select to either use the primary care provider or to use their chiropractor for this benefit. The benefit cannot be combined with primary care annual wellness exams or chiropractor annual wellness exams. The Member has to select one service type to perform their preventive care.

[13] All Laboratory test that are over $ 50.00 may require a yearly, multiple year or single use preauthorization.

Important Questions	Answers	Why This Matters:
	Urinalysis, Glucose blood sugar, hemoglobin A1c, prothrombin time with INR, C-Reactive Protein (CRP) (has-CRP), and thyroid function. There are other lab tests we will cover. For more information on whether a test that is not listed above qualifies as an annual wellness visit please call us. For any laboratory tests that are over $50 dollars ***(See Footnote 14)*** Please contact us to learn how to combine annual wellness visit types such as an OBGYN appointment, a pediatric visit , or a vision/hearing test for children. ***(See Footnote 15 & 16)*** Starting after three months of membership, laboratory tests are covered up to $ 50.00 ***(See Footnote 17 & 18)*** for each lab, paid separately to the laboratory and not applied to the deductible,	and before you meet your deductible. See a list of examples in the section to the left for annual wellness visit. For more information about your coverage, call 833-444-NOVA (6682).

All **copayment** and **coinsurance** costs shown in this chart are aft test er your **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Preferred Providers	What You Will Pay NON-Preferred providers	Limitations, Exceptions, & Other Important Information
If you visit a health care provider office or clinic	**Primary care visit** to **treat an Injury** or **Illness**	0% coinsurance after the deductible has been met. ***(See Footnote 19)***	The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed. ***(See Footnote 20)***	Your provider can refer you to see a specialist with a referral. (This includes holistic/naturopathic providers.) **Please note**: If the specialist needs to provide additional services those services will need a preauthorization. **Note:** If your provider includes holistic / naturopathic providers, their orders and referral may include “over-the-counter” supplements and essential oils. These may be covered as an allowed benefit if the guidelines in the wellness treatments & services are followed for coverage limits.
If you visit a health care provider office or clinic	**Chiropractic care**	***(See Footnote 19 & 21)***	***(See Footnote 20)***	Your provider can refer you to see a specialist with a referral. (This includes holistic/naturopathic providers.) If the specialist needs to provide additional services, those services will need a preauthorization. **Note:** If your provider includes holistic / naturopathic providers, their orders and referral may include “over-the-counter” supplements and essential oils.These may be covered as an allowed benefit if the guidelines in the wellness treatments & services are followed for coverage limits. **Note:** although you can use your wellness treatments & services benefits to see

[14] All Laboratory tests that are over $ 50.00 may require a yearly, multiple-year or single-use preauthorization.
[15] These can be combined with primary care annual wellness visit maximum benefit for combined visits is $ 300.00. An example would be one OBGYN annual wellness visit and one primary care annual wellness visit
[16] All paid fees are based on the allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid for preventive care for OBGYN/pediatric and pediatric vision/hearing visits.
[17] All paid fees are based on the allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid. Members pay the remainder of the lab charges not covered.
[18] Nova will cover annual wellness visit lab tests whose Medicare or Medicaid reimbursement rate is under $ 50.00 for each test ordered.
[19] 0% coinsurance after the deductible has been met.
[20] The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed.

				your Chiropractor without a preauthorization, It is suggested that the Member talks to the Nova benefit department on how to combine visit limits per injury in addition to your wellness treatments and services to increase visit limits.
If you visit a health care provider office or clinic	**Specialist office visit**	***(See Footnote 21)***	The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed. ***(See Footnote 20)***	Your provider can refer you to see a specialist (includes holistic/naturopathic providers) with a referral. Please note if the specialist needs to provide additional services, however, those services will require a preauthorization. **Note:** If your provider includes holistic / naturopathic providers, their orders and referral may include "over-the-counter" supplements and essential oils. These may be covered as an allowed benefit if the guidelines in the wellness treatments & services are followed for coverage limits.
Prescription drugs by primary care provider:	**Prescription Drugs***	0% coinsurance After the deductible has been met. Prior***(See Footnote 46)***		**Note:** See reimbursement policy on our website for submitting receipts. ***(See Footnote 22)***

[21] 0% coinsurance after the deductible has been met.
[22] If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the full amount. The amount will not be applied to the deductible if the deductible is not met, if the deductible is met no reimbursement will be issued.

