Optima Health
Optima Vantage Direct
Large Group

Effective Date: 07/01/2022

Evidence Of Coverage

Underwritten by Optima Health Plan

4417 Corporation Lane
Virginia Beach, VA 23462

OptimaHealth

IMPORTANT INFORMATION ABOUT YOUR HEALTH PLAN

In the event You need to contact someone about this policy for any reason, please contact Your agent or account representative. If no agent was involved in the sale of this insurance or if You have additional questions, You may contact the insurance company issuing this policy at the following address and telephone number:

Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462
Main Phone Number: 757-552-7401 or 1-877-552-7401
TTY for the hearing impaired: 1-800-828-1140 or 711

We recommend that You familiarize yourself with Our grievance procedure and make use of it before taking any other action.

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia Bureau of Insurance at:

Life & Health Division
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218
804-371-9741
In-State Toll Free 1-800-552-7945
Toll-Free: 1-877-310-6560
Fax 804-371-9944

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

Office of the Managed Care Ombudsman.

If You have any questions regarding an appeal or grievance concerning the health care services that You have been provided which have not been satisfactorily addressed by Your Plan, You may contact the Office of the Managed Care Ombudsman. The Managed Care Ombudsman is available to help Virginia consumers who experience problems with, or have questions about managed care. The Managed Care Ombudsman can assist Plan members in understanding and exercising their rights of appeal of adverse decisions. There are several ways to contact the Office of the Managed Care Ombudsman:

Write: Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Telephone: Toll-Free: 1-877-310-6560
Richmond Metropolitan Area: 1-804-371-9032
Fax 804-371-9944
E-Mail: ombudsman@scc.virginia.gov

Introduction And Welcome

Welcome to Optima Health. We are happy to be providing Your health benefits. This is Your Optima Health Evidence of Coverage or EOC. The EOC tells You how to make the most of Your coverage. Please read it carefully and if You have questions please call Member Services at the number on Your Optima Health ID card.

In this EOC You will find important information on:

- How Your policy works;
- Definitions and terms of Your coverage;
- Eligibility and enrollment;
- What is covered;
- What is not covered (exclusions);
- Cost Sharing You must pay out-of-pocket (Your plan Face Sheet);
- Additional coverage riders;
- Health benefits that must be pre-authorized before You receive them;
- Coverage under more than one policy;
- When Your coverage will end;
- Instructions for filing a complaint or an appeal; and
- Other important information.

Optima Health

This health plan is offered and underwritten by Optima Health Plan. In this document We may use the term Optima Health to refer to this plan. Optima Health is the trade name for several different companies including Optima Health Plan, Optima Health Insurance Company, and Sentara Health Plans, Inc. Health Maintenance Organization (HMO) and Point of Service (POS) health plans are provided and underwritten by Optima Health Plan. Preferred Provider Organization (PPO) plans are provided and underwritten by Optima Health Insurance Company. Sentara Health Plans, Inc. provides administrative services for other employer benefit plans.

Optima Health's Corporate Office is located at 4417 Corporation Lane Virginia Beach, Virginia 23462.

Optima Health Plan is subject to regulation in this Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

How to Get Language Assistance

If you, or someone you're helping, has questions about Optima Health you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Member Services phone number on the back of your Optima Health Member ID card.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260

Optima Vantage 150/25/20% Direct

Employer Group Name: Commonwealth of Virginia
Employer Group Number: 3262
Plan Effective Date: 07/01/2022
Optima Health Plan
Large Group Schedule of Benefits

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. This Plan has tiered Copayment or Coinsurance amounts listed for In-Network benefits. For some services You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals or other Facilities or providers. You or Your means the Subscriber and each family member who is a Covered Person under the Plan. Details about Covered Services are in the section "What is Covered." Details about services and treatments that are not covered are in the section "What is Not Covered."

Some benefits require Pre-Authorization before You receive them. These services are marked with an * in this document.

Some Covered Services may have visit limits. Once a visit limit is reached, no additional services are covered under the benefit. If a service is shown as covered under Out-of-Network benefits visit limits are combined with In-Network and Out-of-Network benefits unless otherwise stated.

Services or treatment You receive Out-of-Network or from Non-Plan Providers will not be covered under Your Plan unless:

1. The Covered Service is an Emergency Service;
2. During treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

If Your Plan has a Deductible that is the dollar amount that must be paid out-of-pocket by a Member for Covered Services each year before the Plan begins to pay for benefits.

Copayments and Coinsurances listed in this document are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan's Allowable Charge for Your Covered Service. You will pay a Copayment or a Coinsurance, but not both, for a Covered Service. For some benefits you may see the statement, "Cost sharing determined by the type and place of service." For these services Your cost sharing will be based on where You receive a service, for example in a physician office or inpatient setting, and/or the type of service.

Your Plan's Maximum Out-of-Pocket Amount means the total dollar amount Members pay, or that are paid on their behalf, out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the Maximum Amount.

Deductible and Maximum Out-of-Pocket Amount (MOOP)			
	In-Network Tier 1	**In-Network Tier 2**	**Out-of-Network**
Deductible Contract Year	$150/Individual; $300/Family	$150/Individual; $300/Family	Not Covered

The Plan has one combined Deductible for Tier 1 and Tier 2 In-Network Covered Services. Tier 1 and Tier 2 In-Network Covered Services will count toward meeting the In-Network Deductible.

The Deductible applies to all Covered Services except for:

- In-Network Preventive Care Services required by law;
- Other services in this document shown as Covered without a Deductible.

If You are the Subscriber, and the only Member Covered under Your Plan, the Individual Deductible amount applies. If You have other Family Members on Your Plan the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one Family Member meets the Individual Deductible his or her benefits will begin. Once the total Family coverage Deductible is met benefits are available for all family Members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a Member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible.
Any amounts applied to the Plan Deductible(s) during the last three months of the Plan year can be carried forward to the next year.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Deductible and Maximum Out-of-Pocket Amount (MOOP)			
	In-Network Tier 1	**In-Network Tier 2**	**Out-of-Network**
Maximum Out-of-Pocket Contract Year	$1,500/Individual; $3,000/Family	$1,500/Individual; $3,000/Family	Not Covered

The Plan has one combined Maximum Out-of-Pocket Amount for Tier 1 and Tier 2 In-Network Covered Services. Most amounts You pay, or that are paid on Your behalf, for Tier 1 and Tier 2 In-Network Covered Services will count toward meeting the In-Network Maximum.

The following will not count toward any Plan Maximum Amount(s):

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic is available;
- Other services in this document that are shown as excluded from the Maximum Amount.

If You are the Subscriber, and the only Member covered under Your Plan, the Individual Maximum applies. If You have other Family Members on Your Plan the Family Maximum applies. Under Family coverage, the Individual Maximum applies separately to each Covered Family Member. Once the total Family coverage Maximum is met the Family Maximum Amount is satisfied. No one Member can contribute more than their Individual Maximum Amount to the Family limit.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Optima Health approved providers. ***Pre-Authorization is required for in-office surgery**.			
Primary Care Visit	You Pay $5	You Pay $25	Not Covered
Virtual Consult	No Charge	No Charge	Not Covered
Specialist Visit	You Pay $10	You Pay $40	Not Covered
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Preventive Care Recommended Preventive Care Services are covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits/			
Recommended exams, screenings, tests, immunizations, and other services	No Charge	No Charge	Not Covered
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient facility, a Hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder.			
Occupational and Physical Therapy* Services limited to 30 combined visits per Contract Year.	You Pay $25	You Pay $25	Not Covered
Speech Therapy* Services limited to 30 visits per Contract Year.	You Pay $25	You Pay $25	Not Covered
Cardiac Rehabilitation* Services limited to 30 visits per Contract Year.	No Charge	No Charge	Not Covered
Pulmonary Rehabilitation* Services limited to 30 visits per Contract Year.	No Charge	No Charge	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Vascular Rehabilitation* Services limited to 30 visits per Contract Year.	No Charge	No Charge	Not Covered
Vestibular Rehabilitation* Services limited to 30 visits per Contract Year.	No Charge	No Charge	Not Covered
IV Infusion Therapy	You Pay $40	You Pay $40	Not Covered
Respiratory/Inhalation Therapy	You Pay $40	You Pay $40	Not Covered
Chemotherapy and Chemotherapy Drugs*	You Pay $40	You Pay $40	Not Covered
Radiation Therapy*	You Pay $40	You Pay $40	Not Covered
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	You Pay $100	You Pay $100	Not Covered
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.			
Dialysis Services	No Charge	No Charge	Not Covered
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free standing ambulatory surgery center or Hospital outpatient surgical facility.			
Surgery Services*	You Pay $125	You Pay $125	Not Covered
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient facility or lab or a Hospital outpatient facility or lab.			
Diagnostic Procedures	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
X-Ray Ultrasound Doppler Studies	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Lab Work	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a freestanding outpatient facility or a Hospital outpatient facility or lab.			
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.			
Maternity Care ***Pre-Authorization is required for prenatal services**	You Pay $150 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	You Pay $150 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
Inpatient Services			
Inpatient Hospital Services*	You Pay $300	You Pay $300	Not Covered
Transplants* Covered at contracted facilities only.	You Pay $300	You Pay $300	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Contract Year.	No Charge	No Charge	Not Covered
Ambulance Services Includes Emergency transportation, or non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way.			
Air, Water, Ground Services ***Pre-Authorization is required for non-emergency transportation.**	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered except for Emergency Services

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Emergency Services Includes Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including an independent freestanding Emergency Department, In-Network or Out-of-Network.			
Emergency Services	You Pay $150	You Pay $150	You Pay $150
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance.			
Urgent Care Services	You Pay $40	You Pay $40	Not Covered
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Optima Health providers. ***Pre-Authorization is required for Inpatient Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**			
Inpatient Services*	You Pay $300	You Pay $300	Not Covered
Outpatient Office Visits	You Pay $10	You Pay $10	Not Covered
Virtual Consults	No Charge	No Charge	Not Covered
Other Outpatient Visits (Facility/Freestanding Centers)	You Pay $125	You Pay $125	Not Covered
Employee Assistance Visits Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174.	No Charge for up to 4 visits from Optima Health Employee Assistance providers per presenting issue as determined by treatment protocols.		
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is covered from an In-Network Plan Provider or a participating VSP Vision Care provider at the office visit Copayment or Coinsurance amount.			
Insulin Pumps*	No Charge	No Charge	Not Covered
Pump Infusion Sets and Supplies*	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors, and control solution, and continuous glucose monitors, sensors, and supplies. ***Pre-Authorization is required for talking blood glucose monitors**	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit	Not Covered
Insulin, and Needles, and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	No Charge	Not Covered
Prosthetic Limb Replacement			
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Autism Spectrum Disorder Includes diagnosis and treatment of Autism Spectrum Disorder.			
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Durable Medical Equipment (DME) and Supplies			
DME, Orthopedic Devices, Prosthetic Appliances, Devices *Pre-Authorization is required for items over $750 *Pre-Authorization is required for repair, replacement and rental items.	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Early Intervention Services For Dependent children from birth to age three.			
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices. *	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home			
Home Health Care* Limited to a maximum of 100 visits per Contract Year.	No Charge	No Charge	Not Covered
Hospice Care			
Hospice Care*	No Charge	No Charge	Not Covered
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.			
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Infertility Services Includes limited services, for Members only, to diagnose and treat underlying medical conditions resulting in Infertility			
Endometrial biopsies Limited to 2 per lifetime **Semen analysis** Limited to 2 per lifetime **Hysterosalpingography** Limited to 2 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime **Sims-Huhner test (smear)** Limited to 4 per lifetime	Cost sharing is determined by the type and place of service.	Cost sharing is determined by the type and place of service.	Not Covered
Clinical Trials Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.			
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Allergy Care			
Allergy Care, Testing, and Serum	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.			
Telemedicine Services	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Out of Area Dependent Program Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits when Covered Services are received from Optima Health providers that participate in the Out of Area Program. The Plan will require eligible out of area Dependents to complete an annual certification form prior to being eligible for the program. Except for Emergency Services any Covered Services received outside of the service area from Out of Network Non-Plan Providers that are not included in the Out of Area Dependent Program will not be covered.			
Out-of-Area Program Services *Pre-Authorization requirements apply depending on the type and place of service.	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Optional benefit Chiropractic Care Rider Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit.			
Chiropractic Care Rider ***Pre-Authorization is required by ASH for all Chiropractic services.** Maximum number of visits 30 per Contract year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Contract year when medically necessary.	You Pay $35	You Pay $35	Not Covered
Optional benefit Hearing Aid Rider			
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $1,200: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 48 months from date of acquisition. Batteries and supplies are not covered.	You Pay $40 Cost sharing amounts You pay for this rider will not count toward Your Deductible or Maximum Out of Pocket Amount.	You Pay $40 Cost sharing amounts You pay for this rider will not count toward Your Deductible or Maximum Out of Pocket Amount.	Not Covered
Optional benefit Morbid Obesity Rider			
Morbid Obesity Rider* Covered Services include the treatment of morbid obesity through gastric bypass surgery or other methods recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Not Covered

Prescription Drugs
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This document describes Your Plan's outpatient prescription drug coverage. All drugs must be United States Food and Drug Administration (FDA) approved, and You must have a prescription. You will need to pay Your Copayment or Coinsurance when You fill your prescription at the pharmacy. If Your Plan has a Deductible, You must meet that amount before Your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited.

Details about Covered Services are in the section "What is Covered". Details about services and treatments that are not covered are in the section "What is Not Covered."

Prescriptions may be filled at a participating, In-Network Plan pharmacy or at a non-participating pharmacy or its intermediary if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan or its Pharmacy Benefit Manager, including any Copayment or Coinsurance consistently imposed by the Plan or its Pharmacy Benefit Manager, at the same level as the Plan or its Pharmacy Benefit Manager gives to participating pharmacies.

Our formulary is a list of FDA-approved medications that we cover. Prescription drugs are reviewed by the Plan's Pharmacy and Therapeutics Committee for placement onto the formulary. For a single Copayment or Coinsurance charge, You may receive up to a consecutive 30-day supply of a covered drug at a retail pharmacy. Some drugs may be available under the Plan's mail order pharmacy. Specialty Drugs are available up to a 30-day supply and can be delivered to Your home address from Optima Health specialty mail order drug pharmacy.

This formulary is organized into the following tiers, which determine what You pay out-of-pocket to fill a prescription:

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

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

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

Specialty Drugs (Tier 4) includes those drugs classified by the Plan as Specialty Drugs. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs include the following:

1. Medications that treat certain patient populations including those with rare diseases;
2. Medications that require close medical and pharmacy management and monitoring;
3. Medications that require special handling and/or storage;
4. Medications derived from biotechnology and/or blood derived drugs or small molecules;
5. Medications that can be delivered via injection, infusion, inhalation, or oral administration; and
6. Medications subject to restricted distribution by the U.S. Food and Drug Administration.

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

Tier 4 also includes compound prescription medications. A compound prescription medication is used to meet the needs of a specific individual and must have at least one ingredient requiring a Physician's authorization by State or Federal Law.

Refills

Your Plan has refill limitations. You must use most of Your medication or about 75% of Your medication based on the day supply of Your prescription before You can get a refill. There are several ways to refill Your prescription. In most cases contact the retail, mail order, or specialty pharmacy where You originally filled Your prescription and request a refill. Sometimes Your doctor will prescribe a set amount of refills for Your prescription. If You have run out of refills You will need a new prescription from Your doctor. In some cases Your pharmacist may be able to call Your doctor to get more refills for You.

Deductibles, Maximum Out of Pocket Amount (MOOP), and Benefits	
Deductibles	Your Plan does not have a Deductible
Maximum Out-of-Pocket Amount	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Maximum Medical Out-of-Pocket Limit. Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available are not Covered, do not count toward the Plan's Maximum Out-of-Pocket Amount and must continue to be paid after the Maximum Out-of-Pocket Amount has been met.
Insulin, and Needles and Syringes for Injection	A Member's cost sharing payment for a covered insulin drug will not exceed $50 per 30-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. You pay the cost sharing for the applicable Tier. Deductible does not apply.
Diabetic Testing Supplies, including test strips, lancets, lancet devices, blood glucose monitors, and control solution	No Charge Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. Members that request other brand name supplies will pay the applicable cost share depending on the Tier. *Pre-Authorization is required for talking blood glucose meters.
Continual Glucose Monitors, Sensors, and Supplies	You pay the cost sharing for the applicable Tier.
Formulary	This Plan has an open formulary. Please use the following link to see a list of drugs on the open formulary: www.optimahealth.com. If a brand name medication is dispensed instead of a generic equivalent, You must pay the cost difference between the dispensed brand name drug and the generic drug in addition to the Copayment or Coinsurance charge, unless authorized by the Plan.

