Summary of Benefits and Coverage

EASY ENROLLMENT ON YOUR SCHEDULE

For your peace of mind, Nova Pathfinder Limited offers a 365-day registration (open enrollment) period. You have the flexibility to enroll whenever you like or change your existing plan if you believe your current health insurance costs are too high.

HOLISTIC, ALTERNATIVE, AND CONVENTIONAL HEALTH CARE COVERAGE

Conventional medical treatments can be integrated with holistic, naturopathic, homeopathic, and herbal approaches to offer our members a well-rounded wellness journey. myNovaHealthcare also covers supplements, essential oils, medical marijuana, and holistic dental care. Rest assured; you can keep seeing your current healthcare provider while receiving the same level of care.

A FLEXIBLE HEALTHCARE PLAN

With myNovaHealthcare, our members enjoy the liberty to make their own healthcare choices along with the reassurance of security and peace of mind. What sets us apart is our extensive array of both traditional and alternative healthcare options, which are unparalleled elsewhere. You are in the driver's seat when it comes to managing your healthcare, ensuring that you are well-covered for whatever life may bring your way.

Nova Pathfinder Limited is dedicated to providing a cost-effective and valuable health plan for our members. By making holistic healthcare options more readily available, we aim to enhance the overall well-being of our members while empowering them to select the most suitable healthcare solutions for their needs.

WHAT IS A HIGH DEDUCTIBLE HEALTH PLAN?

A High Deductible Health Plan (HDHP) is a type of health insurance plan that offers lower monthly premiums in exchange for a higher annual deductible. This means that under an HDHP, you will pay less each month for your insurance, but you will need to pay more out-of-pocket for medical expenses before your insurance coverage kicks in. These plans are often paired with Health Savings Accounts (HSAs), which allow you to save money tax-free for qualified medical expenses.

Summary of Benefits:

Lower Premiums: One of the main advantages of an HDHP is that it typically has lower monthly premiums compared to other types of plans like PPOs or HMOs.

High Deductible: You will have a higher annual deductible that you must pay before the insurance company starts covering your medical costs. The deductible for an HDHP is usually significantly higher than for other types of health plans.

Out-of-Pocket Maximum: Like other plans, HDHPs have an out-of-pocket maximum which caps the amount you will have to pay for medical expenses in a single year, including the deductible and any copayments or coinsurance.

Health Savings Account (HSA) Eligibility: Many HDHPs allow you to open an HSA, which lets you save money tax-free for medical expenses. Some employers even contribute to these accounts. Health Savings Account (HSA) - Glossary | HealthCare.gov

Preventive Services: Many HDHPs cover preventive services, like vaccinations and screenings, without requiring you to first meet the deductible.

Choice of Providers: Depending on the HDHP, you may have more flexibility in choosing healthcare providers compared to an HMO, though using in-network providers will usually save you money.

Cost-Sharing: After meeting the deductible, you may still be responsible for a portion of costs (known as coinsurance) until you reach your out-of-pocket maximum.

Catastrophic Coverage: HDHPs can be a good option for those who don't require frequent medical services and want a safety net for major medical expenses.

Ideal For:

- Individuals who are generally healthy and don't anticipate many medical expenses.
- Those who want lower monthly premiums.
- People who are comfortable paying more upfront for medical services.
- Individuals who want to take advantage of an HSA.

Our high-deductible health plan not only includes standard benefits like dental and vision coverage but also offers allowances for holistic and naturopathic care to meet your family's unique health needs. Additionally, your plan features virtual consultations with doctors, an online member portal, a member referral program, and the flexibility to utilize a Health Savings Account (HSA).

COVERAGE LIMITS

Plan Type	Deductible
IND	$5000
IND+1/FAM	$10000

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.

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 Access Network	Yes
Holistic and Naturopathic Providers	Yes
24/7 General Medicine Teladoc Membership	Yes

As a member, you have access to "Healthiest You" by Teladoc, 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: $500 per individual per year is covered toward Dental Care.

Any additional cost above the benefit of $500 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 additional cost above the benefit of $350 is the Member's responsibility. *Members must be active on the plan for three months to qualify.

ACA ESSENTIAL HEALTH BENEFITS

The Affordable Care Act (ACA) mandates that all Essential Health Benefits (EHB) be included to ensure that individuals and small groups in the health insurance market have access to comprehensive coverage encompassing necessary services. The healthcare plan offered by Nova Pathfinder Limited complies with these stipulations.