Annual Wellness Visits

Understanding the annual wellness visits and how they apply toward your deductible:

- If the prescribed test has not been performed in accordance with the age-appropriate guidelines
- Before scheduling your procedure, know your screening/test category. Prior to the procedure ask the provider's scheduler or medical assistant for the pre-procedure diagnosis code (i.e. the reason for the test/screening).
- We may use this information to see whether the screening/test associated with this diagnosis (provided by the physician, scheduler, or medical assistant) is covered under the insurance as preventative or diagnostic.
- Is the diagnosis preventative or diagnostic, and how will it be processed?
- If you are unsure if the test you are having done will be classified as preventative or diagnostic, which may affect the cost, we recommend that you contact our benefits team and/or your provider before the test to help you prepare for the potential costs.
- Is the test preventative, such as a routine mammogram, colonoscopy, or prostate cancer/ colon cancer screening? Is it diagnostic for purposes of evaluation or treatment of a pre-existing condition? Is the test being ordered for chronic disease management for ongoing conditions or to evaluate and diagnose new health issues? Is the exam(s) and screenings/tests and/or vaccinations required solely for employment, immigration, licenses, travel, or other types of insurance?
- If any of the above services are included in your annual wellness visit, but your deductible has not been met, you may be responsible for the service. This is because your procedure will be diagnostic. You may want to ask; if the allowed amount will be allocated toward your deductible. We can help you save money by negotiating a single-use case with agreed-upon pricing if you have your provider obtain a pre-authorization.
- Could my screening/test begin as preventative and become a diagnostic for evaluation reasons or treatment of an existing condition? If this occurs, a patient may be responsible for a part or all of the benefit. Using CMS billing rules, we would assess the CPT/Diagnosis/Modifier combinations and medical history available.

Common Medical Event	Services you may need	What you will pay Preferred Providers	What you will pay Non-Preferred Providers	Limitations, Exceptions, & Other Important Information
Annual Wellness Visits	**Preventative care - Annual Wellness Exams are covered, before you meet your deductible.**	0% coinsurance	See Limit and Exceptions. The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed. ***(See Footnote 23)***	**Yes. Preventive Care & Annual Wellness Visit (AWV) are covered, *(See Footnote 24)* before you meet your deductible.** **Primary Care Annual Wellness Visit** $ 150.00 for two yearly visits are covered starting after three months of membership up to $ 150.00 for each visit or one combined visit for a total of $ 300.00 annually. ***(See Footnote 25 & 26)*** Additional cost over the $ 300.00 is applied toward the deductible and paid by the Member. ***(See Footnote 27)*** **Chiropractor Annual Wellness Visit** . ***(See Footnote 24)*** $100.00 per three visits are covered starting after three months of membership up to $ 100.00 for each visit or one combined visit for a total of $300.00 annually. ***(See Footnote 28)*** Additional costs over the $ 300.00 are applied toward the deductible and paid by the Member. **Standard Diagnostic Tests** Please get a preauthorization if you are unsure if the test or screening will be covered. An EKG or other necessary x-rays (such as a chest x-ray) ordered by your provider are covered as part of your annual wellness visit. For more complex tests that are over $75.00, it is a good idea to request a preauthorization, so you know your cost. **Annual Wellness Visit Laboratory Tests** This list contains examples of standard annual wellness Visit lab tests that may be ordered: Complete Blood Count (CBC), Lipid, Comprehensive Metabolic Panel (CMP), Cholesterol Panel, Urinalysis, Glucose Blood Sugar, Hemoglobin A1c, Prothrombin time with INR, C-Reactive Protein (CRP) (HS-CRP), and Thyroid Function. There are other lab tests we will cover. Please contact us to find out whether a lab test would be covered

[23] Members may pay coinsurance, balance billing based on our Allowable fee schedule if deductible has been met. The member may still have a balance owed.
[24] All services must be billed directly to the claims department on CMS-1500 or UB-04 or other approved claim form types for the services performed. Members are not to pay provider at time of service and submit receipts unless approved in advance.
[25] Paid to provider of services after receiving an approved claim form
[26] All paid fees are based on allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid.
[27] Member must select to either use the **primary care provider** or use their **chiropractor** for this benefit. The benefit cannot be combined with primary care annual wellness visit or chiropractor annual wellness visit, the member has to select one service type to perform their preventive care.
[28] All fees are based off of allowed amount for CPT/diagnosis combinations using billing guidelines for preventive care in chiropractic coding

Common Medical Event	Services you may need	What you will pay Preferred Providers	What you will pay Non-Preferred Providers	Limitations, Exceptions, & Other Important Information
				as part of your yearly wellness visit. **Lab tests** are covered up to $50.00 for each test. Testing facilities are paid directly, not applied to the deductible, starting after three months. For any laboratory tests that are over $ 50.00 *(See Footnote 29)* Because your OBGYN may be an annual wellness visit or a pediatric annual wellness visit, and a pediatric vision/hearing annual wellness visit, please contact us for information on how to combine primary care annual wellness visit types. ***(See Footnote 30 &****Error! Bookmark not defined.****)***
Preventive Care	**Adult Immunization**	Four **Adult Immunizations** are covered, prior to the deductible being met. ***(See Footnote 31)*** 0% coinsurance after the deductible has been met.	***(See Footnote 32).***	1. Annual Flu vaccine 2. Tetanus-diphtheria. 3. Shingles vaccine for ages 50 and older (two dose series). 4. Pneumococcal vaccine (PDF) two different vaccines; one time for ages 65 & older. You may have to pay for services that aren't preventative. Ask your provider if the services need a preauthorization. The list above is what your plan will currently pay for without a preauthorization. If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the full amount. ***(See Footnote 33)***
Preventive Care	**Childhood Immunization**	**Standard Childhood Immunizations** are covered prior to the deductible being met. ***(See Footnote 34)*** 0% coinsurance after the deductible has been met.	See limit and exceptions. The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance	Standard childhood Immunizations are covered under the benefit prior to the deductible being met. See the flu shot limit and exclusions, as well as age-appropriate recommended vaccinations. It is possible that you will have to pay for treatments that aren't preventive in nature. Inquire with your provider about whether the treatments you need are preventive. Then talk to us about what your insurance will cover without a preauthorization. Some vaccinations are required before your child can attend daycare or school, so check with your local or state organization. If the Member fails to follow the reimbursement procedure for submitting receipts, the Member may be responsible for paying the full amount. ***(See Footnote 35)***