Retail Pharmacy Cost Sharing When You pick up Your drug at a retail pharmacy You will pay the Copayment (one Copayment for each 30-day supply) or the Coinsurance amount listed under the applicable Tier for Your drug: • You pay one Copayment or the Coinsurance for up to a 30-day supply, • You pay two Copayments or the Coinsurance for a 31 to 60-day supply, • You pay three Copayments or the Coinsurance for a 61 to 90-day supply. **Tier 4 Specialty Drugs are only available from an Optima Health Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.**	
ACA Preventive Drugs ACA preventive prescription drugs and over-the-counter items identified as an A or B recommendation by the United States Preventive Services Task Force. Please use this link for a list of covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits/.	No Charge. Deductible does not apply. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs **Tier 1**	You Pay $15
Preferred Brand & Other Generic Drugs **Tier 2**	You Pay $30
Non-Preferred Brand Drugs **Tier 3**	You Pay $45
Specialty Drugs **Tier 4**	You Pay $55

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Copayment and Coinsurance Mail Order (If Your Drug is available) for up to a 90-day supply Some Outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available from the Plan's Mail Order Pharmacy Express Scripts. You may call Express Scripts at 1-888-899-2653 to find out if Your drug is available. Tier 4 Specialty Drugs are only available from an Optima Health Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over-the-counter items identified as an A or B recommendation by the United States Preventive Services Task Force. Please use this link for a list of covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits/.	No Charge. Deductible does not apply. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs **Tier 1**	You Pay $30
Preferred Brand & Other Generic Drugs **Tier 2**	You Pay $60
Non-Preferred Brand Drugs **Tier 3**	You Pay $90
Specialty Drugs **Tier 4**	Tier 4 Specialty Drugs are only available from an Optima Health Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of year they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health Benefits.

This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

OPTIMA HEALTH PLAN

VISION CARE AND MATERIALS RIDER

Includes Covered Services for expanded vision care services in lieu of those Preventive Vision Care Benefits described in Section 6 of the Evidence of Coverage.

Optima Health has a contract with VSP Vision Care to administer this benefit for Our Members. To receive Covered Services:

1. Select a participating VSP network provider from the Plan's enhanced provider directory or by calling VSP at 1-800-877-7195. Automated location information is available 24 hours a day. Customer service representatives are available Monday through Saturday 9 a.m.–8 p.m.
2. Visit or call the participating provider and identify yourself as a participant by providing Your Member ID information. The provider will verify eligibility, Your Plan's Covered Services and any applicable Copayment or Coinsurance. Payment is due when You receive services.
3. If the vision provider determines that You need additional medical care You should contact Your Plan Physician.

VISION CARE SERVICES AND MATERIALS SCHEDULE OF BENEFITS

Each Covered Person is eligible to receive a routine eye examination, refraction; and lenses and frames; or contact lenses as follows:

Routine Examination: Covered once every 12 months
Lenses or Contact Lenses: Covered once every 12 months
Frames: Covered once every 12 months

To be covered at the In-Network level of benefits all services must be received from a Participating VSP provider. Some services are limited or excluded when received from non-plan or Out-of-Network providers. Members are responsible for Copayments and Coinsurances listed below. Unless otherwise stated percent Coinsurance is based on provider charges.

Copayments or Coinsurance for Covered Services under this rider that are not Essential Health Benefits (EHBs) for children are not applied toward any Plan Maximum Out-of-Pocket Amount and must continue to be paid after the Maximum is met.

Members are responsible for all applicable Plan Deductibles as stated on the Policy Schedule of Benefits.

	In-Network Coverage from an VSP Provider	Out-of-Network Coverage
Routine Exam with dilation as necessary	$15 Copayment	Members will be reimbursed up to $50 for an eye examination only
Retinal Imaging	Members pay up to $39	Not Covered
Contact Lens Exam options:		
Standard contact lens fit and follow-up	Members pay up to $40	Not Covered
Premium contact lens fit and follow-up	Members pay up to $40	Not Covered
Frames For any available frame at a provider location	No copayment up to a $100 allowance. Members receive 20% off amounts over the allowance.	Members will be reimbursed up to $80
Standard Plastic Lenses		
Single vision	$20 Copayment	Members will be reimbursed up to $50
Bifocal	$20 Copayment	Members will be reimbursed up to $75
Trifocal	$20 Copayment	Members will be reimbursed up to $100
Standard Progressive Lens	$55 Copayment	Members will be reimbursed up to $75
Premium Progressive Lens	$85 copayment	Members will be reimbursed up to $75

Schedule of Benefits continued	In-Network Coverage from an VSP provider	Out-of-Network Coverage
Lens Options		
UV Treatment	$15 Copayment	Not Covered
Tint (Solid and Gradient)	$15 Copayment	Not Covered
Standard Plastic Scratch Coating	$15 Copayment	Not Covered
Standard Polycarbonate Adults	Up to $31 for single vision Up to $35 for multifocal	Not Covered
Standard Polycarbonate Kids Under 19	No Charge	Members will be reimbursed up to $5
Standard Anti Reflective Coating	Up to $41	Not Covered
Polarized	Member will receive 20% discount off the retail price	Not Covered
Other Add-ons	Member will receive 20% discount off the retail price	Not Covered
Contact Lenses Allowance includes materials only.		
Conventional	No copayment up to a $100 allowance. Members receive 15% off amounts over the allowance.	Members will be reimbursed up to $80
Disposable	No copayment up to a $100 allowance. Members are responsible for all amounts over the allowance.	Members will be reimbursed up to $80
Medically Necessary	No copayment covered in full.	Members will be reimbursed up to $210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	Member will receive 15% discount off the retail price or a 5% discount off a promotional price.	Not Covered
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	Not Covered

Members may receive a 20% discount on items not covered by the plan at VSP participating providers. This discount if available cannot be combined with other discounts or promotional offers. The discount would not apply to VSP's professional services or contact lenses.

Members can contact VSP or log onto www.vsp.com for additional information on replacement contact lenses after the initial purchase. The contact lenses allowance is not applicable to this service.

Exclusions and Limitations. The following services are excluded or limited under this rider:

1. Any visions care service or material not listed as covered is excluded from coverage.
2. Any Benefit Allowances not used cannot be retained or carried over for future use.
3. Certain brand name Vision Materials for which the manufacturer imposes a no-discount price may be excluded from benefit allowances and/or discounts stated in the Schedule of Benefits.
4. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing are excluded from coverage.
5. Aniseikonic lenses are excluded from coverage.
6. Medical and/or surgical treatment of the eye, eyes or supporting structure are excluded from coverage.
7. Any eye or vision examination, or any corrective eyewear required by a member as a condition of employment is excluded from coverage.
8. Safety eyewear is excluded from coverage.
9. Services or materials provided as a result of any Worker's Compensation law or similar legislation or required by any governmental agency or program whether federal, state or subdivisions thereof are excluded from coverage.
10. Plano non-prescription lenses and/or contact lenses are excluded from coverage.
11. Non-prescription sunglasses are excluded from coverage.

12. Two pair of glasses in lieu of bifocals is not covered.
13. Services or materials provided by any other group benefit plan providing vision care are excluded from coverage.
14. Services rendered or materials ordered after the date a member's coverage under the Plan ends, except vision materials ordered before coverage ended are delivered, and the services rendered to the member are within 31 days from the date of the order, are excluded from coverage.
15. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit period when vision materials would next become available.

Optima Health Plan Evidence of Coverage Dental Rider

This Dental Rider is added to the Member's Evidence of Coverage ("EOC") and is effective as of the Group Plan Coverage. This Rider is subject to all terms and conditions of the Group Contract and Evidence of Coverage to which it is attached. This Rider does not change any of the terms and conditions of the Evidence of Coverage unless specifically stated in this Rider.

Optima Health contracts with Dominion Dental Services, Inc. d/b/a Dominion National (hereinafter referred to as "Dominion National") to administer and arrange for the provision of Covered Dental Services included in this Rider. Eligible Group Health Plan Members are entitled to Covered Dental Services listed on the Dental Services Schedule of Benefits (hereinafter referred to as "Schedule of Benefits") subject to the definitions, terms and conditions stated in the Rider. Coinsurance and Deductible amounts are shown on the Schedule of Benefits. Applicable annual and lifetime maximum benefits are shown on the Schedule of Benefits.

DEFINITIONS

Annual Deductible means the amount shown in the Schedule of Benefits which each Member must pay each Benefit Year before Benefits under this Rider will be paid.

Annual Maximum shall mean the total amount of Benefits set forth in the Schedule of Benefits that will be paid to the Member in a Benefit Year.

Benefits shall mean the amount payable under the Rider, as set forth in the Coverage Schedule, for a Covered Service.

Benefit Year shall mean the 12 months following the effective date of the Contract.

Coinsurance means the cost-sharing amount the Member will pay out of pocket directly to a dentist for Covered Services under this Rider. Coinsurance is based on Dominion National's allowable amount for Covered Services.

Covered Service or Covered Dental Service shall mean a procedure listed in the Schedule of Benefits.

Dominion National is the entity that has contracted with Optima Health Plan to administer and arrange for the provision of Covered Services under this Rider.

The address of the principal administrative office is:
Dominion National
251 18th Street South, Suite 900
Arlington, VA 22202.
The telephone number is (877)-847-5754

Claim Address is:
Dominion National
PO Box 1126
Elk Grove Village, IL 60009

Eligible Expenses shall mean Covered Dental Services described in this Rider.

Lifetime Maximum shall mean the total amount of Benefits set forth in the Schedule of Benefits that will be paid to the Member in their lifetime.

Maximum Allowable Charge shall mean a limitation on the billed charge as determined by Dominion National by geographic area where the expenses are incurred.

Member shall mean any Subscriber or Dependent that is a Covered Person under the Group Health Plan and entitled to receive services under this Rider.

Non-Participating Dentist shall mean those independent licensed dentist who have not entered into an agreement with Dominion National for the purpose of providing dental services to Members.

Participating Dentist shall mean those independent licensed dentists who have contracted with Dominion National to provide dental services at negotiated fees for Members.

EFFECTIVE AND TERMINATION DATES

Coverage under this Rider is effective as of the date of the Optima Health Plan Evidence of Coverage to which it is attached. Coverage under this Rider will end on the date that the Group Evidence of Coverage terminates or the date the Member ceases to be eligible for Coverage under the Group plan.

BENEFITS AND COVERAGES

Eligible Expenses: Dominion National will pay for Eligible Expenses incurred for Members. Expenses must be incurred while the Rider is in force. The description of Eligible Expenses and Covered Services is shown in the Schedule of Benefits. All Benefits will be paid to the Subscriber unless otherwise designated by the claimant. Benefits will be paid subject to Deductibles, Annual and Lifetime Maximums as specified in the Schedule of Benefits. All Benefits are subject to Plan Exclusions as set forth in the Schedule of Benefits. Benefit amounts will vary depending on whether the Member obtains services from a Participating Dentist or a Non-Participating Dentist. To be considered an Eligible Expense, the service must be performed by a dentist, a physician, or a dental hygienist.

Expenses Incurred: An Eligible Expense is considered incurred on the following dates:

- Dentures: On the date the final impression is taken.
- Fixed bridges, crowns, inlays and onlays: On the date the teeth are initially prepared.
- Root canal therapy: On the date the pulp chamber is opened.
- Periodontal surgery: On the date surgery is performed.
- All other services: On the date the service is performed.

In-Network Benefits: Dominion National will pay a percentage of the Participating Dentist's charge for each Covered Service up to the Participating Dentist's negotiated fee. The percentage of payment by Dominion National is determined by procedure classification as set forth in the Schedule of Benefits. For example, if a procedure is covered at 80%, the Plan will pay 80% and the Member will pay the remaining balance of 20%, up to the Participating Dentist's negotiated fee. The Member may be required to remit payment for the remaining balance at the time of service. Billing arrangements are between the Member and the Participating Dentist. Participating Dentists are listed in the Dentist Directory. Members should confirm continued participation of a Participating Dentist prior to receiving treatment. Members can access the Dentist Directory at dominiondentists.com.

Out-Of-Network Benefits: A Member may choose to receive treatment from a Non-Participating Dentist. Benefit percentages for out-of- network Benefits, if applicable, are listed in the Schedule of Benefits according to procedure classification. Benefits are calculated using a Maximum Allowable Charge. Members are responsible for any amount charged which exceeds the Maximum Allowable Charge per procedure. Billing arrangements are between the Member and the Non-Participating Dentist. If a Member receives treatment from a Non-participating Dentist, the Member may be required to make payment in full at the time of service. The Member may then submit a claim to Dominion National for Benefit payment.

Pre-Determination of Benefits: If the charge for treatment is expected to exceed $300, Dominion National strongly advises the treating dentist to submit a treatment plan prior to initiating services. In accordance with its clinical review guidelines, Dominion National may request x-rays, periodontal charting or other dental records, prior to issuing the pre-determination. The proposed services will be reviewed and a pre- determination will be issued to the Member or dentist, specifying coverage. The pre-determination is not a guarantee of coverage and is considered valid for 180 days.

Alternate Benefit: If: 1) Dominion National determines that a less expensive alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and 2) the alternate treatment will produce a professionally satisfactory result; then the maximum Dominion National will allow will be the charge for the less expensive treatment.

Coordination of Benefits

All Benefits covered under this Contract are subject to coordination. The following definitions apply only to this Coordination of Benefits section:

A. **Plan** shall mean coverage providing hospital, medical or dental benefits or services by: i) group or blanket insurance coverage except school accident coverage; ii) group Blue Cross and Blue Shield, group practice or other pre-payment coverage on a group basis; or iii) labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans. Plan will be construed separately for a policy, contract, or other arrangement for benefits or services that reserves the right to take the benefits or services of their Plans into consideration in determining its benefits, or separately for that portion which does not reserve the right.

B. **Eligible Expenses** shall mean any necessary, reasonable and customary item of expense all or part of which is covered under one of the Plans. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Eligible Expense and a benefit paid.

C. **Claim Period** shall mean a Calendar Year or portion of a Calendar Year for a claim on a Member covered under this Plan.

If Member is also covered under one or more other Plans, the Benefits under this Plan will be coordinated with benefits payable under all other Plans. The coordination will apply in determining the benefits payable for any Claim Period if the sum of: i) the benefits that would be payable under this Plan in absence of the coordination; and ii) the benefits that would be payable under all other Plans without provisions for coordination in those Plans, would exceed such benefits. Except as provided in the following paragraph, when Coordination of Benefits applied to the benefits payable for any Claim Period, the benefits that would be payable for Eligible Expenses under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Eligible Expenses under all other Plans will not exceed the total of those Eligible Expenses.

The rules establishing the order of benefit determination are:

1. The benefits of a plan covering a person for whom claim is made other than as a dependent will be determined before the benefits of a plan covering such person as a dependent.

2. Except as stated in (3) below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":

    a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
    b. if both parents have the same birthday, the benefits of the Plan covering the parent longer are determined before benefits of the Plan covering the other parent for the shorter period of time. However, if the other Plan does not have the rule described in a. above, but instead uses a different method, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for such child are determined in this order:

    a. first, the Plan of the parent with custody of the child;
    b. then, the Plan of the spouse of the parent with custody of the child; and
    c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of such parent has actual knowledge of those terms, the benefits of that Plan are determined first. This does not apply with respect to any Claim Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. The benefits of a Plan covering a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as the employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule 4 is ignored.

5. If none of the above rules determines the order of benefits, the benefits of a Plan which has covered the person for whom claim is made for the longer period of time will be determined before the benefits of a Plan covering the person the shorter period of time.

If this Plan is responsible for secondary coverage for Eligible Expenses, this Plan will not deny coverage or payment of the amount it owes as secondary payer solely on the basis of the failure of another group contract, which is responsible as the primary payer, to pay for such Eligible Expenses. For the purposes of administering the above provisions of this Contract or any similar provisions of other Plans, this Plan may, without consent or notice to any person, release to or obtain from any other insurance company, organizations or person, any information concerning any individual which is considered necessary. Any person claiming Benefit will furnish the Plan with any information necessary. Whenever payments which should have been made under this Contract in accordance with the above provisions have been made under any other Plans, this Plan has the right, at its sole discretion, to pay any organizations making these payments any amount this Plan determines to be due. Amounts paid in this manner will be considered to be Benefits paid under this Contract and, to the extent of these payments, Plan will be fully discharged from liability under this Contract. Whenever payments have been made by this Plan, for Eligible Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, this Plan will have the right to recover the excess from one or more of the following: (i) other health insurance companies; or (ii) persons to or for whom payments were made.

SUBMISSION OF CLAIMS

Dominion National must receive written proof of loss within 180 days of treatment. Failure to provide proof of loss within the time required will not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one year from the time proof is otherwise required.

Submit all dental claims to:

Dominion National
PO Box 1126
Elk Grove Village, IL 60009
Fax: 888.208.8290

Electronic Claims: Use the payor ID of DOM01

Refer to the In-Network and Out-of-Network Benefits section in this Rider for additional information.

COMPLAINTS AND GRIEVANCES

Please refer to Section 13 in Your Evidence of Coverage under "How to File A Complaint" for more information on filing a complaint including how long you have to file a complaint, submitting additional information, and how Your complaint will be resolved.

For grievances involving patient care, Dominion National encourages communication between our Members and Participating Dentists to come to a mutually satisfactory resolution. If a Member has discussed a grievance with a Participating Dentist and is not satisfied with the resolution (or if the dentist is not available to receive the grievance), the Member may refer the matter to a Dominion National Member Service Representative by calling toll-free (888) 518-5338.