THE NOVA PATHFINDER EHB COVERAGES INCLUDE:

- Birth control coverage
- 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:

- Maternity Allowances with a pre authorization

ADDITIONAL COVERED SERVICES AS BENEFITS:

- Annual Wellness
- Dental coverage
- Vision coverage

ALLOWANCES BENEFITS and COVERAGE - ABCs

Allowances refer to the approved wellness treatments or services that contribute toward your deductible. In the context of your health insurance policy, allowances are designed to encourage you to take advantage of proactive and preventive healthcare services, like chiropractic treatments and massage therapy. These allowances also help our members meet their deductible by covering preventive and wellness services they are already using.

APPROVED WELLNESS TREATMENTS & SERVICES INCLUDE:

- Acupuncture
- Massage Therapy
- Chiropractic Care
- Naturopathic Care

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

BENEFITS

Benefits refer to “non-medically necessary” treatments or services also offered in the myNovaHealthCare plan. Benefits included are Dental, Vision and Wellness Visits. See Health & Wellness Treatments and Services for details. Other notable benefits are the Member Services, Open Enrollment, and our Open Access Network.

COVERAGE

Coverage pertains to healthcare services rendered by a provider for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms. It is not designed to cover elective, preventive, or wellness treatments and services. Rather, the focus of coverage is to provide financial protection in the event of a significant health crisis. As previously mentioned, the myNovaHealthcare plan includes all Essential Health Benefits as mandated. *See above in ACA Essential Health Benefits for a list of EHB's

HEALTH AND WELLNESS TREATMENTS AND SERVICES

Due to a strong commitment to enhancing the health and well-being of our members through natural approaches, Nova Pathfinder Limited provides both holistic/naturopathic healthcare allowances and traditional coverage options. Services such as acupuncture, massage therapy, chiropractic care, naturopathy, homeopathy, physical therapy, and approved supplements and essential oils are all included in the plan. Recognizing that these are highly valued services and products among our member base, Nova Pathfinder Limited has structured these allowances to count toward meeting the deductible. This approach enables members to reach their deductible more quickly, especially since many already utilize these services.

Health and Wellness Treatments and Services: Acupuncture, Massage Therapy, Physical Therapy, Chiropractic Care, Naturopathic Care, Holistic Care, Homeopathic Services, Supplements & Essential Oils.

Health and Wellness Limits

- $ 2000.00 max allowance for Individual
- $ 3000.00 max allowance for Individual +1
- $ 4000.00 max allowance for Family

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

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

Massage Therapy: 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 $300 annually, starting after three months of membership. Office visit, basic labs and chest Xray up for a total of $300 annually. Any additional cost over $300 is applied toward the deductible and paid by the 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.

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 preauthorization

Chiropractic Care: $1200 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.

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.

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.

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.

Supplements & Essential Oils: This service can be combined with any other service in the wellness treatment & 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

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

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: $350 per member,after the member has been on the plan for 90days.

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 $500 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 be .

Dental Benefits: $500 per membership year, after the member has been on the plan for 90days.

The billing process is as follows: Vision and Dental services are not applied toward the deductible. These benefits 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 the 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 Member Services 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.

*Using the member portal to submit claims is strongly encouraged for both efficiency and HIPAA compliance.

WOMEN'S HEALTH SERVICES

Nova Pathfinder Limited covers a comprehensive range of women's health services, including contraception, prenatal, neonatal, and postpartum care. Your healthcare package also encompasses well visits, accredited birth centers, and childbirth services. You retain full autonomy over your parenting journey. To facilitate a smooth birthing experience, Nova Pathfinder Limited mandates pre-authorization and planning. Therefore, you will need to collaborate with our Member Services Department to develop a customized pregnancy plan for both you and your newborn.

Please note that all copayments and coinsurance fees for the services listed below are applied before your deductible, if applicable. This means you are responsible for covering all provider fees up to the deductible amount before this plan starts to pay for the subsequent expenses. After meeting the deductible, members are subject to 0% coinsurance or a $0 copay for birth control. This includes all standard methods of contraception as outlined in the Affordable Care Act (ACA), encompassing all contraceptive methods approved by the Food and Drug Administration (FDA) and 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 Limited 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, preauthorization is required.
- 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 for directly, not applied to the deductible, starting after three months.

Pre-planned C-section births require pre-authorization, a provider's order, and planning with our Member Services 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 preauthorization.

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 should 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 medical needs will be covered within the 30-day grace period under the mother's plan up to the limits. If a necessity 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 are referred to as outpatient routine newborn circumcisions.

All Durable Medical Equipment (DME) requires 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.

Breast Pumps fall under DME and are limited to a maximum of $500.00 each calendar year.