[29] All laboratory test that are over $50 dollars may require a yearly, multiple year or single use preauthorization.
[30] Can be combined with primary care annual wellness visit maximum benefit for combined visits is $300.00. Example would be one OBGYN annual wellness visit and one primary care annual wellness visit.
[31] All paid fees are based on allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid for preventive care for adult immunizations. Nova may have limits and exceptions to this benefit for travel and employment or duplicate immunization.
[32] Members may pay coinsurance, balance billing based on our Allowable fee schedule if deductible has been met. The member may still have a balance owed.
[33] All provider-based services must be bill directly from the providers office for reimbursement on proper claim form. See reimbursement policy for clarification of details.
[34] All paid fees are based on allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid for preventive care for adult immunizations. Nova may have limits and exceptions to this benefit for travel and employment or duplicate immunization.
[35] All provider-based services must be billed directly from the providers office for reimbursement on the proper claim form. See the reimbursement policy for clarification of details.

Common Medical Event	Services you may need	What you will pay Preferred Providers	What you will pay Non-Preferred Providers	Limitations, Exceptions, & Other Important Information
			owed.	
Preventive Care	**Laboratory tests**	Limited coverage prior to the deductible being met for annual wellness visit lab test 0% coinsurance after the deductible has been met.	See limit and exceptions. The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed.	**Annual wellness visit laboratory tests** ***(See Footnote 36 & 37)*** This list contains examples of standard annual wellness visit lab tests that may be ordered. Complete Blood Count (CBC), lipid, Comprehensive Metabolic Panel (CMP), cholesterol panel, urinalysis, Glucose Blood Sugar, Hemoglobin A1c, Prothrombin Time with INR, C-reactive protein (CRP) (h-CRP), and thyroid function. There are other lab tests we will cover. If you have any questions about whether the test will be covered as part of your annual wellness visit lab test, please contact us or request a prior authorization. After three months of membership, lab tests are covered up to $50.00 ***(See Footnote 36 & 37 & 38)*** for each lab, paid individually to the laboratory and not applied to the deductible. All Laboratory tests that are over $ 50.00 ***(See Footnote 38)*** If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the full amount. ***(See Footnote 35 & 36 & 37)***
Preventive Care	**Screening**	0% coinsurance after the deductible has been met.***(See Footnote 39)***	See limit and exceptions. The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed.	**Age-appropriate recommended screenings** A few we can list here, preventive colonoscopy screening, bilateral mammography screening, cervical cancer screening (pap test), and male prostate cancer screening[40], are covered. You may have to pay for services that aren't preventive. Talk with your provider to see whether the treatments you need are preventative, then check what your plan will pay for. If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the full amount. ***(See Footnote 35 & 36 & 37)***
Telemedicine	**24/7 Teladoc Telehealth service subscription**	0% coinsurance	0% coinsurance	Teladoc Telehealth services provide 24/7 telephone conference access for general medicine, anywhere in the United States and is included with your membership. ***(See Footnote 41)***

[36] All paid fees are based on the allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid. Members pay the remainder of the lab charges not covered.
[37] Nova will cover annual wellness visit lab tests whose Medicare or Medicaid reimbursement rate is under $ 50.00 for each test ordered without preauthorization prior to the deductible being met.
[38] All Laboratory test that are over $ 50.00 may require a yearly, multiple year or single use pre-authorization.
[39] 0% coinsurance after the deductible has been met.

[41] Our Members have access to an amazing benefit, HealthiestYou. No more waiting at the doctor's office for General Medical. See (Televideo) or talk to a doctor 24/7. Talk to a licensed doctor by phone or video from anywhere. Get an Expert Medical Opinion or get a second opinion from leading experts on more-serious conditions.