A Member may submit a complaint in writing to:

Grievances and Appeals
c/o Dominion National
251 18th Street South, Suite 900
Arlington, VA 22202
Fax: (703) 518-4450

If a Member has any questions regarding a grievance or complaint concerning the health care services that they have been provided which have not been satisfactorily addressed by Dominion National, the Member may contact:

The Office of the Managed Care Ombudsman
P.O. Box 1157
Richmond, VA 23218

Phone: (804) 371-9032 or toll-free (877) 310-6560
Email: Ombudsman@scc.virginia.gov.

For Quality of Care complaints, a Member may contact:

The Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, VA 23233-1463
Phone: (800) 955-1819
Fax: (804) 527-4503.
Email: mchip@vdh.virginia.gov.

Please see the section below for information on appealing an adverse benefit determination.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Please refer to Section 13 in Your Evidence of Coverage under "Appeals of an Adverse Benefit Determination" for more information on filing an appeal including how long you have to file appeal, submitting additional information and how Your appeal will be resolved.

An Adverse Determination means that a decision has been made not to authorize, cover, or pay (in whole or in part) for a service because:

- A Member is not eligible for benefits; or
- The service does not meet requirements for:
  - Medical Necessity;
  - Appropriateness;
  - Health care setting;
  - Level of care;
  - Effectiveness; or
- The service is Experimental or Investigational;

Members have the right to a full and fair appeal of adverse determinations as described in the Evidence of Coverage to which this Rider is attached.

Dominion National will administer internal, expedited, and urgent appeals for claims for Covered Services under this Rider. Dominion National will notify the Member of the outcome of any appeal and include notice of independent external appeal rights available.

To initiate an appeal of an adverse benefit determination, contact Dominion National:

Grievances and Appeals
c/o Dominion National
251 18th Street South, Suite 900
Arlington, VA 22202
Fax: (703) 518-4450

ANNUAL AND LIFETIME MAXIMUM BENEFITS

Covered Services under this Rider are limited as stated on the Schedule of Benefits. After a benefit limit has been reached, Members are responsible for payment for all additional services. Unless otherwise noted benefit limits are combined for services received both In-Network and Out-of-Network.

Annual and lifetime benefit dollar limits do not apply to Covered Services that are considered Essential Health Benefits whether provided in-network or out-of-network.

DENTAL SERVICES SCHEDULE OF BENEFITS: CHOICE PPO

This Schedule includes Your Covered Dental Benefits and cost sharing amounts under the Rider. You must meet all Deductibles listed below. After You meet Your Deductible You pay the applicable Coinsurance for Your Covered Service. Coverage is limited to the Maximum Benefits stated below.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT

	In-Network Benefits	Out-of-Network Benefits
Deductibles Combined In-Network and Out-of-Network per Member per Benefit Year.	$50 per Person $150 per Family	$50 per Person $150 per Family
Annual and Lifetime Maximum Benefits Combined In-Network and Out-of-Network per Member per Benefit Year for Annual Maximum.	**Class II and Class III Services:** Annual $2,000 per Person **Class IV Orthodontia Services** Lifetime $2,000 per Person	**Class II and Class III Services:** Annual $2,000 per Person **Class IV Orthodontia Services** Lifetime $2,000 per Person

Out-of-Network Allowance

If the course of treatment will exceed $300 pre review is requested. Members may receive Covered Services from Participating Dentists or Non-Participating Dentists. Unlike Participating Dentists that have agreed to accept negotiated fees for services, Non-Participating Dentists have no contract with Dominion National or Dominion National's leased dental networks. As such, Non-Participating Dentists set their own fees and Dominion National only reimburses the Member based on the established Participating Dentist's fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the Non-Participating Dentist's fee is higher than Dominion National's Participating Dentist's fee schedule, the Member will be billed the remaining balance to cover the Non-Participating Dentist's fee.

DENTAL SERVICES

Class I Diagnostic and Preventive Services Pre-Authorization is Required.	In-Network Benefits Copayments/Coinsurance	Out-of-Network Benefits Copayments/Coinsurances
1. Two evaluations per Benefit Year including a maximum of one comprehensive evaluation per 36 months 2. One emergency or problem focused exam (D0140) per Benefit Year 3. Two prophylaxis (cleaning, scaling and polishing teeth) per Benefit Year (one additional cleaning is covered during pregnancy and for diabetic patients) 4. One topical fluoride per Benefit Year, to age 16 5. Bitewing x-rays, 2 per Benefit Year 6. Periapical x-rays 7. One diagnostic x-ray, full or panoramic per 60 months 8. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service) 9. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)	Covered at 100%	Covered at 100%

Class II Basic Services Pre-Authorization is Required.	In-Network Benefits Copayments/Coinsurance	Out-of-Network Benefits Copayments/Coinsurances
1. Simple extraction of teeth 2. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months 3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin) 4. Antibiotic injections administered by a dentist 5. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment) 6. Oral surgery, including postoperative care for: a. Removal of teeth, including impacted teeth b. Extraction of tooth root c. Alveolectomy, alveoplasty, and frenectomy d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy e. Reimplantation or transplantation of a natural tooth f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst 7. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage) b. Pulpotomy c. Apicoectomy d. Retrograde fillings, per root per lifetime 8. Periodontic services, limited to: a. Two periodontal cleanings following surgery per Benefit Year (D4341 is not considered surgery) b. One root scaling and planing per quadrant of mouth per 24 months from age 21 c. Occlusal adjustment performed with covered surgery d. Gingivectomy and gingival curettage e. Osseous surgery including flap entry and closure f. One pedicle or free soft tissue graft per site per lifetime g. One appliance (night guards) per 5 years within 6 months of osseous surgery h. One full mouth debridement per lifetime	After Deductible Covered at 80%	After Deductible Covered at 80%

Class III Major Services Pre-Authorization is Required.	In-Network Benefits Copayments/Coinsurance	Out-of-Network Benefits Copayments/Coinsurances
1. One study model per 36 months 2. Crown build-up for non-vital teeth 3. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter 4. One repair of dentures or fixed bridgework per 24 months 5. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery or implant placement procedures 6. Restoration services, limited to: a. Gold or porcelain inlays, onlays, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced (will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage) c. Stainless steel crowns up to age 14 (one per tooth per lifetime) d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally 7. Prosthetic services, limited to: a. Initial placement of dentures or fixed bridgework (including acid etch metal bridges) b. Replacement of dentures or fixed bridgework that cannot be repaired after 7 years from the date of last placement c. Addition of teeth to existing partial denture d. One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement) 8. Implants and related services	After Deductible Covered at 50%	After Deductible Covered at 50%
Class IV Orthodontia Services Pre-Authorization is Required.	**In-Network Benefits Copayments/Coinsurance**	**Out-of-Network Benefits Copayments/Coinsurances**
Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy	Covered at 50%	Covered at 50%

Plan Exclusions:
The following are not Covered Dental Services under this Rider.

1. Treatment required for conditions resulting while on active duty as a Member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
2. Services which are covered under Medicare, worker's compensation or employer's liability laws.
3. Services and treatment provided without charge or for which there would be no charge in the absence of insurance.
4. Services not listed as covered.
5. Hospitalization for any dental procedure.
6. Services and treatment for which Member is eligible for coverage under his or her hospital, medical/surgical or major medical plan.
7. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
8. Elective surgery including, but not limited to, extraction of non-pathologic,asymptomatic impacted teeth.
9. Replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
11. Services for increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
12. Oral hygiene instructions; plaque control; completion of a claim form; acid etch; broken appointments; prescription or take-home fluoride; or diagnostic photographs.
13. Dispensing of drugs.
14. Diagnosis or treatment of temporomandibular joint (TMJ) syndromes, problems and/or occlusal disharmony.
15. Procedures that in the opinion of Dominion National are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, anodontia, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

Optima Health Amendments/Riders

CHIROPRACTIC SERVICES RIDER.

We have a contract with American Specialty Health Group (ASH) to provide Chiropractic Services in the Plan's Service Area. Pre-Authorization is required by ASH for all services. If You have questions about what is covered or how to find an ASH provider please call ASH toll free at 1-800-678-9133 Monday through Friday 5 a.m. to 6 p.m.

To receive services call an ASH participating provider and schedule an appointment. You do not need a referral. The ASH chiropractic provider is responsible for getting authorization from ASH before You receive care except for initial examination and Emergency Services. The number of visits allowed per year, any benefit maximums, and Your out of pocket amounts are listed on the Schedule of Benefits in this Certificate of Insurance.

Covered Services include examination, re-examination, manipulation, conjunctive therapy, radiology, chiropractic appliances, and laboratory tests related to the delivery of chiropractic services subject to the following:

1. An initial examination is performed by the participating provider to determine the nature of the Member's problem and, if Covered Services appear warranted, a treatment plan of services to be furnished is prepared. One initial examination is provided for each new patient. A Copayment is required when services are rendered.

2. A re-examination may be performed by the participating provider to assess the need to continue, extend, or change a treatment plan approved by ASH. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a co-payment is required.

3. Subsequent office visits, as set forth in a treatment plan approved by ASH, may involve an adjustment, a brief re-examination and other services, in various combinations. A co-payment is required for each visit to the office.

4. Adjunctive therapy, as set forth in a treatment plan approved by ASH, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.

5. X-rays and clinical laboratory tests are payable in full when referred by a participating chiropractor and authorized by ASH. Radiological consultations are a covered benefit when authorized by ASH as Medically Necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital which has contracted with ASH to provide those services.

6. Chiropractic appliances are covered up to a maximum benefit of 1 appliance per year when prescribed by a participating chiropractor and authorized by ASH.

Exclusions and Limitations

1. Any services or treatments not authorized by ASH, except for initial examination and Emergency Services.

2. Any services or treatments not delivered by participating chiropractors for the delivery of chiropractic care to Members, except for Emergency Services.

3. Services for examinations and/or treatments for conditions other than those related to neuromusculoskeletal disorders from participating chiropractors.

4. Hypnotherapy, behavior training, sleep therapy, and weight programs.

5. Thermograph.

6. Services, lab tests, X-rays and other treatments not documented as clinically necessary as appropriate or classified as experimental or investigational and/or as being in the research stage.

Optima Health Amendments/Riders

7. Services and/or treatments that are not documented as Medically Necessary services.

8. Magnetic resonance imaging, CAT scans, bone scans, and nuclear radiology and any diagnostic radiology other than covered plain film studies.

9. Transportation costs including local ambulance charges except for Emergency Services.

10. Education programs, non-medical self-care or self-help or any self-help physical exercise training or any related diagnostic testing.

11. Services or treatments for pre-employment physicals or vocational rehabilitation.

12. Any services or treatments for pre-employment physicals or vocational rehabilitation.

13. Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment, except as described as covered in this Rider.

14. Drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

15. Services provided by a chiropractor practicing outside the Service Area, except for Emergency Services.

16. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

17. All auxiliary aids and services, including but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

18. Adjunctive therapy not associated with spinal, muscle or joint manipulation

19. Vitamins, minerals, or other similar products.

Optima Health Amendments/Riders

HEARING AID RIDER

Pre-Authorization for all Covered Services is required.

Covered Services include the following:

1) The hearing aid(s);
2) Audiometric Specialist office visit(s) for fitting , including molds, and dispensing; and
3) Repair, or refurbishment of the hearing aid(s).

The Member will be responsible for all applicable Copayments, Coinsurances, and/or Deductibles depending on the type and place of service related to hearing aid services under this rider. Copayments, Coinsurances and/or Deductibles are listed on the Plan's Face Sheet or Schedule of Benefits. The Member will be responsible for the cost of all services once the maximum benefit is met.

Hearing aid providers are reimbursed using the Plan's established fee schedule. If the Member elects to get a hearing aid which exceeds the benefit maximum, the Member will be responsible for the difference between the plan's maximum allowable amount, or fee schedule, and the cost of the hearing aid.

Exclusions and limitations:

- Batteries and supplies are not Covered Services;
- The Member will be responsible for the cost of all services once the maximum benefit is met;
- Once the benefit maximum is met, the Plan will not cover repair, refurbishment;
- Replacement is covered only every 36 months from date of acquisition; and
- Copays or Coinsurance for Covered Services under this rider are not applied toward any Plan Maximum Out of Pocket Limit and must continue to be paid after the maximum is met.

Optima Health Amendments/Riders

MORBID OBESITY TREATMENT RIDER

Coverage includes treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.

The reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such Coverage shall have durational limits, dollar limits, Deductibles, Copayments and Coinsurance factors that are no less favorable than for physical Illness generally. The Plan will not restrict access to surgery for morbid obesity based upon dietary or any other criteria not approved by the National Institutes of Health.

"Morbid Obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

The Member will be responsible for all applicable Copayments, Coinsurances, and/or Deductibles depending on the type and place of service related to treatment for Morbid Obesity. Copayments, Coinsurances and/or Deductibles are listed on the Plan's Face Sheet or Schedule of Benefits.

Table of Contents

Section 1
How Your Plan Works

This section is an overview of how Your coverage works. You will need to read all of this book to understand all the terms and conditions of coverage.

Patient Protections Disclosure Notice

For Optima Health plans that require that You choose a Primary Care Provider You have the right to choose any Primary Care Provider who participates in Our network and who is available to accept You or Your family members. If You do not choose a PCP Optima Health will assign a PCP to You and Your family until You choose a PCP. For information on how to select or change a Primary Care Provider, and for a list of the participating Primary Care Providers, contact Optima Member Services at the number on Your ID card, or log on to Our website at Optimahealth.com. For children, You may choose a pediatrician as the Primary Care Provider.

You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Member Services at the number on Your ID card or log on to Our website at optimahealth.com.

Your Evidence of Coverage or EOC

This booklet, any endorsements, the Face Sheet, riders and Your enrollment application make up Your Optima Health policy. Please read every part of this booklet carefully so You will understand how Your coverage works. Call Member Services if You have any questions.

Words or Terms We Use in this EOC

We use certain words and terms to explain how Your Coverage works. When You see a word that is capitalized You can refer to the Definition Section to see what the word means. We may also explain what a word or term means in the chapter or section that it is used in. Whenever We use the word We or Us, or The Plan that means this benefit plan or Optima Health. You or Your means the employee or Subscriber and each family member covered as a Dependent under the Plan.

Your Optima Health ID Card

Everyone covered under Your plan will have an Optima Health ID card. You always need to carry Your ID card with You. When You go to the doctor, hospital or a pharmacy show Your ID card so they know You are an Optima Health Member. Keep Your ID card safe and never let anyone else use Your card to get health care.

Your Face Sheet Schedule of Benefits and Your Cost Sharing Amounts

When You get services under this plan You will usually have to pay a Copayment or Coinsurance to the doctor or the facility (the place You get the service). You may also have a Deductible to meet before We begin to pay for your Covered Services. Your Face Sheet in this booklet lists Your cost sharing amounts. Please read Your entire Face Sheet so You will understand what You will have to pay out-of-pocket for each Covered Service.

Section 1
How Your Plan Works

Benefit Limits

Some medical care and services are not covered under this Plan. If We do not cover Your medical care or service You will have to pay for those services. Some services are limited to a certain number of visits or by a dollar amount. You will have to pay for all services after You reach a benefit limit. Benefit limits are on Your Face Sheet. No annual or lifetime dollar limits are imposed on Essential Health Benefits.

Pre-Authorization

Some Covered Services under this Plan require Pre-Authorization to be covered. Please read the entire section on Pre-Authorization in the EOC.

Optima Health Provider Networks

Optima Health contracts with certain doctors and Hospitals to provide Your benefits. These doctors and Hospitals make up the Plan's Provider Network. We also call them Plan Providers or In-Network Providers. Plan Providers also include skilled nursing facilities, urgent care centers, outpatient care centers, laboratories, and other facilities and professionals. This Plan is an HMO and except in limited situations, Your health care is only covered when You use an In-Network Plan Provider.

Access to a list of the In-Network Plan Providers is provided to Subscribers at the time of enrollment. You can also call Member Services to ask if a provider is in Our network. A list of Plan Providers is also on the Plan's website at optimahealth.com.

Optima Health Direct Plan Tiered Plans

This Plan has tiered Copayment or Coinsurance amounts listed for some In-Network benefits. For tiered benefits You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals or other Facilities or providers. When you use Tier 2 Physicians, Hospitals or other Facilities or other providers Your out of pocket costs will be higher. You can access Tier 1 or Tier 2 Primary Care Physicians (PCP) or Specialist providers without a referral.

Tier 1 Physician, Facility or other provider means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 1 cost sharing amounts listed on the Plan Face Sheet Schedule of Benefits. Tier 1 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 1 Physicians, Facilities, and other providers and their locations is available to each enrollee during enrollment and anytime upon request.

Tier 2 Physician, Facility, or other provider means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 2 cost sharing amounts listed on the Plan Face Sheet Schedule of Benefits. Tier 2 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 2 Physicians and Facilities and other providers and their locations is available to each enrollee during enrollment and anytime upon request.

Primary Care Providers.

When You enroll You and each of Your Dependents must chose a Primary Care Physician (PCP) from the list of Plan Providers. PCPs include Internists, Pediatricians, and Family Practitioners. Sometimes the Plan will allow another provider to act as Your PCP if Your medical condition requires it. If You do not select a PCP We will assign one.

Section 1
How Your Plan Works

If You are not satisfied with Your PCP You have the right to select another PCP from Our list of available Plan Providers. We will process Your request for change as soon as possible. There may be a short waiting period for this transfer.