Excluded 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.

OPEN ACCESS NETWORK

An Open Access Network in health insurance offers members a broader range of healthcare providers to choose from without requiring a referral from a primary care physician. This model provides more flexibility and less administrative hassle for insured individuals. However, it's important to note that costs may vary depending on whether the provider is in-network or out of-network. For healthcare providers, participating in an Open Access Network can lead to increased patient volume and a more diverse patient base. Members should also understand their plan's details, such as co-payments and deductibles, especially when utilizing network services.

***Consult with the Member Services Department prior to receiving services.**

PREFERRED PROVIDERS

We aim to cultivate a relationship with healthcare providers before services are agreed upon. This approach ensures a mutual understanding of expectations, service quality, and financial arrangements, benefiting both parties involved.

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 Limited 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 NonPreferred Provider than with a Preferred Provider. Nova also refers to these providers as "nonparticipating."

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 Pathfinder Limited requests healthcare providers to submit their bills directly to us for payment processing.

Any bills you may receive should be sent to:

claims@mynovahealthcare.org *or*

faxed to 1-805-375-6090 *or* mailed to**: Nova** Pathfinder HealthCare 5739 Kanan Road, Suite # 336 Agoura, CA 91301

All inquires regarding Reimbursement or to check the status of your reimbursement, email Reimbursementdepartment@mynovahealthcare.org (Please note, one claim number must be submitted per ticket or your request will not be accepted.)

For non-emergency care, contact Teladoc first 1(800) 835-2362. Pre-authorizations should be filled out for all optional inpatient and outpatient surgical and diagnostic procedures.

MyNovaPathfinderHealthcare 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 Pathfinder Limited HealthCare Claims Department by email at: claims@mynovahealthcare.org, or call 1(888)-266- 4462, ext. 4

- "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.

Claims for Physician, Provider, or Hospital Services

Nova Pathfinder Limited advises members **not** to make upfront payments for services until the Claims department has determined the allowed reimbursement. This is to prevent any situations where the member may end up overpaying for a service.

If the member ends up paying for the service themselves, they must obtain a claim for that encounter. A simple payment receipt will **not** be sufficient for reimbursement; a claim form providing details about the service and payment is required.

In this way, Nova's reimbursement policy aims to create a balance between encouraging wellness activities and maintaining efficient, accountable reimbursement practices. It is crucial for members to understand these terms and follow the guidelines to make the most of out of their health benefits.

- Any service that requires a Pre-authorization will **not** be paid without an approved Preauthorization 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.

For faster and more secure processing, all Claims must be submitted directly through the Member portal.

Claim Form Accepted:

- Member Expenses
- CMS-1500
- UB-04

- Other specialties

Receipts (not Claims)

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

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. Any non-provider receipt over $100 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 day**s 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. The 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 reimbursement 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

Chiropractor Annual Wellness Visit

If your chiropractor is your primary care provider, they can perform a health and wellness visit. See a list of examples in the section 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.

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 panel
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.

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

- 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 preauthorization.

- 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.

Primary Care Annual Wellness Visit

Yearly visits are covered starting after three months of membership for a total of $300.00 annually.

Additional costs exceeding the $300.00 limit will be applied to the deductible and will be the responsibility of the Member.

MEMBERSHIP CARD INFORMATION

Your Membership Card/ID contains valuable information about your health insurance account. Your Membership ID number, key claim information and contacts, can be found on your card. Save your Membership card in a secure location. If you misplace your membership card, you can request a replacement from our Member Service Department. You can also download a copy from your member portal.

Member portal <---- link to member login

MEMBER SERVICES

Our Member Services 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 member services department 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 our member services department at memberservices@mynovahealthcare.org or by calling (888) 266-4462, Ext. 3.

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 do not follow the referral requirements. Your PCD/hospital or clinic cannot submit a retroactive referral for these circumstances.

- Your Primary Care Doctor (PCD) hospital or clinic appointment line/referral manager failed to submit the referral to us. We advise our members to contact the hospital's or clinic's patient advocate to determine if they will submit a referral for services already rendered.

  If the referral is approved, members can then contact us for a claim adjustment. Nova Pathfinder Limited 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 us, or the referral was submitted and rejected. If your PCD gave you a written referral but did not submit a referral to us, 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 Member services 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:

U.S. mail: Nova Pathfinder Healthcare Claims Correspondence
5739 Kanan Road Suite 336, Agoura, CA 91301

Other reasons not listed above you may also submit a request for review online:

Email via secure Encryption claims@mynovahealthcare.org

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