Health and Wellness Treatments & Services

"None of the services in this category can be reimbursed until the deductible has been met. You may combine any health and wellness treatments & services up to the limits below to reach the deductible**:**

- $ 2000.00 max benefit for Individual
- $ 4000.00 max benefit for Individual +1
- $ 4000.00 max benefit for Family

Common Medical Event	Services You May Need	What You Will Pay Preferred Providers	What You Will Pay NON-Preferred providers	Limitations, Exceptions, & Other Important Information
Health, Wellness Treatments & Services	**Chiropractic care**	0% coinsurance after the deductible has been met. ***(See Footnote 42)***	If the deductible has been met, the member may still have a balance owed and will need to pay coinsurance balance billing based on our allowable fee schedule. ***(See Footnote 43)***	**Note:** You may combine any service in the wellness treatments & services benefit package *until the maximum limit has been met.* Your chiropractic provider can refer you to see a specialist, which includes holistic / naturopathic providers. Please note if the specialist needs to provide additional services, those services will need a preauthorization. **Note:** If your provider includes holistic / naturopathic doctors, their orders and referrals may include "over-the-counter" supplements and essential oils, which may be reimbursed as an authorized benefit if the rules for coverage limitations are followed in the wellness treatments and services. **Note:** Although you can see your Chiropractor without a preauthorization using your wellness treatments & services benefits, it is recommended that the member speak with the Nova Claims department about how to combine visit limits per injury with your wellness treatments & services to increase visit limits. The member may be responsible for paying the entire cost if the reimbursement procedure for submitting receipts is not followed. ***(See Footnote 44 & 48 & 45)***
Wellness Treatment Services:	**Massage therapy**	***(See Footnote 42)***	***(See Footnote 43)***	**Note:** This Service can be paired with any other Service in the wellness treatments & services benefit package until the maximum limit has been reached. If the reimbursement policy for submitting receipts is not followed, the member may be responsible for paying the whole amount. ***(See Footnote 44 & 48)***
Wellness Treatments & Services:	**Homeopathy providers**	***(See Footnote 42)***	***(See Footnote 43)***	**Note:** This Service can be combined with any other Service in the Wellness Treatments & Services benefit package until the maximum limit has been reached. If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the full amount. ***(See Footnote 44 & 48)***
Wellness Treatments & Services:	**Holistic providers**	0% coinsurance after the deductible has been met ***(See Footnote 46)***	The Member may pay coinsurance, balance billing	**Note:** This Service can be combined with any other Service in the wellness treatments & services benefit package until the maximum limit has been reached. If the reimbursement policy for submitting receipts is not followed, the Member

[42] 0% coinsurance after the deductible has been met.
[43] If the deductible has been met, the member may still have a balance owed and will need to pay coinsurance balance billing based on our allowable fee scheduled.
[44] All provider-based services must be billed directly from the providers' office for reimbursement on the proper claim form. See reimbursement policy for clarification of details.
[45] All provider-based services must be billed directly from the providers' office for reimbursement on the proper claim form. See reimbursement policy for clarification of details.
[46] 0% coinsurance after **the** deductible has been met.

Common Medical Event	Services You May Need	What You Will Pay Preferred Providers	What You Will Pay NON-Preferred providers	Limitations, Exceptions, & Other Important Information
			based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed. ***(See Footnote 47)***	might be responsible for paying the full amount. ***(*See Footnote *44 & 48*)**
Wellness Treatments & Services:	**Naturopathic providers**	***(See Footnote* 46*)***	***(See Footnote 47)***	**Note:** This Service can be combined with any other Service in the wellness treatments & services benefit package until the maximum limit has been met. If the reimbursement policy on our website for submitting receipts is not followed, the Member might be responsible for paying the full amount. ***(See Footnote 48*)**
Wellness Treatments & Services:	**Hearing tests & aids**	***(See Footnote* 46*)***	***(See Footnote47)***	**Note:** This Service can be combined with any other Service in the wellness treatments & services benefit package until the maximum limit has been reached.If the reimbursement policy on our website for submitting receipts is not followed, the Member might be responsible for paying the full amount***. (See Footnote 48)***
Wellness Treatments & Services:	**Acupuncture**	***(See Footnote* 46*)***	***(See Footnote47)***	**Note:** This Service can be combined with any other Service in the wellness treatments & services benefit package until the maximum limit has been reached. If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the full amount. ***(See Footnote 48)***
Wellness Treatments & Services:	**Supplements & Essential Oils***	0% coinsurance After the deductible has been met. ***(See Footnote 46)***	***(See Footnote 47)***	**Note:** This service can be combined with any other Service in the wellness treatments & services benefit package until the maximum limit has been met. These are the plan limitations for this benefit category: There will be no reimbursement until the deductible has been satisfied. • No more than three bottles of a 30-day supply of supplements each month from an approved manufacturer of supplements. • No more than two bottles of essential oils per person each month. ***(See Footnote 49)*** It is important to note that not all supplements and essential oils are equal, nor will all of them be accepted. A USP dietary supplement verification program stamp or mark should be present on the supplements you buy. For essential oils, we have two approved manufacturers you can purchase from as they follow good manufacturing standards (CGMPs). dōTERRA Essential Oils and or Young Living Essential Oils. See reimbursement policy on our website for submitting receipts. ***(See***

[47] Members may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed.
[48] All paid fees are based on allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid. Members pay the remainder of the lab charges not covered.
[49] Some essential oils will be considered one bottle per plan due to the nature of the oil. Please contact benefits to review a specific essential oil. The member will need to follow all reimbursement guidelines posted on our website to ensure the cost is credited to the deductible or if the deductible is met then reimbursed to the Member directly.