Specialty Care Providers.

You don't need a referral from a PCP for specialist care, including second opinions; but all specialist care must be received from Plan Providers in order to be Covered by the Plan.

Choosing a Provider for Your Covered Services

This Plan is a Health Maintenance Organization (HMO) and except in limited situations below, Your health care is only Covered when You use an In-Network Plan Provider. The following services from Out-of-Network Providers are covered under In-Network benefits; and Member's are protected from balance billing:

- Emergency Services provided by an out-of-network provider. This also includes post-stabilization services including any additional Covered Services furnished by a an out of network provider or emergency facility (regardless of the department of the hospital in which the items and services are furnished) after a Member is stabilized as part of outpatient observation, or as part of an inpatient or outpatient stay with respect to the visit in which Emergency Services are furnished.

- Emergency air ambulance services provided by an out of network provider.

- Nonemergency services provided by an out of network provider at an in-network facility if the nonemergency services involve otherwise covered Surgical or Ancillary Services, or other Covered Services provided by an out-of-network provider.

For the services above Members are responsible for In-Network Copayments, Coinsurance and Deductibles which will be applied to In-Network Maximum Out of Pocket amounts. If You are balance billed in any of these situations please contact Member Services at the number on Your OptimaHealth ID Card. You may also file a complaint with the Plan. Please see "**Section 13 How To File A Complaint, Grievance, Or Appeal An Adverse Benefit Determination.**" Please also see the Plan's full notice on balance billing protections.

In all other situations if there is no In-Network Provider available to provide a Covered Service You must contact Us before You have the service or treatment form an Out-of-Network Provider. We may be able to help You find an In-Network Provider; or We may approve Your service or treatment as an Authorized Out-of-Network Service. An Authorized Out of Network Service means a Covered Service provided by an Out-of-Network Provider, which has been specifically authorized in advance by Us to be Covered under the Plan's In-Network level of benefits and cost sharing. All other requirements for Pre-Authorization under the Plan will also apply to Covered Services from Out-of-Network Providers. Except as stated above, if You see an Out-of-Network provider without advance approval from the Plan We may deny Your claim and You may be responsible for the entire cost or all charges for your services. Advance approval is not required for Out-of-network Emergency Services.

Service Area

Your Plan has a specific Service Area in the Commonwealth of Virginia where We have arranged directly or indirectly to provide Covered Services. All non-emergency care outside the service area must be received from Plan Providers to be covered.

Out of Area Dependent Program.

Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits listed on the Plan Face Sheet or Schedule of Benefits when Covered Services are received from Optima Health providers that participate in the Out of Area Program. A list of contracted providers that participate in the program is available at www.optimahealth.com or by calling Member Services at the number on the Member's ID card.

The Plan will require eligible out of area Dependents to complete an annual certification form prior to being eligible for the program. Completed certification forms must be submitted directly to Optima Health. A copy of the form is available at www.optimahealth.com or by calling Member Services. All other eligibility requirements under the Plan must be met.

Eligible Dependents who are enrolled in the program will have a unique ID card that must be presented to the provider when services are received.

All Pre-Authorization requirements apply depending on the type and place of service. Members must pay all applicable In-Network Copayments, Coinsurance, and/or Deductibles listed on the Plan's Face Sheet or Schedule of Benefits.

Except for Emergency Services any Covered Services received outside of the service area from Out of Network Non-Plan Providers that are not included in the Out of Area Dependent Program will not be covered.

Providers will usually file claims for Members. If a Provider is unable to file a claim, Members may have to pay the provider directly for services and file a claim with Optima Health for reimbursement. Please see the Claims and Payments section in this Evidence of Coverage for help in filing a claim directly with the Plan.

Pre-existing Conditions

This Plan does not have pre-existing condition exclusions waiting periods.

Special Enrollment Opportunity for Children under Age 26.

Children under age 26 that aged off their parent's health plan or were not allowed to enroll because they did not meet their Plan's dependent age requirements are eligible to enroll in the Plan during a 30-day special enrollment period. Individuals may request enrollment for such children for 30 days from the date of notice of special enrollment. If the Child is enrolled during the special enrollment period coverage will be effective on the first day of the Plan's coverage. Children who do not enroll during the special enrollment period will have to wait until the Plan's next open enrollment period or a qualifying event.

Lifetime Limits and Opportunity to Enroll

Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan will have an opportunity to enroll in the Plan. Individuals have 30 days from the date of notice of special enrollment to request enrollment. For individuals who enroll under this opportunity, coverage will take effect not later than the first day of the Plan effective date.

Coverage Under a Group Plan

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How Your Plan Works

This Plan is an employer group plan sponsored by Your employer. Your employer sends premiums to Optima Health each month on Your behalf to pay for Your Coverage. Your employer will let You know if You must contribute any amount for Coverage.

Optima Health will provide employer group policyholders written notice of any benefit reductions during the contract period at least 60 days before such benefit reductions become effective. Employer Group policyholders shall, in turn, provide to their enrollees written notice of any benefit reductions during the contract period at least 30 days before such benefit reductions become effective. Optima Health will provide 60 days advance notice to enrollees before the effective date of any material modification including changes in preventive benefits, benefit changes, premium changes, Copayment or Coinsurance changes, or changes to the Service Area.

If Your employer is offering coverage under an HMO health plan You should be offered the option to enroll in an optional point of service plan which permits eligible dependents to receive the full range of covered benefits from non-plan providers.

After Hours Nurse Triage Program

The After Hours Nurse Triage Program lets Members talk to a professional nurse who can help them find the most appropriate care in the most appropriate setting. Professional nurses listen to concerns, analyze the situation, and advise Members where to get medical care on evenings and weekends when the doctor's office is closed. If Medically Necessary, the nurse will send Members to Emergency Departments or urgent care centers where they can get appropriate treatment. When You call After Hours have Your ID card ready. Be prepared to describe Your immediate medical situation in as much detail as possible. Make sure to tell After Hours about any other medical problems You are being treated for. Also tell After Hours what prescriptions You take.

In a life-threatening situation call 911 or proceed to the nearest Emergency Department. The After Hours nurse cannot diagnose medical conditions or write prescriptions.

The After Hours Nurse Triage Program is available twenty-four hours a day seven days a week. The After Hours Program can be reached by calling 757-552-7250 or 1-800-394-2237.

Wellness and Disease Management Programs

Optima Health offers disease management programs designed to help improve health for our Plan Members with specific health conditions. All of our programs are designed to give You opportunities to improve Your health and Your coverage experience with us. You may be eligible to earn rewards for completing certain activities, or by participating in programs that we may make available while You are an Optima Health Member.

In most cases We will contact You with details about programs that You are eligible to participate in. You should always check with Your regular doctor first; and You should continue to see Your doctor while you are enrolled in the wellness program.

While You are in a program We may encourage and remind You to see Your doctor and to keep up with important screenings and tests and stay current with all your medications. We may send You emails or texts or contact You by phone with important tips and reminders. Some of our programs will provide You access to coaches and other health care professionals to provide guidance and help set up personalized plans to manage Your condition. We may also ask You to complete a health assessment. For some of our programs You may also be able to download and use mobile applications for program activities.

Section 1
How Your Plan Works

If Your program includes an incentive or reward and You complete all of the requirements, incentives may include:

- Modifications to Your health plan copayment, coinsurance, or deductible amounts;
- Gift or debit cards;
- Other rewards.

All of Optima's wellness programs are voluntary. Rewards will not be based on a health outcome. If You decide to participate in a program, or not to participate, it will not affect Your eligibility wo enroll or remain enrolled in Your health plan or to receive Covered Services.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Here are some things that You can do to prevent fraud:

- Do not give Your plan identification (ID) number or other personal information over the telephone or email it to people You do not know, except for Your health care providers or Optima Health representative.
- Don't go to a doctor who says that an item or service is not usually covered, but they know how to bill Us to get it paid. Do not ask Your doctor to make false entries on certificates, bills or records in order to get Us to pay for an item or service.
- Carefully review explanations of benefits (EOBs) statements that You receive from Us. If You suspect that a provider has charged You for services You did not receive, billed You twice for the same service, or misrepresented any information call the provider and ask for an explanation. There may be an error.

Optima Health provides health plan members a way to report situations or actions they think may be potentially illegal, unethical or improper. If You want to report fraudulent or abusive practices You can call the Fraud & Abuse Hotline at the number below. You can also send an email, or forward Your information to the address below. All referrals may remain anonymous. Please be sure to leave Your name and number if You wish to be contacted for follow up. If appropriate, the necessary governmental agency (DMAS, CMS, OIG, BOI, etc.) will be notified as required by law.

Fraud & Abuse Hotline: (757) 687-6326 or 1-866-826-5277 or
E-mail: compliancealert@sentara.com
U.S. Mail: Optima Health c/o Special Investigations Unit
4417 Corporation Lane
Virginia Beach, VA 23462

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

Section 2
Definitions

We use certain words and terms to explain how Your Coverage works. When You see a word that is capitalized You can refer to this chapter to see what the word means. We may also explain what a word or term means in the chapter or section that it is used in. These definitions will apply to the Group Contract and the Evidence of Coverage and any Enrollment Application, questionnaire, form or other document provided or used in connection with Your Coverage.

ACCIDENT/INJURY means physical damage to a Member's body caused by an unexpected event or trauma independent of all other causes. Only a non-occupational Injury (i.e., one which does not arise out of or in the course of any work for pay or profit) is considered for benefits under the Plan.

ADMISSION means registration as a patient under the patient's own name at a Hospital for purposes of determining the applicability of Copayments, Coinsurances, and Deductibles. A newborn that remains in the Hospital after the mother is discharged will be registered as a patient under the newborn's own name, and a separate Copayment, Coinsurance, and Deductible may be applied.

ADVERSE BENEFIT DETERMINATION in the context of the internal appeals process means: (i) a determination by a health carrier or its designee utilization review entity that, based on the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the requested benefit; (ii) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review entity of a covered person's eligibility to participate in the health carrier's health benefit plan; (iii) any review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit; (iv) a rescission of coverage determination as defined in § 38.2-3438 of the Code of Virginia; or (v) any decision to deny individual coverage in an initial eligibility determination.

ADVERSE DETERMINATION in the context of external review means a determination by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or is determined to be experimental or investigational, and the requested service or payment for the service is therefore denied, reduced or terminated.

ALLOWABLE CHARGE is the amount the Plan determines will be paid to a Provider for a Covered Service. When You use In-Network benefits the Allowable Charge is the lesser of: (1) the Provider's contracted rate with the Plan or its third party administrator or (2) the Provider's actual charge for the Covered Service. When You use an Out-of-Network Provider, the Allowable Charge is the lesser of the usual and customary charge for the service as determined by the Plan or the actual charge. For Out-of-Network Emergency Services, Out-of-Network Emergency air ambulance services, or Out-of-Network ancillary and surgical services received at an In-Network facility, the Allowable Charge will be determined using the Plan's average In-Network contracted rate for the same or similar service in the same or similar location.

AUTHORIZED OUT OF NETWORK SERVICE means a Covered Service provided by an Out-of-Network Provider, which has been specifically authorized in advance by Us to be Covered under the Plan's In-Network level of benefits.

CASE MANAGEMENT/CLINICAL CARE SERVICES means individual review and follow-up for ongoing services.

Section 2
Definitions

CHILD/CHILDREN means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child, or any other child eligible for coverage under the health benefit plan.

CLAIM means a request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's reasonable procedure for filing claims.

CLAIMANT means a Member or person authorized to act on their behalf in filing a request for Plan benefits.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law No. 99-272. COBRA provisions apply to groups of more than 20 employees.

COINSURANCE means the charges required to be paid by the Member for certain services covered under this Plan or in conjunction with any applicable rider hereto. Coinsurance amounts are expressed as a percentage of the Plan's fee schedule or of an allowable charge for a specific health care service. Coinsurance may be required to be paid to the provider of the service at the time service is received.

CONCURRENT CARE CLAIM/DECISION means a Claim regarding a decision by the Plan to terminate or reduce benefits that it previously approved. Concurrent Claim also may be a request to extend the course of treatment already approved by the Plan.

CONCURRENT REVIEW means ongoing medical review of the Member's care while hospitalized.

COORDINATION OF BENEFITS means those provisions by which the Plan physician or the Plan either together or separately seek to recover costs of an incident of sickness or accident on the part of the Member, which may be covered by another group insurer, group service plan, or group health care plan including coverage provided under governmental programs subject to any limitations imposed by a Group Agreement preventing such recovery.

COPAYMENT means a specific dollar amount which may be collected directly from a Member as payment for Covered Services covered under this Evidence of Coverage. The schedule of Copayments is contained in the Face Sheet to this Evidence of Coverage. Copayment may be required to be paid to the provider of the service at the time service is received.

COVERAGE or COVER means the right to benefits as defined in this Evidence of Coverage which a Member is entitled to receive on the effective date until termination, subject to the Plan's conditions, and exclusions and limitations.

COVERED PERSON means a Subscriber as described herein and the enrolled eligible Dependent(s) as defined in this document.

COVERED SERVICE OR COVERED SERVICES means those health services and benefits to which Members are entitled under the terms of this Evidence of Coverage. Except as otherwise provided, Covered Services must be Medically Necessary, and Pre-Authorized if Pre-Authorization is required in this EOC.

CUSTODIAL CARE means treatment or services which could be rendered safely and reasonably by a person not medically skilled or trained, regardless of who recommends them and where they are provided, and which are designed mainly to help the patient with daily living activities. Such activities include, but are not limited to:

1. Help in walking, getting in and out of bed, bathing, eating by any method, exercising, dressing;
2. Preparing meals or special diets;
3. Moving the patient;

4. Acting as a companion; and
5. Administering medication which can usually be self-administered.

"Custodial Care" includes: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, per the attending physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him or her to live outside an institution; and (3) rest cures, respite care and home care provided by family members. The Plan will determine if a service or treatment is Custodial Care.

DEDUCTIBLE means the dollar amount of covered medical expenses for which a Member is responsible to pay before benefits are payable under the Plan. Such amount will not be reimbursed under the Plan. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

DEPENDENT means any person who is a member of a subscriber's family and who meets all applicable eligibility requirements of this Evidence of Coverage and is enrolled pursuant to the Group Contract, and for whom the required fees have been received by the Plan.

EMERGENCY MEDICAL CONDITION means, regardless of the final diagnosis rendered to a covered person, a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMERGENCY SERVICES means, with respect to an Emergency Medical Condition- (A) A medical screening examination that is within the capability of a licensed Hospital's emergency department or a licensed freestanding emergency facility, including ancillary services routinely available to the Hospital emergency department or freestanding emergency facility, to evaluate such Emergency Medical Condition, and B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or freestanding emergency facility, to stabilize the patient. Emergency Services also include emergency air ambulance services, and post stabilization services including any additional Covered Services furnished by an out of network provider or emergency facility (regardless of the department of the hospital in which the items and services are furnished) after a Member is stabilized as part of outpatient observation, or as part of an inpatient or outpatient stay with respect to the visit in which Emergency Services are furnished.

ENROLLMENT APPLICATION means an application furnished or approved by the Plan, executed by a person meeting the eligibility requirements of a Subscriber, pursuant to which such person applies on his or her own behalf and/or on behalf of eligible members of his or her family for Coverage for Health Services in connection with the Group Contract .

ESSENTIAL HEALTH BENEFITS PACKAGE OR EHB PACKAGE OR ESSENTIAL HEALTH BENEFIT(S) means the scope of covered benefits and associated limits of a health plan offered by an issuer that provides at least the following ten statutory categories of benefits, as described in **PPACA:** (1) Ambulatory patient services; (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care; (5) Mental health and substance use disorder services, including behavioral health treatment; (6) Prescription drugs; (7) Rehabilitative and habilitative services and devices; (8) Laboratory services; (9) Preventive and wellness services and chronic disease management; (10) Pediatric services, including oral and vision care.

Section 2
Definitions

Member cost sharing including Copayments, Coinsurance, and Deductibles for Essential Health Benefits will count toward the Maximum Out-of-Pocket Amount listed on the Face Sheet or Schedule of Benefits for this Plan.

EVIDENCE OF COVERAGE means this document evidencing covered health care services which is issued to each subscriber.

eVISIT means an email exchange between a primary care or specialty physician and his/her established patient that substitutes for a standard office visit for the purpose of providing substantive advice or intervention for a non-urgent problem. Lesser services usually provided by phone or mail that would not qualify as an eVisit include, but are not limited to, reporting normal lab results, making appointments, or prescription refills.

EXPERIMENTAL/INVESTIGATIONAL: A drug, device, medical treatment or procedure may be considered experimental/investigational if:

1. The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
2. The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies; or
3. The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
4. The drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
5. The drug, device, or medical treatment is approved as Category B Non-experimental/Investigational by the FDA; or
6. The drug, device, medical treatment or procedure is:
    a. Currently under study in a Phase I or II clinical trial or
    b. An experimental study/investigational arm of a Phase III clinical study or
    c. Otherwise under study to determine safety and efficacy/compare its safety and efficacy to current standards of care.