Common Medical Event	Services You May Need	What You Will Pay Preferred Providers	What You Will Pay NON-Preferred providers	Limitations, Exceptions, & Other Important Information
				***Footnote* 50)**

Common Medical Event	Services You May Need	What You Will Pay Preferred Providers	What You Will Pay NON-Preferred providers	Limitations, Exceptions, & Other Important Information
Weight Loss, Strength training training Programs	**Gym Membership**	Reimbursed to the Member after 12 months of continuous membership*	Reimbursed to the Member after 12 months of continuous membership*	Includes standard Gym fitness programs, Yoga studios, Pilates studios • $200.00 toward yearly gym membership Individual* • $400.00 toward yearly gym membership Individual+1/Family Must be a yearly membership and must complete one year of plan enrollment lessor of clause applies.
Vision Coverage	**Routine Eye Care**	$350.00 benefit per person on plan	$350.00 benefit per person on plan	Vision coverage $350.00 towards any vision service per year. $350.00 benefit per person on the plan. Benefit starts three months after date of enrollment or anniversary enrollment date of each year enrolled. This includes adult / child screenings / eye refraction for vision correction purposes.
Biological/Holistic Dental Care	**Routine Dental Care Biological Dental Care / Holistic Dental Care**	$ 1,000.00 max per individual per year	$ 1,000.00 max per individual per year	$ 1,000.00 max per individual per year Benefit starts three months from the date of enrollment or each year's anniversary enrollment date. This covers tests for adults and children, as well as eye refraction for vision correction.

Common Medical Event	Services You May Need	What You Will Pay Preferred Providers	What You Will Pay NON-Preferred providers	Limitations, Exceptions, & Other Important Information
Laboratory, Diagnostic or Imaging	**Laboratory testing** (blood work)	0% coinsurance after the deductible has been met. ***(See Footnote 51)***	The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has	Excluding the laboratory tests below, Nova requires a preauthorization for lab tests where the billed amount is over $50.00. ***(See Footnote 53 & 54 & 44)*** This list contains examples of standard annual wellness visit lab tests that may be ordered. Complete Blood Count (CBC), lipid, Comprehensive Metabolic Panel (CMP), cholesterol panel, urinalysis, glucose blood sugar, hemoglobin A1c, prothrombin time with INR, C-reactive protein (CRP) (HS-CRP), and thyroid function. It is possible that additional lab tests could still

[50] If the reimbursement policy for submitting receipts is not followed, the Member might be responsible for paying the full amount. The amount will not be applied to the deductible if the deductible is not met, if the deductible is met no reimbursement will be issued.
[51] 0% coinsurance after the deductible has been met.
[53] All paid fees are based on the allowed amount for CPT/Diagnosis combinations using billing guidelines from Medicare and Medicaid. Members pay the remainder of the lab charges not covered.
[54] Nova will cover Annual Wellness Visit lab tests whose Medicare or Medicaid reimbursement rate is under $ 50.00 for each test ordered without preauthorization prior to the deductible being met.

			been met. The Member may still have a balance owed. ***(See Footnote 52)***	be covered. Please contact us if you have any questions about whether a particular test would be covered as part of an annual wellness visit lab test. ***(See Footnote 55)*** If a preauthorization is not obtained prior to the services being rendered, the member is responsible for paying the full amount.
Laboratory, Diagnostic or Imaging	**Diagnostic test** (X-Ray,) Imaging (CT/PET Scans, MRIs, Ultrasounds, etc.…)	0% coinsurance after the deductible has been met. ***(See Footnote 51)***	***(See Footnote 52)***	If a preauthorization is not obtained prior to the services being rendered, the Member is responsible for paying the full amount. All diagnostic tests must meet the definition of **medically necessary** based on Medicare/Medicaid and our guidelines***. (See Footnote*** *53 & 56 & **57**)*
Outpatient Surgery	Facility fee (e.g., **Ambulatory surgery** center) includes all additional provider fees and services.	0% coinsurance after the deductible has been met. ***(See Footnote 51)***	***(See Footnote 52)***	**All** outpatient surgical procedures require a preauthorization and a provider order. See the preauthorization form for details on how to submit a complete request for preauthorization for surgery. The preauthorization should include all professional, facility, and other charges that will be billed as part of the surgery. **All preadmission testing** must be performed and included in the surgical procedure when possible. All surgeries must meet the definition of **medically necessary** based on Medicare/Medicaid and our guidelines***.*** ***(See*** *Footnote 59)*
Outpatient Surgery	**Additional physician/ surgeon fees**	0% coinsurance after the deductible has been met***.(See Footnote 51****)*	The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed. ***(See Footnote 58)***	The following must be included in the **preauthorization** request for surgery or procedure. **All outpatient surgical procedures** require a preauthorization and a provider order. See preauthorization form for details on how to submit a complete request for preauthorization for a surgery. The preauthorization should contain all professional, facility, and other charges that will be billed as part of the surgery. **All preadmission testing** must be performed and included in the surgery procedure when possible. All surgeries must meet the definition of **medically necessary** based on Medicare/Medicaid and our guidelines*. (See Footnote 59)*
If you need immediate medical attention	**Emergency Room Care**	0% coinsurance after the deductible has been met. ***(See Footnote 60)***	***(See Footnote 58)***	Once the patient is stabilized and is able, we ask that the patient notify the hospital that emergency room surgical procedures may require a preauthorization and a provider order. Details on how to submit a complete Preauthorization request may be found on the preauthorization form.

[52] The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed.
[55] All Laboratory tests that are over $ 50.00 may require a yearly, multiple year or single use preauthorization.
[57] All provider-based services must be billed directly from the providers office for reimbursement on the proper claim form. See the reimbursement policy for clarification of details.
[58] The Member may pay coinsurance, balance billing based on our allowable fee schedule if the deductible has been met. The Member may still have a balance owed.

				All professional, facility, and other charges that will be billed as part of the emergency room care should be included in the preauthorization when possible. **All emergency room care must meet the definition of medically necessary based on Medicare/Medicaid and our guidelines. *(See Footnote 59 & 60)***
If you need immediate medical attention	**Emergency medical transportation**	Limited coverage	Limited coverage	The current benefit is $ 300.00 towards a one-way trip. This is not paid prior to the **deductible** being met. Round-trip emergency medical transportation is not covered by Nova Pathfinder Healthcare.
If you need immediate medical attention	Urgent **care**	0% coinsurance after the deductible has been met. ***(See Footnote 60)***	***(See Footnote 58)***	Once the patient is stabilized, Nova Pathfinder Healthcare asks that the patient notify the urgent care clinic that some urgent care surgical procedures require a preauthorization and a provider's order. See the preauthorization form for details on how to submit a complete request for preauthorization. **All professional, facility, and other charges** that will be billed as part of the urgent care should be included in the preauthorization. **All surgeries must meet the definition of medically necessary based on Medicare/Medicaid and our guidelines. *(See Footnote 59).***
If you have a **Hospital Stay**	**Inpatient/ observation** Facility fee (e.g., hospital room includes diagnosis services)	0% coinsurance after the deductible has been met. ***(See Footnote 60)***	The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed. ***(See Footnote 62)***	Once the patient has stabilized, Nova Pathfinder Limited Healthcare asks that the patient notify the hospital admissions department that all Inpatient stays and surgical procedures require a preauthorization and a provider order. See the preauthorization form for details on how to submit a complete request for preauthorization. **The preauthorization should include all proessional, facility, and other charges** that will be billed as part of the surgery. **All preadmission testing** must be performed and included in the surgical procedure when possible. All surgeries must meet the definition of **medically necessary** based on Medicare/Medicaid and our guidelines. *(See Footnote 59)*
If you have a **Hospital Stay**	**Inpatient physician/ surgeon fees**	0% coinsurance after the deductible has been met. ***(See Footnote 62)***	***(See Footnote** Error! Bookmark not defined.**)***	**All Physician/Surgeon** fees for outpatient surgical procedures require a preauthorization and a provider order. See the preauthorization form for details on how to submit a complete request for preauthorization. All professional, facility, and other charges that will be billed as part of the surgery should be included in the preauthorization. **All preadmission testing** must be performed and included in the surgical procedure when possible. **All surgeries must meet the definition of medically necessary based on Medicare/Medicaid and our guidelines.**

[59] All paid fees are based on the allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid. Members pay the remainder of the lab charges not covered.
[60] 0% coinsurance after the deductible has been met.

				(See Footnote 61)
Outpatient Services If you need Mental Health, Behavioral Health, or Substance Abuse Services	Mental health, behavioral health, or substance abuse services office visit	***(See Footnote 62)***	***(See Footnote** Error! Bookmark not defined.**)***	**All** office visits for **outpatient services** do not require a referral. However they do require a provider order and a preauthorization when additional services are requested.
Outpatient Services If you need Mental Health, Behavioral Health, or Substance Abuse Services	**Facility fee (e.g., hospital room services, physician/ surgeon fees**	***(See Footnote 62)***	***(See Footnote** Error! Bookmark not defined.**)***	Once the patient is stabilized, Nova Pathfinder Healthcare asks that the patient notify the hospital admissions department that all inpatient stays and surgical procedures might require a preauthorization and a provider order. See the preauthorization form for details on how to submit a complete request for preauthorization for surgery. **All professional, facility, and other charges** that will be billed as part of the surgery should be included in the preauthorization. **All preadmission testing** must be performed and included in the surgical procedure when possible. **All surgeries must meet the definition of medically necessary based on Medicare/Medicaid and our guidelines.** ***(See Footnote 61)***
Maternity Services: If you are pregnant	**Office visits**	0% coinsurance after the deductible has been met. ***(See Footnote 63)***	The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed. ***(See Footnote 64)***	If you have not met your deductible and/or the services are not part of our pregnancy protocol, you may have to pay for services that aren't preventative or part of your birth. Talk with your provider about whether the services you need are preventative or part of your delivery. Then, using the pregnancy protocol as a guideline, see what your plan will cover. **All services require a preauthorization** and a provider order. See the preauthorization form for details on how to submit a complete request for surgery preauthorization. **All professional, facility, and other charges** that will be billed as part of the surgery should be included in the preauthorization. **All Preadmission Testing** must be performed and included in the surgical procedure when possible. **All surgeries must meet the definition of medically necessary based on Medicare/Medicaid and our guidelines**. ***(See Footnote 65 & 67)***
If you are pregnant	**Childbirth/ delivery**	***(See Footnote 63)***	***(See Footnote 64)***	Nova Pathfinder Healthcare allows for coverage based on pregnancy protocol for delivery, pre-and post-maternity services and facilities that