FACILITY is an institution providing health care related services or a health care setting, including:

1. Hospitals and other licensed inpatient centers;
2. Ambulatory surgical or treatment centers;
3. Skilled Nursing Facilities;
4. Residential treatment centers;
5. Diagnostic, laboratory, and imaging centers; and
6. Rehabilitation and other therapeutic health settings.

GENERIC DRUG/GENERIC PRODUCT LEVEL is approved by the FDA as having the same active ingredient as the brand name drug. FDA-approved generic equivalents are considered bioequivalent to the brand name drug in dosage form and strength, route of administration, safety, quality, performance characteristics and intended use.

GROUP HEALTH CONTRACT OR CONTRACT means the contract executed between the Plan and the respective group which expresses the agreed upon contractual rights and obligations of the parties thereto, and which describes the costs, procedures, benefits, conditions, limitations, exclusions, and other obligations to which members are subject under the Plan's prepaid Health Services plan(s).

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

Section 2
Definitions

GROUP OR SUBSCRIBING GROUP OR EMPLOYER GROUP means the organization or firm contracting with the Plan to provide and/or arrange health care services for its employees and their eligible Dependents.

HEALTH SERVICES means those services, procedures and operations more particularly described in this Evidence of Coverage.

HOME HEALTH SERVICES means care or service provided by an organization licensed by the State and operating within the scope of its license when such services provide for the care and treatment of a homebound Member in his or her home under a treatment plan established and approved in writing by his/her ordering physician, as required for the proper treatment of the injury or Illness, in place of inpatient treatment in a Hospital or Skilled Nursing Facility.

HOSPICE SERVICES means a coordinated program of home and inpatient care including palliative and supportive physical, psychological, psychosocial and other Health Services to individuals with a terminal illness, whose medical prognosis is death within six months.

HOSPITAL means an institution which:

1. Is accredited under one of the programs of the Joint Commission on Accreditation of Healthcare Organizations; or
2. Is licensed as a Hospital under the laws of the jurisdiction where it is located, and
3. Is primarily engaged in providing, for pay and on its own premises, inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities; and
4. Is under the direction of a staff of physicians; and
5. Provides 24-hour nursing service rendered or supervised by a registered graduate nurse; and
6. Has facilities on its premises for major surgery (or a written contractual agreement with an accredited Hospital for the performance of surgery).

"Hospital" does not include a facility, or part thereof, which is principally used as: a rest or Custodial Care facility, nursing facility, convalescent facility, extended care facility, or facility for the aged or for the care and treatment of drug addicts or alcoholics, unless specifically provided herein and/or as mandated by state law. It does not mean an institution in which the Member receives treatment for which he or she is not required to pay.

ILLNESS means a pregnancy or a bodily disorder or infirmity that is not work-related. Only a non-occupational illness (i.e., one which does not arise out of or in the course of work for pay or profit) is considered for benefits under the Plan. However, if proof is furnished to the Plan that a Member covered under a Workers' Compensation law, or similar law, is not covered for a particular Illness under such law, then such Illness shall be considered "non-occupational," regardless of its cause.

IN-NETWORK OR IN-NETWORK SERVICES means the level of benefits a Member uses when he or she seeks care from a Plan Provider. All policies and procedures of the plan must also be followed.

INFERTILITY means that the Member is unable to conceive or produce conception after one year of unprotected intercourse; or if older than age 35 the Member is unable to conceive or produce conception after six months of unprotected intercourse; and/or in either of the above situations the Member is unable to carry the fetus to term (e.g. three or more consecutive spontaneous miscarriages prior to 20 weeks gestational age).

MAXIMUM OUT-OF-POCKET LIMIT, MAXIMUM OUT-OF-POCKET AMOUNT, MAXIMUM, INDIVIDUAL MAXIMUM, or FAMILY MAXIMUM means the total amount a Member and/or eligible Dependents pay, or that are paid on their behalf, during a year as specified on the Schedule of Benefits.

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

Section 2
Definitions

Member cost sharing including Copayments, Coinsurance, and Deductibles for most covered services will count toward the Maximum Out-of-Pocket Amount listed on the Schedule of Benefits for this Plan.

MEDICAL DIRECTOR means a duly licensed physician or designee who is employed by the Plan to monitor the quality and delivery of health care to Members in accordance with this Evidence of Coverage and the accepted medical standards of this community.

MEDICALLY NECESSARY services and/or supplies means the use of services or supplies as provided by a Hospital, Skilled Nursing Facility, Physician or other provider which are:

1. Required to identify, evaluate or treat the Member's condition, disease, ailment or injury, including pregnancy related conditions; and
2. In accordance with recognized standards of care for the Member's condition, disease, ailment or injury; and
3. Appropriate with regard to standards of good medical practice; and
4. Not solely for the convenience of the Member, or a participating Physician, Hospital, or other health care provider; and
5. The most appropriate supply or level of service which can be safely provided to the Member as substantiated by the records and documentation maintained by the provider of the services or supplies.

MEMBER means a Subscriber as described herein and the enrolled eligible Dependent(s) as defined in this document.

NON-PLAN PROVIDER means any provider that is not a Plan Provider.

OPEN ENROLLMENT PERIOD means a period of time no longer than thirty (30) days occurring at least once annually during which time any eligible employee of a Subscribing Group may join or transfer from one type of health care plan (e.g. indemnity or Health Maintenance Organization) to another.

OUT-OF-NETWORK or OUT-OF-NETWORK SERVICES means Covered Services from an Out-of-Network Non-Plan Provider that are not Emergency Services, Emergency air ambulance services or nonemergency surgical and ancillary services provided by an Out-of-Network Provider at an In-Network facility..

PARTICIPANT EMPLOYER means any employer, sole proprietorship, partnership, corporation or firm which:

1. Is a subsidiary of or affiliated with the group; and
2. By written mutual agreement between the group and Plan, has been included under the Agreement; and
3. Has not been removed in accordance with any of the Agreement terms.

PHYSICIAN means, with respect to any medical care and service, a person:

1. Certified or licensed, under the laws of the state where treatment is rendered, as qualified to perform the particular medical or surgical service for which claim is made and who is practicing within the scope of such certification or licensure; and
2. Any other health care provider or allied practitioner if, and as, mandated by state law.
3. This term does not include: (1) an intern; or (2) a person in training.

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

Section 2
Definitions

PLAN means Optima Health Plan which is licensed to conduct business in the Commonwealth of Virginia as a Health Maintenance Organization (HMO), which arranges to provide to Members health care services that are set forth herein.

PLAN PHARMACY means a duly licensed pharmacy which has a contract with the Plan.

PLAN PROVIDER OR PLAN FACILITY means a Physician, Hospital, Skilled Nursing Facility, urgent care center, laboratory or any other duly licensed institution or health professional under contract to provide professional and Hospital services to Members. A list of Plan Providers and their locations is available to each Subscriber upon enrollment. Such list shall be revised from time to time as necessary and is available upon request. A Plan Provider's contract may terminate, and a Subscriber may be required to use another Plan Provider.

POST-SERVICE CLAIM means any Claim for a benefit under the Plan that is not a Pre-Service claim.

PPACA or ACA means the Patient Protection and Affordable Care Act (P.L. **111-148**), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. **111-152**), and as it may be further amended.

PRE-AUTHORIZATION means an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care.

PREMIUM means the amount of money prepaid to the Plan by the Group, including Subscriber contributions, if any, on behalf of enrolled Subscribers and Dependents enrolled through that Group.

PRE-SERVICE CLAIM means any claim for a benefit under the Plan for which the Plan requires approval before the Member obtains medical care.

PRIMARY CARE PROVIDER (PCP) means the participating provider selected by a Member to provide first contact medical care and/or coordinate medical care, which includes pediatricians, family practitioners, nurse practitioners, internists, obstetricians-gynecologists for females age thirteen (13) or older, and such other physicians as designated by the Plan. At the time of enrollment each Member shall have the right to select a Primary Care Provider from among the Plan's affiliated Primary Care Providers, subject to availability. Any Member who is dissatisfied with his Primary Care Provider shall have the right to select another Primary Care Provider from among the Plan's affiliated Primary Care Providers, subject to availability. The Plan may impose a reasonable waiting period for this transfer.

RESCISSION or RESCIND means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. Rescission does not include:

1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or
2. A cancellation or discontinuance of coverage when the health benefit plan covers active employees and, if applicable, dependents and those covered under continuation coverage provisions, if the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative recordkeeping.

RETROSPECTIVE REVIEW means the review of the Member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment. Emergency Services will be covered regardless of the final diagnosis given.

Section 2
Definitions

DIRECT PLAN SERVICE AREA means the geographic area in which the Plan has directly or indirectly arranged for the provision of Covered Services to be generally available to Members. The Plan's service area includes the following cities and counties:

Accomack Co, Albemarle Co, Alleghany Co, Amelia Co, Amherst Co, Appomattox Co, Augusta Co, Bath Co, Bedford City, Bedford Co, Bland Co, Botetourt Co, Bristol City, Brunswick Co, Buchanan Co, Buckingham Co, Buena Vista City, Campbell Co, Caroline Co, Carroll Co, Charles City Co, Charlotte Co, Charlottesville City, Chesapeake City, Chesterfield Co, Clarke Co ,Colonial Heights City, Covington City, Craig Co, Culpeper Co, Cumberland Co, Danville City, Dickenson Co, Dinwiddie Co, Emporia City, Essex Co, Fauquier Co, Floyd Co, Fluvanna Co, Franklin City, Franklin Co, Frederick Co, Fredericksburg City, Galax City, Giles Co, Gloucester Co, Goochland Co, Grayson, Co, Greene Co, Greensville Co, Halifax Co, Hampton City, Hanover Co, Harrisonburg City, Henrico Co, Henry Co, Highland Co, Hopewell City, Isle of Wight Co, James City Co, King and Queen Co, King George Co, King William Co, Lancaster Co, Lee Co, Lexington City, Loudoun Co, Louisa Co, Lunenburg Co, Lynchburg City, Madison Co, Martinsville City, Mathews Co, Mecklenburg Co, Middlesex Co, Montgomery Co, Nelson Co, New Kent Co, Newport News City, Norfolk City, Northampton Co, Northumberland Co, Norton City, Nottoway Co, Orange Co, Page Co, Patrick Co, Petersburg City, Pittsylvania Co, Poquoson City, Portsmouth City, Powhatan Co, Prince Edward Co, Prince George Co, Pulaski Co, Radford City, Rappahannock Co, Richmond City, Richmond County, Roanoke City, Roanoke Co, Rockbridge Co, Rockingham Co, Russell Co, Salem City, Scott Co, Shenandoah Co, Smyth Co, Southampton Co, Spotsylvania Co, Stafford Co, Staunton City, Suffolk City, Surry Co, Sussex Co, Tazewell Co, Virginia Beach City, Warren Co, Washington Co, Waynesboro City, Westmoreland Co, Williamsburg City, Winchester City, Wise Co, Wythe Co, York Co

SKILLED NURSING FACILITY means an institution which is licensed by the State and is accredited under one of the programs of the Joint Commission on Accreditation of Health Care Organizations as a Skilled Nursing Facility or is recognized by Medicare as an extended care facility; and furnishes room and board and 24-hour-a-day skilled nursing care by, or under the supervision of, a registered graduate nurse (RN); and, other than incidentally, is not a clinic, a rest facility, a home for the aged, a place for drug addicts or alcoholics, or a place for Custodial Care.

SPECIALIST means any Physician who is not a Primary Care Physician. A Plan Specialist shall mean a Specialist who is a Plan Provider.

SUBSCRIBER means the individual, employee, or Member who meets the eligibility requirements of the group, who has made an application, and whose premiums have been paid.

SURGICAL OR ANCILLARY SERVICES are any professional services, including:

1. Surgery;
2. Anesthesiology;
3. Pathology;
4. Radiology;
5. Hospitalist services;
6. Laboratory services.

TIER 1 PHYSICIAN, FACILITY OR OTHER PROVIDER means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 1 cost sharing amounts listed on the Plan Face Sheet Schedule of Benefits. Tier 1 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 1 Physicians, Facilities, and other providers and their locations is available to each enrollee during enrollment and anytime upon request.

Section 2
Definitions

TIER 2 PHYSICIAN, FACILITY, OR OTHER PROVIDER means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 2 cost sharing amounts listed on the Plan Face Sheet Schedule of Benefits. Tier 2 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 2 Physicians and Facilities and other providers and their locations is available to each enrollee during enrollment and anytime upon request.

URGENT CARE CLAIM means any claim for medical care or treatment where (1) if the Plan were to use its normal Pre-Service standards for making a coverage decision or a decision on appeal it would seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or (2) in the opinion of a physician with knowledge of the Member's medical condition, following the Plan's normal appeal procedure would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A prudent layperson standard applies when determining what is an urgent care claim, except where a physician with knowledge of the Member's medical condition determines that the claim is urgent.

URGENT CARE SERVICES means those covered outpatient services which are non-life-threatening but Medically Necessary in order to prevent a serious deterioration of the Member's health that results from an unforeseen Illness or injury.

USUAL AND CUSTOMARY RATE means the rate determined by the Plan to be the rate paid by the Plan (or when unavailable the rate paid by other health plans that is publicly available) and customarily accepted by other providers who render or furnish such treatments, services or supplies to persons: (1) who reside in the same area; and (2) whose injury or illness is comparable in nature and severity. When applied to a Plan Provider, "Usual and Customary Rate" means the rate agreed to by the Plan Provider in its contract with the Plan with respect to Covered Persons.

VIRTUAL CONSULT means a medical consult using a secure platform (as determined by Optima Health in its sole discretion) with email, interactive video, and telephone to connect a provider and a patient.

WE, US, or OUR means this plan or Optima Health**.**

YOU or YOUR means the employee or Subscriber and each family member covered as a Dependent under the Plan.

Section 3
Who is Eligible to Enroll

To enroll, and to continue enrollment, You must meet all of the eligibility requirements described in this section. You must also meet all of Your Group's eligibility requirements that We have approved. All of Your required premium payments must be current. Unless We agree otherwise, Independent contractors, agents or consultants who do not receive W-2 forms are not eligible. Unless We agree otherwise, You must provide all required enrollment information within 31 days of Your effective date or You may have to wait until Your group's next open enrollment period.

WHO IS ELIGIBLE FOR COVERAGE UNDER THE PLAN.

You may be eligible to enroll and continue enrollment as a Subscriber if:

- You are an employee of Your group; **and**
- You are Actively at Work (defined below); **and**
- You provide Us a complete enrollment application and any premiums or fees for yourself and any dependents within 31 days of Your coverage effective date; **and**
- You do not knowingly give Us any incorrect, incomplete or deceptive information about yourself or Your Dependents; **and**
- You meet all other requirements listed in this document or specified by Your employer.

ACTIVELY AT WORK.

You must be "actively at work" to receive covered benefits and services. Employees who, for any reason, are not actively at work on the Group's effective date of Coverage must wait until they return to being actively at work to receive Covered Services. Actively at work means:

- You are employed by the group; **and**
- You meet all eligibility requirements; **and**
- Your premiums are being paid to Us.

If You are absent from work because of a health factor (such as being absent from work on sick leave) You are still considered actively at work.

Retired employees, COBRA beneficiaries, or employees receiving Workers' Compensation will be considered actively at work on any day that all of the eligibility requirements are met and premiums are being paid to Us.

SHORT TERM LEAVE OF ABSENCE.

During a short term leave of absence You may still be considered actively at work and eligible for coverage. The leave of absence must be approved by the group. Coverage may continue for up to three months if Your group plan remains in effect, **and** Your premiums continue to be paid to Us. The group and the plan may agree to continue coverage for a longer leave of absence.

ABSENCE FROM WORK DUE TO DISABILITY.

For an employee who is totally disabled, Coverage will continue for a period of not longer than six months or until the date the employee is covered under Medicare or Medicaid, whichever happens first. We may require certification of disability from the employer or the employee.

Section 3
Who is Eligible to Enroll

COVERAGE FOR DEPENDENTS.

If You are a Subscriber, the following persons may be eligible to enroll as Your Dependents:

- Your lawful spouse; or
- Children up to the age 26 including:

    - Natural or step children; or
    - Legally adopted children; or
    - Children placed for adoption; or
    - Children placed in foster care; or
    - Other Children for whom the Subscriber or covered spouse is a court appointed legal guardian.

    The Plan will not deny or restrict eligibility for a Child who has not attained age 26 based on any of the following:

    - Financial dependency on the Subscriber or any other person; or
    - Residency with the Subscriber or any other person; or
    - Student status; or
    - Employment status; or
    - Marital status.

    The Plan will not deny or restrict eligibility of a Child based on eligibility for other coverage.

    Eligibility to age 26 does not extend to a spouse of a Child Covered as a Dependent.

    Eligibility to age 26 does not extend to a Child of a Child Covered as a Dependent unless the grandparent Subscriber or spouse becomes the legal guardian or adoptive parent of that grandchild.

- Any other person or persons(s) mutually agreed to by the Plan and the Group.

To complete enrollment We must receive all required information on the enrollment application and all premiums for each Dependent. Unless We agree otherwise, You must provide all required enrollment information within 31 days of Your effective date or You may have to wait until Your group's next open enrollment period.

INELIGIBLE INDIVIDUALS.

In certain circumstances a person who meets eligibility requirements may not be able to enroll in the plan. Anyone terminated from the plan for cause is not eligible. A person may be ineligible if that person or someone else in his or her family unit has been terminated for specific reasons as defined in Section 11.

A person who would otherwise be eligible for Coverage may not eligible if that person would cause Optima Health to violate any of its policies for doing business with or providing services to a person who appears on any official sanction list maintained by local, state or federal government agencies.

CHANGES IN ELIGIBILITY.

The Plan must be notified of a change in the status of a Subscriber, spouse or other Dependent that would make them ineligible to remain covered under the Plan.

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

Section 3
Who is Eligible to Enroll

WHEN A CHILD AGES OFF THE PLAN.

Unless otherwise stated coverage for a Child ends the last day of the year the child reaches the limiting ages on Your Face Sheet.

CONTINUATION OF COVERAGE FOR CHILDREN WITH AN INTELLECTUAL DISABILITY OR PHYSICAL HANDICAP.

Children will continue to be eligible for coverage beyond the Plan's limiting ages when both of the following conditions are true:

- The child is incapable of self-sustaining employment by reason of an intellectual disability or physical handicap; **and**
- The child is chiefly dependent upon the Subscriber for support and maintenance.

We will require acceptable proof of incapacity and dependency within 31 days of the child's reaching the limiting age on Your Face Sheet. Proof of incapacity consists of a statement by a licensed psychologist, psychiatrist, or other Physician stating the Child is incapable of self-sustaining employment by reason of an intellectual disability or physical handicap. We may require additional statements, but not more than once a year.

VERIFICATION OF ELIGIBILITY.

Your Employer is responsible for determining Your eligibility, and the eligibility of any of Your Dependents for Coverage under the Plan. However, We reserve the right to request or review at any time, at Our sole and absolute discretion, proof of eligibility of any Subscriber or other covered family member.

Section 4
When You Can Enroll and When Coverage Begins

When You are eligible to enroll in the Plan You must provide a signed completed application with all required information for yourself and any dependents that will be covered under the plan. To complete enrollment We must receive all required information on the enrollment application and all premiums. Unless We agree otherwise, You must provide all required enrollment information within 31 days of Your effective date or You may have to wait until Your group's next open enrollment period. If We determine Your application is incomplete and We request additional information You must provide the information in a timely manner or You may not be able to enroll until Your groups next open enrollment period. We may not recognize retroactive adjustments of enrollment due to the group's failure to furnish enrollment applications or fees to Us within 31 days of the Coverage effective date.

PLAN OPEN ENROLLMENT.

Your group will hold an annual open enrollment period. During open enrollment eligible employees and dependents can apply for coverage. Your group will let You know when Your open enrollment period starts and when Your coverage is effective.

NEW EMPLOYEES.

When Your Group tells You that You are eligible to enroll as a Subscriber You may apply for Coverage for Yourself and Your dependents within 31 days.

NEW DEPENDENTS.

A Subscriber may enroll or disenroll an eligible Dependent within 31 days of the occurrence of one of the following qualifying events:

- Change in legal marital status including marriage, death of a spouse, divorce, legal separation, and annulment; or
- Change in number of subscriber's dependents including birth, death, adoption, placement for adoption or court appointed legal guardianship; or
- Change in employment status, including a change in work site, a switch between hourly and salaried status, and any other employment status change resulting in a gain or loss of eligibility of the employee, spouse, or dependent; or
- Change in dependent's eligibility for coverage; or
- Change in residence of employee, spouse, or dependent that affects eligibility; or
- Other changes in status that the group and the plan agree to.

CONSISTENCY RULE.

In order for one of these events to qualify as an occasion for changing coverage under the Plan, it must have a direct effect on the Subscriber's present coverage. For example, marriage is a permissible reason to change from Subscriber only coverage to family coverage. However, the death of a child has no effect on the Subscriber's coverage if he/she has a spouse and another child, and is carrying family coverage.

EFFECTIVE DATE OF SUBSCRIBER COVERAGE.

If We have received and accepted a complete enrollment application Coverage will become effective on the earliest of the following dates, unless otherwise agreed to by Optima Health and the Employer:

- When a person makes a written application for coverage on or prior to the date he or she satisfies the eligibility requirements above, coverage shall be effective as of the first of the month

following the date eligibility requirements are satisfied, unless otherwise agreed to by Optima Health and the Employer; or

- When a person makes written application for coverage after the date he or she satisfies the eligibility requirements above, coverage will be effective as of the first day of the calendar month following the month in which such application is received by the Plan, unless otherwise agreed to by Optima Health and the Employer.

A Member can only be a Subscriber under one group plan even if he or she is connected with more than one employer. A Subscriber will be considered an employee of one employer.

EFFECTIVE DATE OF DEPENDENT COVERAGE.

A Subscriber must enroll all Dependents. If We have received and accepted a complete enrollment application(s) coverage will become effective on the latter of:

- The date the Subscriber's Coverage becomes effective; or
- On the date the Subscriber acquires eligible Dependents.

Newborn Children.

A newborn child will be covered from the moment of birth for 31 days if the Subscriber's Coverage under this Plan is in effect. An adopted child whose placement has occurred within thirty-one days of birth will be considered a newborn child of the Subscriber as of the date of adoptive or parental placement. The newborn child's Coverage will be identical to Coverage provided to the Subscriber. It also will provide Coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Inpatient and outpatient dental, oral surgical and orthodontic services which are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia will be covered. In order for coverage to continue beyond the first 31 days the Subscriber must add the newborn to the Plan within 31 days of birth. If the newborn is not added to the Plan within 31 days of birth the newborn may not be eligible to enroll until the next Plan Open Enrollment Period.

Adopted Children.

An adopted child will be eligible for Coverage from the date of placement with an eligible Subscriber for the purpose of adoption. A child whose placement has occurred within thirty-one days of birth will be considered a newborn child of the Subscriber as of the date of adoptive or parental placement. Evidence of placement and any applicable Premiums must be submitted to the Plan within 31 days from the date of placement. If the adopted child is not added to the Plan within 31 days of placement, the child may not be eligible to enroll until the next Open Enrollment Period.

Coverage Mandated by Court Order.

Coverage mandated by court order issues, including Qualified Medical Child Support Orders (QMCSOs), will begin on the date of the court order if the request is made and an Enrollment Application is submitted within 31 days of the order. Coverage mandated by the Child Support Act will begin on the first of the month following the Group's notification to the Plan. Subject to the eligibility requirements of the Plan and/or the Group in order to provide Coverage to a Dependent child, both the child and the parent ordered to provide support may be required to enroll in the Plan.

SPECIAL LATE ENROLLMENT PROVISIONS.

The Plan provides special late enrollment periods for eligible Subscribers and Dependents that fall into the following categories:

Late Enrollees with Other Coverage.

Employees or Dependents who initially decline Coverage because they have other group health coverage or other health insurance will be allowed to enroll late without evidence of insurability if the following conditions are met:

1. The employee and/or Dependent is eligible under the Plan's terms; and
2. When the employee declined enrollment for the employee or Dependent, either the employee or Dependent had COBRA continuation coverage under another Plan and that coverage has since run out; or if the other Coverage was not under COBRA, either the other coverage has ended because of loss of eligibility, or the employer has stopped contributions toward the other coverage; and
3. An individual must request enrollment no more than 31 days from the time that he or she knew or should have known that his or/her other Coverage had ended.

Late enrollment is effective no later than the first day of the first calendar month after the date the Plan receives a completed request for enrollment.

Late Enrollees Due to Marriage, Birth, Adoption, or Placement for Adoption or Placement of a Child in Foster Care.

If a Dependent is added through marriage, birth, adoption, placement for adoption or placement in foster care, the employee and Dependents may apply for Coverage through special late enrollment. Individuals in this category do not have to have previously declined Coverage because of other Coverage. Individuals must request Coverage within 30 days of marriage, birth, adoption, placement for adoption or placement in foster care.

For special enrollment due to birth, adoption or placement of a child in foster care late enrollment is effective on the date of the birth, adoption, placement for adoption or placement in foster care.

For special enrollment due to marriage late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.

Special Enrollment for Employees and Dependents that Lose Eligibility Under Medicaid or Children's Health Insurance Program (CHIP) Coverage.

Your employer is required to provide You notice of special enrollment rights and premium assistance under CHIP. Employees or Dependents who are eligible for group coverage will be permitted to enroll late if they (1) lose eligibility for Medicaid or CHIP coverage or (2) they become eligible to participate in a premium assistance program under Medicaid or CHIP. In both cases the employee must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

ENROLLMENT IN MEDICARE.

A Covered Person, who is eligible to be covered under Medicare (Title XVIII of the Social Security Act of 1965, as amended), is encouraged to enroll in Parts A and B coverage on the date they are eligible. If You are under age 65, entitled to Medicare because of End Stage Renal Disease (ESRD), and have employer group health coverage, please contact the Plan regarding Your participation with Medicare Part B or assistance in obtaining Part B.

Section 5
Utilization Management Procedures for Coverage Decisions for Claims for Covered Services

This Chapter explains how We determine Medical Necessity for payment of a claim. We use the following review processes to make coverage decisions on Pre-Service, Post-Service, Concurrent, and Urgent Care claims:

- Pre-Authorization;
- Concurrent Review;
- Retrospective Review; and
- Case Management.

Compliance with any of the review processes is not a guarantee of benefits or payment under the Plan.

PRE-AUTHORIZATION.

Some services require Pre-Authorization before You receive them. Your Physician or other provider is responsible for getting Pre-Authorization. We have instructions and procedures in place for providers to obtain Pre-Authorization.

Pre-Authorization is an evaluation process We use to assess the Medical Necessity and coverage of proposed treatment. It also checks to see that the treatment is being provided at the appropriate level of care. Pre-Authorizations are approved or denied based on current medical practice and guidelines and not on incentives or bonus structures. Pre-Authorization is certification by the Plan of Medical Necessity and not a guarantee of payment by the Plan. Payment by the Plan for Covered Services is contingent on the Member being eligible for Covered Services on the date the Covered Service is received by the Member.

On Your Face Sheet We tell You what services require Pre-Authorization before You receive them. You can also look in the What is Covered Section of this document or call Member Services to find out about Pre-Authorization. Generally the following types of services require Pre-Authorization:

- Inpatient hospital services;
- Partial hospitalization services;
- Non-emergency ambulance transport;
- Inpatient and outpatient surgery;
- Surgery in a physician's office;
- Single items of durable medical equipment and orthopedic and prosthetic appliances over $750;
- Rental of durable medical equipment and orthopedic and prosthetic appliances;
- Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances;
- Artificial prosthetic limbs;
- Prenatal maternity services;
- Home health care;
- Skilled nursing facility care;
- Physical, occupational, and speech therapy;
- Cardiac, pulmonary, and vascular rehabilitation;
- IV therapy with medications;
- Inhalation therapy;
- Early intervention services;
- Clinical trials;
- Hospice services;
- Oral surgery;
- TMJ services;
- Tubal ligation;
- Hospitalization and anesthesia for dental procedures;

- Treatment of lymphedema;
- Magnetic Resonance Imaging (MRI);
- Magnetic Resonance Angiography (MRA);
- Positron Emission Tomography (PET) scans;
- Computerized Axial Tomography (CT) scans;
- Computerized Axial Tomography Angiogram (CTA) scans;
- Sleep studies;
- Transplant services;
- Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee;
- Intensive outpatient programs (IOP);
- Medical, psychological and neuro psychological diagnostic procedures and testing;
- Electro-convulsive therapy;
- Telemedicine services;
- Transcranial Magnetic Stimulation (TMS);
- Insulin pumps and insulin pump infusion sets;
- Chemotherapy and Chemotherapy Drugs;
- Radiation Therapy;
- Dialysis Services;
- Other ridered services**.** If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

Standard of Clinical Evidence for Decisions on Coverage for Proton Radiation Therapy.

"Proton radiation therapy" means the advanced form of radiation therapy treatment that utilizes protons as an alternative radiation delivery method for the treatment of tumors.

"Radiation therapy treatment" means a cancer treatment through which a dose of radiation to induce tumor cell death is delivered by means of proton radiation therapy, intensity modulated radiation therapy, brachytherapy, stereotactic body radiation therapy, three-dimensional conformal radiation therapy, or other forms of therapy using radiation.

The Plan will not hold proton radiation therapy to a higher standard of clinical evidence for decisions regarding coverage under the Plan than is applied for decisions regarding coverage of other types of radiation therapy treatment.

Nothing in this section shall be construed to mandate the coverage of proton radiation therapy under the Plan.

Organ Transplant

For Covered organ transplants, including eye or tissue transplants and related services, Optima Health will not discriminate in coverage decisions based on disability.

Newborn Mother Transfer

Optima Health will not require prior authorization for the interhospital transfer of:

- A newborn infant experiencing a life-threatening emergency condition; or
- The hospitalized mother to accompany the infant.

Section 5
Utilization Management Procedures for Coverage Decisions for Claims for Covered Services

Pre-authorization for Drugs Prescribed for the Treatment of a Mental Disorder

If We have previously Pre-Authorized a drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, no additional prior authorization will be required provided that:

- The drug is a covered benefit; and
- The prescription does not exceed the FDA-labeled dosages; and
- The prescription has been continuously issued for no fewer than three months; and
- The prescriber performs an annual review of the patient to evaluate the drug's continued efficacy, changes in the patient's health status, and potential contraindications.

We may require Pre-Authorization for any drug that is not listed on Our prescription drug formulary at the time the initial prescription for the drug is issued.

PRE-SERVICE CLAIMS DECISIONS.

A pre-service claim means a claim for a benefit that requires Pre-Authorization before the Member has the service done.

We make decisions on Pre-Service Claims within 15 days from receipt of request for the service. We may extend this period for another 15 days if We determine We need more time because of matters beyond Our control. If We extend the period We will notify the Member/Provider before the end of the initial 15 day period. If We make an extension because We do not have enough information to make a decision We will notify the Member/Provider of the specific information missing and the timeframe within which the information must be provided. We will make a decision within 2 business days of receiving all the required medical information needed to process the Claim.

When the Plan has made a decision We will send the Member/treating Physician written notice.

EXPEDITED DECISIONS FOR URGENT CARE CLAIMS.

We will consider a request for medical care or treatment to be an urgent request if using Our normal Pre-Authorization standards would:

- Seriously jeopardize the Member's life or health; or
- Seriously jeopardize the ability of the Member to regain maximum function; or
- In the opinion of a Physician with knowledge of the Member's medical condition, subject the Member to severe pain that cannot be adequately managed without the care or treatment.

We will notify the Member/Provider of Our decision not later than 72 hours from receipt of the request for service. If We require additional information to make a decision We will notify the Member/Physician within 24 hours of receipt of the request. We will include the specific information that is missing and the applicable timeframes within which to respond to Us.

EXPEDITED DECISIONS FOR CANCER PAIN MEDICATIONS.

For requests for prescriptions for the relief of cancer pain We will notify the Member/Physician of Our decision within 24 hours of receipt of the request.

Section 5
Utilization Management Procedures for Coverage Decisions for Claims for Covered Services

CONCURRENT REVIEW AND APPROVAL OF CARE INVOLVING AN ONGOING COURSE OF TREATMENT.

Concurrent Reviews means ongoing medical review of a Member's care during Hospital and Skilled Nursing Facility confinements. We may also do Concurrent Review for Home Health, therapy, and rehabilitation services treatment plans. If We decide to reduce or end care We will notify the Member or provider before the care is reduced and early enough to allow for an appeal of Our decision.

Plan Providers must follow certain procedures to make sure that if a previously approved course of treatment or hospital stay needs to be extended, the extension is requested in time to minimize disruption of needed services. We will notify the Member of a coverage decision within 24 hours of the request. Notification will include information on how to appeal an Adverse Benefit Determination prior to services being discontinued. Requests for extensions of therapy or rehabilitative treatment plans must be made 7 days prior to the end of the authorized timeframe to avoid disruption of care or services.

RETROSPECTIVE REVIEW OF POST-SERVICE CLAIMS.

Retrospective Review means Our review of the Member's medical records and other supporting documentation after services have been received to determine if the services were Medically Necessary and if We will pay for them.

We will make coverage decisions on Post-Service Claims within 30 calendar days from receipt of request for the service. We may extend this period for another 15 days if We determine it to be necessary because of matters beyond Our control. If an extension is necessary, the Member will be notified prior to the end of the initial 30 day period. If the extension is necessary due to Us not having enough information to make the initial coverage decision, the Member/Provider will be notified of the specific information missing and the timeframe within which the information must be provided.

We will make Our decision within 2 business days of receiving the medical information needed to process the claim. The Plan will provide the Member and Physician written notice of its decision.

ADVERSE BENEFIT DETERMINATIONS.

You have certain rights if We deny a request for Pre-Authorization or make other Adverse Benefit Determinations. We will provide written notice of Adverse Benefit Determinations. For Urgent claims notification may be provided orally and then confirmed in writing up to three days after the oral notice. If Coverage is being Rescinded You will receive written notice 30 days prior to the Rescission. Written notification will include the following:

- The specific reason or reasons for the adverse benefit determination; and
- Reference to the specific Plan provisions on which the determination is based; and
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, experimental treatment, or similar exclusion or limit, You are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying

the terms of the Plan to the Member's medical circumstances. **Please also read Section 13 How to File a Complaint, Grievance, or Appeal an Adverse Benefit Determination**.