[61] All provider-based services must be billed directly from the providers office for reimbursement on the proper claim form. See the reimbursement policy for clarification of details.
[62] 0% coinsurance after the deductible has been met.
[63] 0% coinsurance after the deductible has been met.
[64] The Member may pay coinsurance, balance billing based on our allowable fee schedule if the deductible has been met. The Member may still have a balance owed
[65] All provider-based services must be billed directly from the providers office for reimbursement on the proper claim form. See the reimbursement policy for clarification of details.

	facility/ professional services			provide the lowest risk to the expectant mother and the baby in the listed options. A licensed hospital or birthing facility, OBGYN/hospital delivery, and c-section are all included.
If you are pregnant	**Newborn**	***(See Footnote 63)***	***(See Footnote 64)***	Newborn or newborns must be added to the plan within 30 days after birth under the family plan. A member who is currently on an individual +1 plan, must upgrade to family plan.
If you need help recovering or have other special health needs	***"At home"*** **non-skilled home health care**	(See Footnote 63)	***(See Footnote 64)***	A **non-skilled *"At home"* healthcare** benefit of $50.00 per day for a maximum of 30 days. This is not paid until the deductible has been met. ***(See Footnote & 66)*** Limited to 30 visits per calendar year (rehabilitation,outpatient habilitation, and home health services are each limited to separate visit limits each calendar year). **All home health care** requires a preauthorization and a provider's order. See the preauthorization form for details on how to submit a complete request for preauthorization. **All services must meet the definition of medically necessary based on Medicare/Medicaid and our medical review board guidelines.** ***(See Footnote 66 & 67)***
If you need help recovering or have other special health needs	***"At home"*** home health **care services**	***(See Footnote 63)***	***(See Footnote 64)***	*"At home"* skilled home healthcare benefit is $ 50.00 per day for a maximum of 30 days. This is not paid until the deductible has been met. ***(See Footnote 66)*** Limited to 30 visits per calendar year (rehabilitation, outpatient rehabilitation,and home health services are each limited to separate visit limits each calendar year). **All *"At home"* skilled home health care** services require a preauthorization and a provider's order. See the preauthorization form for details on how to submit a complete request for preauthorization. All *"At home"* skilled home health care services must meet the definition of medically necessary based on Medicare/Medicaid and our medical review board guidelines. *(See Footnote 68 & 70)*
If you need help recovering or have other special health needs	**Rehabilitation services**	0% coinsurance after the deductible has been met. ***(See Footnote 71)***	The Member may pay coinsurance, balance billing based on our allowable fee schedule if the deductible has been met. The Member may still	**Outpatient rehabilitation services** benefit is $ 50.00 per day for a maximum of 30 days and is limited to 30 visits per calendar year. (Rehabilitative/habilitative home health services are each limited to separate visit limits each calendar year). **All outpatient rehabilitation services** require a preauthorization and a provider's order. See the preauthorization form for details on how to submit a complete request for preauthorization**. All outpatient rehabilitation services must meet the definition of medically necessary.** The *"at home"* outpatient rehabilitation services benefit is $ 50.00 per day for a maximum of

[66] "At home" skilled home health care services include skilled nursing, physical therapy, speech therapy, and occupational therapy etc. These are limited hours sessions.
[67] All paid fees are based on **allowed amount** for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid. Members pay the remainder of the lab charges not covered.
[68] All **provider**-based services must be billed directly from the **providers**' office for reimbursement on the proper claim form. See the reimbursement policy for clarification of details.

			have a balance owed. ***(See Footnote 72)***	30 days. Not paid until the deductible has been met. ***(See Footnote 69)*** Limited to 30 visits per calendar year (rehabilitation and outpatient habilitation home health services are each limited to separate visit limits each calendar year). **All *"at home"* outpatient rehabilitation services** require a preauthorization and a provider order. See the preauthorization form for details on how to submit a complete request for preauthorization. **All outpatient rehabilitation services must meet the definition of medically necessary based on Medicare/Medicaid and our medical review board guidelines. *(See Footnote 68 & 71)***
If you need help recovering or have other special health needs	**Habilitation services**	***(See Footnote 71)***	***(See Footnote 72)***	*The "At home"* outpatient habilitation services benefit is $ 50.00 per day for maximum of 30 days and limited to 30 visits per calendar year. (Rehabilitative/habilitative home health services are each limited to separate visit limits each calendar year). **All outpatient** habilitation services require a preauthorization and a provider's order. See the preauthorization for details on how to submit a complete request for preauthorization. All outpatient habilitation services must meet the definition of medically necessary based on Medicare and our guidelines. *(See Footnote 73 & 76)*
If you need help recovering or have other special health needs	**Skilled nursing care**	0% coinsurance after the deductible has been met. ***(See Footnote 74)***	The Member may pay coinsurance, balance billing *based on our* Allowable fee schedule *if* deductible *has been met. The Member may still have a balance owed.* ***(See Footnote 75)***	There is a $ 175.00 per day for maximum of 30 days. This is limited to 30 visits per calendar year. (Rehabilitative/habilitative and skilled nursing care services are each limited to rehabilitation and skilled nursing care combined visit limits each calendar year). **All skilled nursing care services** require a preauthorization and a provider order. See the preauthorization form for details on how to submit a complete request for preauthorization. All skilled nursing care services must meet the definition of medically necessary based on Medicare and our guidelines. *(See Footnote 73 & 76)*
If you need help recovering or have other special health needs	**Durable Medical Equipment (DME)**	***(See Footnote 74)***	***(See Footnote75)***	**DME** (Durable Medical Equipment) are limited to a maximum of $ 500.00 each calendar year. **All DME** require a preauthorization and a provider's order. See the preauthorization form for details on how to submit a complete request for preauthorization for a surgery. All DME must meet the definition of medically

[69] "At home" skilled home health care services include skilled nursing, physical therapy, speech therapy, and occupational therapy etc. These are limited hours sessions.
[71] 0% coinsurance after the deductible has been met.
[72] The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed.
[73] All provider-based services must be billed directly from the providers office for reimbursement on the proper claim form. See the reimbursement policy for clarification of details.
[74] 0% coinsurance after the deductible has been met.
[75] The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed.

				necessary based on Medicare and our guidelines.*(See Footnote 73 & 76)*
If you need help recovering or have other special health needs		0% coinsurance after the deductible has been met. ***(See Footnote 74)***	***(See Footnote 75)***	DME are limited to a maximum of $ 500.00 each calendar year. **All DME** require a preauthorization and a provider's order. See the preauthorization form for details on how to submit a complete request for preauthorization for a surgery. All DME must meet the definition of **medically necessary** based on Medicare and our guidelines.*(See Footnote 73 & 76)*
If you need help recovering or have other special health needs	**Hospice Care Services**	0% coinsurance after the deductible has been met. ***(See Footnote 74)***	The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met. The Member may still have a balance owed. ***(See Footnote*** *Error! Bookmark not defined.**)***	There is a $ 175.00 per day for maximum of 30 days. This is limited to 30 visits per calendar year. (Rehabilitative/habilitative and hospice care services are each limited to rehabilitation and skilled nursing care combined visit limits each calendar year). **All hospice care services** require a preauthorization and a provider's order. See the preauthorization form for details on how to submit a complete request. **All hospice care services must meet the definition of medically necessary based on Medicare and our guidelines. *(See Footnote 77 & 76)***
If your child needs eye care	**Children's Eye Exam & Children's Glasses**	***(See Footnote 78)***	***(See Footnote*** *Error! Bookmark not defined.**)***	Vision coverage pays $ 350.00 toward any Vision service per 12-month benefit period per person on the plan.
If your child needs dental	**Children's Dental Check-up**	0% coinsurance after the deductible has been met. ***(See Footnote 78)***	The Member may pay coinsurance, balance billing based on our Allowable fee schedule if the deductible has been met.	$ 1,000.00 max per individual per year per person on the plan. This is the Member's child dental benefit.

Excluded Services & Other Covered Services:

[76] All paid fees are based on allowed amount for CPT/diagnosis combinations using billing guidelines from Medicare and Medicaid. Members pay the remainder of the lab charges not covered.
[77] All provider-based services must be billed directly from the providers office for reimbursement on the proper claim form. See the reimbursement policy for clarification of details.
[78] 0% coinsurance after the deductible has been met.

Services your plan generally does NOT cover (This is not a complete list. Please see your plan document.)		
• Cosmetic surgery • Bariatric surgery (covered through the preferred provider network if medically necessary)	• Infertility services • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Long-term care

Other covered services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)
• Abortion services • Hearing aids • Routine foot care

Health economics, pricing, benefits, preauthorization, and reimbursement information provided by NOVA Healthcare are gathered from third-party sources and are subject to change without notice due to complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute medical, reimbursement, or legal advice. NOVA Healthcare encourages providers to submit accurate and appropriate requests for services; and to submit accurate and appropriate requests for payment of claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services that are to be preauthorized and/or services to be rendered. NOVA Healthcare recommends that you consult with any additional providers that will provide service to document additional preapprovals or reimbursements agreements. If there is a need to consult other reimbursement specialists and/or legal counsel regarding coding, coverage, and reimbursement matters. NOVA Healthcare uses nThrive to determine the most appropriate reimbursement. The provider and facility will hold harmless NOVA HealthCare against any claims outside of allowed and not allowed pricing requests when accepting to provide services to NOVA Healthcare members. NOVA Healthcare works with providers to avoid balance billing members. We strive to work with providers to pay reasonable, fair prices. The information included herein is current as of 10/13/2021 and is subject to change without notice.

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