Section 6
What is Covered

This Chapter explains Your Covered Services. Covered Services must be:

- Medically Necessary;
- Listed as a Covered Service;
- Ordered or provided by a licensed Provider;
- Non-excluded.

Some services may require Pre-Authorization by the Plan before You receive them. You can read about Pre-Authorization in Section 5.

When You receive a Covered Service You will pay a Copayment or Coinsurance depending on the type and place of service. If Your plan has a Deductible You will pay that amount out of Your pocket before the Plan will pay for benefits. Your Copayments, Coinsurance and Deductibles are listed on the Schedule of Benefits.

ACCIDENTAL DENTAL SERVICES.

Pre-Authorization is Required.

We cover Medically Necessary dental services as a result of accidental injury, regardless of when the injury occurred. For injuries that happen on or after Your effective date of coverage, treatment must be sought within 60 days of the accident.

A health care professional such as a nurse or a physician must document treatment.

You will pay a specialist Copayment or Coinsurance for each visit to a dentist or oral surgeon.

If You choose to receive care from a Non-Plan dentist or oral surgeon the provider may bill You for amounts in excess of the Plan's fee schedule or allowable charge. We will not pay for these amounts over Our allowable charge.

We cover dental services performed during an Emergency Department visit immediately after an Accidental Injury in conjunction with the initial stabilization of the injury. We may retrospectively review all Emergency Department services. You will pay Your Emergency Department Copayment or Coinsurances. Emergency Department visits will not be subjected to pre-authorization.

ALLERGY CARE.

We cover the following Allergy Care services:

- Physician office visits; and
- Performance and evaluation of scratch, puncture or prick allergy tests; and
- Allergy shots and serum; and
- Professional services for supervising and providing allergy serum antigens for allergy injections.

AMBULANCE, STRETCHER, & WHEELCHAIR SERVICES.

Pre-Authorization is Required for Non-Emergency Transportation.

We Cover ambulance services that are:

- Provided by a professional agency licensed to provide transportation service; and

- Provided in a state licensed vehicle designed, equipped, and used only to transport the sick and injured;
- Staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals.
- Medically Necessary.

Emergency Air, Ground, Water Services

In an Emergency, We cover ambulance services from Your home or the place of Injury or medical Emergency to the nearest Hospital where appropriate treatment can be provided. This includes ground and water transportation. The Plan will provide reimbursement directly to the professional agency for Covered Services provided by an Emergency medical services vehicle when presented with an assignment of benefits. Your benefits also include air Emergency transportation by fixed wing or rotary wing when transport to an acute care Hospital is Medically Necessary and ground or water transportation is not appropriate for Your condition. We also may authorize Coverage of transportation between Hospitals or other facilities if Medically Necessary.

Please note the following about air transportation benefits under the Plan:

- Benefits are available for air emergency transportation when using ground ambulance would endanger Your health, and Your medical condition requires more urgent transportation to an acute care Hospital than a ground ambulance can provide.
- Your benefits include air transportation to the closest Hospital that can treat You.
- Transportation or transfer by air ambulance from one Hospital to another Hospital is only a Covered Service when Your condition requires certain specialized medical services that are not available at the Hospital that first treats You and using a ground ambulance would endanger Your health.
- Transportation or transfer by air is not a Covered Service just because You, Your family, or Your provider prefers You receive treatment by a specific provider or at a specific Hospital.
- In the case of non-emergent air ambulance transportation, We reserve the right to select the air ambulance provider. If You do not use the air ambulance Provider We select, the Out-of-Network Provider may bill You for charges.
- Air ambulance is not Covered for transportation to other facilities such as a Skilled Nursing Facility, a doctor's office or Your home.

Non-Emergency Stretcher & Wheelchair Transportation Services

Ambulance transportation by stretcher and wheelchair transportation services that are not Emergency Services must be pre-authorized by the plan. We will not cover transportation that is not required by the person's physical or mental condition. Transportation from Hospital to Hospital may be covered if Medically Necessary and pre-authorized by the Plan.

The Federal No Surprises Act prohibits balance billing for out-of-network emergency air ambulance services. Emergency air ambulance service provided by an out of network provider is covered under in-network benefits. Members will be responsible for in-network cost sharing including copayment, coinsurance and deductible amounts under the Plan. Providers cannot balance bill members for amounts above in-network cost sharing.

If You are balance billed please contact Member Services at the number on Your OptimaHealth ID Card. You may also file a complaint with the Plan. Please see "**Section 13 How To File A Complaint, Grievance, or Appeal An Adverse Benefit Determination.**" Please also see the Plan's full notice on balance billing protections.

Section 6
What is Covered

ANESTHESIA SERVICES.

Pre-Authorization is Required.

When Medically Necessary the following are Covered Services:

- General and regional anesthesia in an inpatient Hospital or outpatient facility;
- Supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure;
- Preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids, and/or blood and the usual monitoring services.

AUTISM SPECTRUM DISORDER.

Pre-Authorization is Required.

Covered Services include the "Diagnosis" and "Treatment" of "Autism Spectrum Disorder."

The following definitions apply to all Covered Services provided under this benefit.

"Applied Behavior Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder - Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral Health Treatment" means professional counseling and guidance services and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

"Diagnosis of Autism Spectrum Disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder.

"Medically Necessary" means based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

"Pharmacy Care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

"Psychiatric Care" means direct or consultative services provided by a psychiatrist or licensed professional counselor that is licensed in the state in which the psychiatrist or counselor practices.

"Psychological Care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

"Therapeutic Care" means services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or clinical social workers.

"Treatment for Autism Spectrum Disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavior analysis when provided or supervised by a board certified behavior analyst who shall be licensed by the Board of Medicine. The prescribing practitioner shall be independent of the provider of applied behavior analysis.

"Treatment Plan" means a plan for the treatment of Autism Spectrum Disorder developed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

Except for inpatient services, if an individual is receiving treatment for an Autism Spectrum Disorder, We have the right to request a review of that treatment, including an independent review, not more than once every 12 months unless We and the individual's licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review, including an independent review, will be covered under the Plan.

Coverage under this section will not be subject to any visit limits, and will not be different or separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors.

We may apply benefit management and Pre-Authorization procedures to determine the appropriateness of, and medical necessity for, "treatment" of "Autism Spectrum Disorder" in the same way that We apply them to all other Covered Services under the Plan.

Coverage for "Autism Spectrum Disorder" is in addition to coverage provided under the Plan for Early Intervention Services and Biologically Based Mental Health Illness.

BONES AND JOINTS (TEMPOROMANDIBULAR JOINT (TMJ) DIAGNOSTIC AND SURGICAL PROCEDURES.

Pre-Authorization is Required.

We cover Medically Necessary services and supplies to treat TMJ. TMJ diagnostic and surgical procedures and devices are covered when Medically Necessary to attain functional capacity of the affected part. Members who choose to receive care from Non-Plan dentists or oral surgeons may be billed by the Non-Plan Provider for charges in excess of the Plan's fee schedule.

Bone or Joint treatment involving a bone or joint of the head, neck, face or jaw is covered like any other bone or joint of the skeletal structure. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone.

Section 6
What is Covered

CLINICAL TRIALS.

Pre-Authorization is Required.

For a Qualified Individual Covered Services includes;

- Participation in an Approved Clinical Trial; and
- Routine Patient Costs for items and services furnished in connection with participation in an Approved Clinical trial.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is (i) a federally funded or approved trial, (ii) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) a drug trial that is exempt from having an investigational new drug application.

Life Threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted.

Qualified Individual means a Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual's participation in such trial is appropriate to treat the disease or condition, or the individual's participation is based on medical and scientific information.

Routine Patient Costs means all items and services consistent with the coverage provided under the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine patient costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

We may require that a Qualified Individual participate in an Approved Clinical Trial through a Plan Provider if the provider will accept the individual as a participant in the trial.

DIABETIC EQUIPMENT AND SUPPLIES.

Pre-Authorization is Required for Insulin Pumps and Insulin Pump Infusion Sets.

Some equipment and supplies under this benefit may be covered under the Plan's outpatient prescription drug benefits. However, if Your Plan excludes coverage for outpatient prescription drugs the Plan will provide coverage under the Plan's medical benefits for treatment of diabetes as shown on the Face Sheet Schedule of Benefits.

We cover FDA approved equipment and supplies prescribed by a provider for the treatment of these types of conditions:

- Insulin dependent diabetes;
- Non-Insulin dependent diabetes;
- Gestational diabetes.

We also cover outpatient self-management training and education when provided in person. This training and education includes medical nutrition therapy. Training must be provided by a certified, registered or

licensed health care professional. Members may call 1-800-SENTARA for information on educational classes.

An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating VSP Vision Care Provider at the applicable office visit Copayment or Coinsurance amount.

We do not consider supplies under this section to be Durable Medical Equipment. These benefits are not subject to any Plan maximum benefit limitations.

Insulin, syringes, needles, blood glucose monitors, test strips, lancets, lancet devices and control solution are covered under the Plan's Prescription Drug Benefit.

DIAGNOSTIC, X-RAY, AND LABORATORY SERVICES.

Pre-Authorization is Required for Outpatient Advanced Imaging Procedures including Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET Scans), Computerized Axial Tomography (CT Scans), Computerized Axial Tomography Angiogram (CTA Scans) Sleep Studies.

We cover Medically Necessary diagnostic X-ray, ultrasound and laboratory services.

DURABLE MEDICAL EQUIPMENT (DME) AND ORTHOPEDIC AND PROSTHETIC APPLIANCES. (Other than Prosthetic Artificial Limbs)

Pre-Authorization is Required for Items Over $750.
Pre-Authorization is Required for All Rental Items.
Pre-Authorization is Required for All Repair and Replacement.

We only cover DME that is Medically Necessary and prescribed by an appropriate Provider. We also cover colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters. We do not cover DME used primarily for the comfort and wellbeing of a Member. We will not cover DME if We deem it useful, but not absolutely necessary for Your care. We will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items.

Coverage for Orthopedic appliances includes the initial appliance. Repair and replacement are covered unless due to Member's neglect, misuse or abuse. We may also cover Medically Necessary customized splints and customized braces when pre-authorized by the Plan.

Coverage for Prosthetic appliances includes Medically Necessary surgically implanted prosthetic devices. For children up to age 18, We will cover replacement of prosthetic devices for growth if Medically Necessary. This also applies if the child's condition is from an injury or Illness which happened before the child became a Member under this Plan.

EARLY INTERVENTION SERVICES.

Pre-Authorization is Required.

We cover early intervention services for dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act. We cover the following services:

- Speech and language therapy;

- Occupational therapy;
- Physical therapy; and
- Assistive technology services and devices.

Medically Necessary early intervention services help an individual attain or retain the capability to function like someone of his age within his environment. They include services that enhance the ability to function but do not cure.

We may ask You to provide a copy of the certification. Deductible, Copayment, or Coinsurance amounts apply depending on what type of service is provided. This benefit is not subject to any maximum dollar limits.

EMERGENCY SERVICES.

"Emergency" means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (a) serious jeopardy to the mental or physical health of the individual, or (b) danger of serious impairment of the individual's bodily functions, or (c) serious dysfunction of any of the individual's bodily organs, or (d) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency Medical Condition" means, regardless of the final diagnosis rendered to a Covered Person, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency Services" means, with respect to an emergency medical condition –
(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient. **"Stabilize"** means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

The Plan covers Emergency Services In or Out-of-Network. Emergency Services do not require Pre-Authorization In or Out-of-Network. Your Copayment or Coinsurance amount will be determined by the type and place of service associated with the Emergency. Your Face Sheet or schedule of benefits lists Your out-of-pocket Copayment or Coinsurance rate for Emergency Services, inpatient hospital Admissions, ambulance services and urgent care visits. If You receive Emergency Services Out-of-Network from a Non-Plan Provider Your Copayment or Coinsurance rate cannot exceed the cost-sharing requirement that would apply if services were provided In-Network from Plan Providers.

Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket Amounts.

The maximum allowable amount or Allowable Charge for Emergency Care from an Out-of-Network Non-Plan Provider will be determined using the Plan's average In-Network contracted rate for the same or similar service in the same or similar location.

You must notify Us within 48 hours or 2 business days when You receive Emergency Services and You are admitted to the hospital from the emergency department. If You can't notify Us because of Your medical condition, have a friend or relative call Us. You can use the number on the back of Your Optima Health ID card.

Some examples of Emergency Medical Conditions include:

- Heart attacks;
- Severe chest pain;
- Strokes;
- Excessive bleeding;
- Poisoning;
- Major burns;
- Loss of consciousness;
- Serious breathing difficulties;
- Spinal injuries; and
- Shock.

We may include other acute medical conditions that require immediate attention. Routine follow up care after an emergency is not considered an Emergency Service unless authorized by the Plan.

"Ambulance Services" means transportation services from the place of injury to the nearest hospital where treatment can be provided. Transportation must be provided by a professional agency authorized to provide service in a vehicle staffed by medically trained personnel equipped to handle a medical emergency. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life.

"Urgent Care Center Services" means facility, physician, and other services provided during an urgent care center visit for treatment of medical conditions from an unforeseen Illness or injury which are non-life-threatening, but Medically Necessary to prevent a serious deterioration of a Member's health. Members should get care at the nearest Plan urgent care center.

The Plan will reimburse a hospital emergency facility or independent freestanding Emergency Department and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility or independent freestanding Emergency Department. Emergency services will be Covered regardless of the final diagnosis.

The After Hours Nurse Triage Program lets Members talk to a professional nurse who can help them find the most appropriate care in the most appropriate setting. Professional nurses listen to concerns, analyze the situation, and advise Members where to get medical care on evenings and weekends when the doctor's office is closed. If Medically Necessary, the nurse will send Members to Emergency Departments or urgent care centers where they can get appropriate treatment.

When You call After Hours have Your ID card ready. Be prepared to describe Your immediate medical situation in as much detail as possible. Make sure to tell After Hours about any other medical problems You are being treated for. Also tell After Hours what prescriptions You take.

Section 6
What is Covered

In a life-threatening situation call 911 or proceed to the nearest Emergency Department. The After Hours nurse cannot diagnose medical conditions or write prescriptions.

The After Hours Nurse Triage Program is available twenty-four hours a day seven days a week. The After Hours Program can be reached by calling 757-552-7250 or 1-800-394-2237. This program is not a substitute for contacting your doctor.

FAMILY PLANNING SERVICES.

We cover the following services:

- Counseling and education for birth control options;
- Tubal ligation services **(Pre-Authorization is required);**
- Vasectomy services;
- Depo-Provera, lunelle injections or other injections approved by the plan;
- Intrauterine devices (IUDs) and cervical caps and their insertion;
- All other Food and Drug Administration approved contraceptive methods as required by Women's Preventive Services .
- A prescription for up to a 12 month supply of hormonal contraceptive when dispensed or furnished at one time.
    - The Plan will cover up to a 12-month supply of hormonal contraceptives when dispensed or furnished at one time for a Covered Person by an In-Network provider or pharmacy or at a location licensed or otherwise authorized to dispense drugs or supplies that participates in the Plan's provider network.
    - Members will be responsible for payment of their outpatient prescription cost sharing based on a 12 month supply when the prescription is filled.
    - "Hormonal Contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration for such purpose.
    - "Provider" means a facility, physician or other type of health care practitioner licensed, accredited, certified or authorized by statute to deliver or furnish health care items or services.

HEMOPHILIA AND CONGENITAL BLEEDING DISORDERS.

Pre-Authorization is Required for Home Treatment.

We cover the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits include the purchase of blood products and blood infusion equipment required for home treatment. The home treatment program must be under the supervision of a state-approved hemophilia treatment center.

HOME HEALTH CARE SKILLED SERVICES.

Pre-Authorization is Required.

We cover **Home Health Care Skilled Services** for members who are homebound for medical reasons, physically unable to seek care on an outpatient basis, or in place of inpatient hospitalization. See Your Face Sheet or schedule of benefits for visit limits.

We will only cover services when they are provided by a certified **Home Health Care Agency**.

Section 6
What is Covered

We will not cover any services not in the approved **Home Health Care Plan.** If Your home care includes any therapy or rehabilitation benefits they will count toward Your total benefit limit for therapy services.

The following definitions apply to services under this section:

"Home Health Care Agency" means an agency or organization, or subdivision thereof, which:

1. Is primarily engaged in providing skilled nursing services and other therapeutic services in the Member's home; and
2. Is duly licensed, if required, by the appropriate licensing facility; and
3. Has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered nurse (RN) to govern the services provided; and
4. Provides for full-time supervision of such services by a Physician or by a registered nurse (RN); and
5. Maintains a complete medical record on each patient; and
6. Has a full-time administrator.

"Home Health Care Plan" means a program:

1. For the care and treatment of the Member in his or her home; and
2. Established and approved in writing by the attending Physician; and
3. Certified, by the attending Physician, as required for the proper treatment of the injury or Illness, in place of inpatient treatment in a Hospital or in a Skilled Nursing Facility.

"Home Health Care Skilled Services" means:

1. Part-time or intermittent nursing care by a nurse; or
2. Part-time or intermittent home health aide services which consist primarily of medical or therapeutic caring for the patient; or
3. Physical, speech, and occupational therapy, if provided by the home health care agency; or
4. Surgical dressings, medical appliances, oxygen and supplies which are Medically Necessary for treatment of the Member at home, but only to the extent such items or services would have been covered under this Plan if the Member had been confined in a Hospital or Skilled Nursing Facility.

"Home Health Skilled Care Visit" means:

1. Each visit by an RN or by an LPN to provide nursing care; or
2. Each visit by a therapist to provide physical, occupational, or speech therapy.

"Part-time or Intermittent Care" means one to four hours of Medically Necessary care administered in a 24-hour period.

HOSPICE CARE.

Pre-Authorization is Required.

We cover **Hospice Services** for members whose condition has been diagnosed as terminal with a life expectancy of 6 months, and who elect to receive **Palliative Care** instead of curative care.

"Hospice Services" means a coordinated program of home and inpatient care provided directly or under the direction of a licensed hospice. We cover palliative and supportive physical, psychological, psychosocial and other health services provided by a medically directed interdisciplinary team.

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

"Palliative Care" means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

HOSPITAL SERVICES.

Pre-Authorization is Required.

Inpatient Room and Board.

We cover room and board in a semi-private room including general nursing care, and meals and special diets. We do not cover private duty nursing while in the Hospital.

Other Hospital Services.

We cover other hospital services You receive during an inpatient stay or as an outpatient that are required to treat Your medical condition or diagnosis. Other services include:

- Physician, surgical, and general nursing care;
- Use of operating and recovery room facilities;
- Use of intensive care or cardiac care units and services;
- Use of delivery room and care
- Laboratory services;
- Diagnostic tests;
- X-ray facilities (diagnosis and therapy);
- Medications;
- Anesthesia and oxygen services;
- Inhalation therapy;
- Physical and occupational therapy;
- Dialysis, hemodialysis, peritoneal;
- Blood and blood products and their administration;
- Surgically implanted prosthetic devices;
- Outpatient ambulatory surgical or other services (i.e., observation room);
- Medical detoxification;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Injectable medications
- Nuclear medicine services;
- Other services approved by the plan.

Inpatient Length of Stay Requirements

Your coverage provides for minimum lengths of stay for Covered Hospital admissions for the conditions listed below. In each case the attending physician in consultation with the patient may decide that a shorter stay is appropriate.

- Not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy.
- Not less than 48 hours for a vaginal hysterectomy.
- Not less than 48 hours for a patient following a radical or modified radical mastectomy for the treatment of breast cancer.
- Not less than 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.

**To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.**

- A minimum length of stay of 48 hours for a vaginal delivery, and 96 hours following a cesarean section.

HOSPITALIZATION AND ANESTHESIA FOR DENTAL PROCEDURES.

Pre-Authorization is Required.

We cover hospitalization and anesthesia for dental procedures in certain circumstances. The Covered Person must be determined by a dentist, in consultation with their treating physician, to require general anesthesia and admission to a hospital or outpatient facility. The covered person must also:

- Be under age 5; or
- Severely disabled; or
- Have a medical condition that requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment.

Covered services include Medically Necessary general anesthesia and hospitalization or facility charges for a facility licensed to provide outpatient surgical procedures for dental care. For services under this section a determination of medical necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the covered person requires the utilization of general anesthesia and the Admission to a Hospital or outpatient surgery facility to safely provide the underlying dental care.

INFANT HEARING SCREENINGS.

Pre-Authorization is Required.

We cover newborn infant hearing screenings and all necessary audiological examinations required by § 32.1-64.1 of the Code of Virginia. Screenings and examinations in this section are covered using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Coverage also includes follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

INFUSION SERVICES

Pre-Authorization is required.

We cover infusion therapy and medications administered intravenously or parenterally. Services are covered in inpatient, outpatient, physician office, and home settings. Covered services include:

- Infusion therapy and medications;
- Professional nursing services and DME required for the infusion;
- Blood products and injectables that are not self-administered;
- Total Parenteral Nutrition (TPN);
- Enteral nutrition therapy;
- Antibiotic therapy;
- Chemotherapy;
- Pain care;
- Infusion of special medical formulas that are the primary source of nutrition for Members with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

INTERRUPTION OF PREGNANCY SERVICES.

Abortion is covered in the first 12 weeks of pregnancy. After 12 weeks abortion is covered if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

LYMPHEDEMA.

Pre-Authorization is Required.

We cover the following services to treat lymphedema if they are prescribed by a health care professional legally authorized to prescribe or provide such items under law:

- Equipment,
- Supplies,
- Complex decongestive therapy,
- Outpatient self-management training and education

We will not impose upon any person receiving benefits pursuant to this section any Copayment, fee, policy year or calendar year, or durational benefit limitation or maximum for benefits or services that is not equally imposed upon all individuals in the same benefit category.

MATERNITY SERVICES.

Pre-Authorization is Required for Prenatal Services.

We cover the following maternity services:

- Obstetrical and prenatal care and all related inpatient hospital services;
- Postpartum inpatient care; and a home visit or visits in accordance with the medical criteria;
- Lab work and genetic testing authorized by the Plan;
- All care and services related to a miscarriage;
- A minimum length of stay of 48 hours for a vaginal delivery, 96 hours following a cesarean section. The attending Physician and patient may decide that a shorter Hospital stay is appropriate.

Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally.

Members must pay Copayments for a confirmation of pregnancy visit. Members must also pay Copayments in effect at the time of delivery to the delivering obstetrician and any authorized specialist. The Member is entitled to a refund from the delivering OB provider if the total amount of the global OB Copayment as shown on the Face Sheet is more than the total Copayments the Member would have paid on a per visit or per procedure basis for delivering obstetrician prenatal and postpartum services.

MEDICAL SUPPLIES AND MEDICATIONS.

We cover medical supplies and prescription medications prescribed by Your provider. Some medications and supplies may be covered under the Plan's outpatient prescription drug benefit. Covered medications and supplies include:

- Hypodermic needles and syringes;

- Prescription medications and infused medications;
- Oxygen and equipment for administration of oxygen;
- Surgical supplies (examples include ostomy, tracheostomy and ileostomy supplies); and
- Cancer chemotherapy drugs administered orally and intravenously or by injection.

MEDICALLY NECESSARY FORMULA AND ENTERAL NUTRITION PRODUCTS

"Medically necessary formula and enteral nutrition products" means any liquid or solid formulation of formula and enteral nutrition products for covered individuals requiring treatment for an inherited metabolic disorder and for which the covered individual 's physician has issued a written order stating that the formula or enteral nutrition product is medically necessary and has been proven effective as a treatment regimen for the covered individual and that the formula or enteral nutrition product is a critical source of nutrition as certified by the physician by diagnosis. The medically necessary formula or enteral products do not need to be the covered individual's primary source of nutrition.

"Inherited metabolic disorder" means an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

Covered Services:

- Apply to partial or exclusive feeding by means of oral intake, or enteral feeding by tube;
- Include medical equipment, supplies, and services to administer formula or enteral nutrition products;
- Apply when formula and enteral nutrition products are (i) furnished pursuant to the prescription or order of a physician or other health care professional qualified to make such prescription or order for the management of an inherited metabolic disorder and (ii) used under medical supervision, which may include a home setting; and
- Do not apply to nutritional supplements taken electively.

We will apply the same cost sharing as we do for other medicines Covered under the Plan.

MEDICATIONS ADMINISTERED BY A MEDICAL PROVIDER

We cover prescription medications ordered and administered by Your Provider as part of a doctor's visit, home health care visit or at an outpatient facility. This includes for example drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products and office-based injectables that must be administered by a Provider. Supplies, needles and syringes required for administration or infusion of medications administered by Your Provider are also Covered Services. Medications administered at an Inpatient facility or during an Emergency Room Visit as needed for your medical condition are also Covered Services under the Plan's Inpatient and Emergency Services benefits.

Drugs that You pick up at a retail pharmacy or receive from the Plan's mail order benefit or specialty pharmacy are Covered under the Plan's Outpatient Prescription Drugs Benefit.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS.

Pre-Authorization is Required for all Inpatient Services, Partial Hospitalization Services, Intensive Outpatient Program (IOP), Electro-Convulsive Therapy, and Transcranial Magnetic Stimulation (TMS).

Section 6
What is Covered

Inpatient, Emergency, and outpatient mental health services and substance use disorder services are covered on parity with the medical and surgical benefits covered under the Plan in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).

The following definitions apply to this section:

"Alcohol or Drug Rehabilitation Facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the Department of Behavioral Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 or (ii) a state agency or institution.

"Inpatient Treatment" means mental health or substance abuse services delivered on a 24-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate Care Facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured 24-hour per day, state-approved program of inpatient substance abuse services.

"Medication Management Visit" means a visit no more than 20 minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.
"Mental Health Services" or "Mental Health Benefits" means benefits with respect to items or services for mental health conditions as defined by the Plan. Any condition defined by the Plan as being or as not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice.

"Mental Health Treatment Center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Outpatient Treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall also include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial Hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Substance Abuse Services" or "Substance Use Disorder Benefits" means benefits with respect to items or services for substance use disorders as defined under the Plan. Any disorder defined by the Plan as being or as not being a substance use disorder shall be defined to be consistent with generally recognized independent standards of current medical practice.

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

"Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist or clinical nurse specialist. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor or substance abuse counseling assistant, limited to the scope of practice set forth in § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed to provide such treatment.

Employee Assistance Visits.

Services include short-term counseling by licensed mental health providers and referral services 24 hours a day, seven days a week for employees and their immediate family members and household members who are experiencing personal problems of such a level that their ability to work and function is, or may be, impaired.

Using employee assistance visits will not reduce covered mental health benefits.

Non-emergency appointments are scheduled within 72 hours after the person calls. Whenever possible, appointments are scheduled to meet the person's time and location requests. For more information or to schedule an appointment, call (800) 899-8174 or 363-6777.

ORAL SURGERY.

Pre-Authorization is Required.

We cover the following:

- Surgical procedures required to repair accidental injuries to the jaws, mouth, lips, tongue or hard and soft palates;
- Treatment of fractures of the facial bones;
- Excision including diagnostic biopsy of malignant and/or symptomatic tumors and cysts of the jaws, gums, cheeks, lips, tongue, hard and soft palates, and salivary glands;
- Orthognathic surgical procedures such as osteotomy or other reconstruction of the jaws and/or facial bones (when associated with severe malocclusion) that are necessary to restore and maintain function; and
- Coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Inpatient and outpatient dental, oral surgical and orthodontic services which are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia will be covered.

Members may choose to receive care from Non-Plan Providers including dentists or oral surgeons. The Non-Plan Provider may balance bill the Member for charges in excess of the Plan's fee schedule.

OTHER OUTPATIENT THERAPY SERVICES

Includes Chemotherapy, Radiation Therapy, IV Infusion Therapy, and Respiratory/Inhalation Therapy

Pre-Authorization is required for Chemotherapy and Chemotherapy Drugs, and Radiation Therapy services.

Section 6
What is Covered

Services are covered when administered as part of a doctor's office or home health care visit, or at an inpatient or outpatient facility for treatment of an illness. Covered Services include the following therapy or services when Medically Necessary, prescribed by a physician and performed by a provider properly licensed or certified to provide the therapy services:

- **Radiation Therapy** is treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, treatment planning, and certain other covered services.
- **Respiratory/Inhalation Therapy** includes the use of dry or moist gases in the lungs, non-pressurized inhalation treatment; intermittent positive pressure breathing treatment; air or oxygen, with or without nebulized medication; continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronco pulmonary drainage and breathing exercises.
- Chemotherapy includes treatment of an illness by chemical or biological antineoplastic agents. The criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection will be consistently applied within the same plan.
- **IV Infusion Therapy** includes nursing, durable medical equipment and drug services that are delivered and administered to you through an IV. Also includes Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See also **INFUSION SERVICES**.
- **Vascular Rehabilitation.**
- **Vestibular Rehabilitation.**

PPACA RECOMMENDED PREVENTIVE CARE SERVICES.

Please use the following link for a complete list of covered preventive care services:
https://www.healthcare.gov/what-are-my-preventive-care-benefits/

In addition to the Preventive Care Services described in this Chapter of the EOC, We will cover preventive services according to PPACA federal health care reform laws and further defined under related federal regulations with no Member cost sharing if services are received from In-Network Plan Providers according to the following:

1. Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; and
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings not described in item (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph including:

    - **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

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

5. Additional breast cancer screening, mammography, and prevention according to recommendations of the United States Preventive Service Task Force.

PHYSICIAN SERVICES.

All Pre-Authorization and Referral Requirements Apply Depending on the Type and Place of Service.

We cover the physician services listed below:

- Surgical, home, Hospital, and office visits, for diagnosis and treatment of an injury or Illness;
- Covered preventive care and preventive screenings;
- Professional services received while You are receiving covered services in an Inpatient Hospital, Skilled Nursing Facility, Emergency Department; ambulatory surgery, or other outpatient facility;
- Specialist care and consultations;
- A second opinion from a Plan Provider;
- A second opinion from a Non-Plan Provider only if a Plan Provider is unavailable;
- Virtual Consults when provided by an Optima Health approved provider;
- Maternity care and related checkups; and
- Annual school and sports physicals.

PRESCRIPTION INSULIN DRUG COST SHARING

A Member's cost sharing payment for a covered prescription insulin drug will not exceed $50 per 30-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription.

"Cost-sharing payment" means the total amount a Covered Person is required to pay at the point of sale in order to receive a prescription drug that is covered under the Covered Person's health plan.

"Prescription insulin drug" means a prescription drug that contains insulin and is used to treat diabetes.

Section 6
What is Covered

PREVENTIVE CARE SERVICES AND SCREENINGS.

Annual Physicals.

We cover one routine physical exam each year. Coverage also includes annual school and sports physicals.

Annual Gynecological (GYN) Exams.

We cover one routine annual GYN exam every 12 months for females 13 years or older. You must see a Plan provider. You do not need a referral from a PCP. We cover routine Medically Necessary services for the care of, or related to the female reproductive system and breasts that are done during or related to the annual visit.

All of Our Pre-Authorization requirements apply for any additional services.

Infertility services are not considered routine. Services related to high risk OB are not considered routine.

Screening Mammograms.

We cover one screening mammogram for Members between the ages of 35 to 39. We cover a screening mammogram each year for Members age 40 and over.

Pap Smears.

We cover annual Pap smears including coverage for annual testing performed by any FDA approved gynecologic cytology screening technologies.

Prostate Screening Tests (PSA).

We cover one PSA test in a 12-month period and digital rectal examinations for persons over age 50 and persons over age 40 who are at high risk for prostate cancer.

Colorectal Cancer Screening.

We cover colorectal cancer screening. Services are covered in accordance with most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in the recommendations including:

- An annual occult blood test;
- Flexible sigmoidoscopy or colonoscopy; and
- Radiologic imaging in appropriate circumstances.

Routine Hearing Tests.

We cover one annual routine hearing test.

Well Child Care.

We cover routine care and periodic review of a child's physical and emotional status. Covered services include:

- A history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards;
- Benefits will be provided at approximately birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, and 6 years; and
- Well-baby services which are rendered during a periodic review will be covered to the extent that such services are provided by or under the supervision of a single Physician during the course of one office visit.

Immunizations for Newborn Children from Birth to Age 36 Months.

We cover immunizations for each child from birth to thirty-six months of age including:

- Diphtheria;
- Pertussis;
- Tetanus;
- Polio;
- Hepatitis B;
- Measles;
- Mumps;
- Rubella; and
- Other Immunizations Prescribed By The Commissioner Of Health.

Immunizations for older Children and Adolescents ages 7-18.

We cover the following immunizations according to Center for Disease Control (CDC) recommendations:

- Tetanus;
- Diphtheria;
- Pertussis;
- Human Papillomavirus;
- Meningococcal;
- Influenza;
- Pneumococcal;
- Hepatitis A;
- Hepatitis B;
- Inactivated poliovirus;
- Measles;
- Mumps;
- Rubella; and
- Varicella

PREVENTIVE VISION CARE SERVICES.

In-Network Coverage.

We contract with VSP Vision Care to administer preventive vision benefits. We cover a routine eye examination, refraction, and prescription for eyeglass lenses from an VSP Vision Care provider.

To receive Covered Services:

1. Select a participating VSP Vision Care network provider from the Plan's provider directory or by 1-800-877-7195. Automated location information is available 24 hours a day.

Customer service representatives are available Saturday 9 a.m.–8 p.m.
2. Visit or call the participating provider and identify yourself as a participant by providing Your Member ID information. The provider will verify eligibility, Your Plan's Covered Services and any applicable Copayment or Coinsurance. Payment is due when You receive services.
3. If the vision provider determines that You need additional medical care You should contact Your PCP or other physician for treatment options.

Out-of-Network Coverage.

If You use a provider that is not in the VSP Vision Care network for an examination You must pay the provider in full when You receive services. Only the eye examination is covered as listed on Your Face Sheet or schedule of benefits. For reimbursement call VSP Vision Care Customer Service at 1-800-877-7195. VSP Vision Care will verify eligibility and give You a claim form. Mail the completed form with a copy of Your bill to:

Vision Service Plan
Attn: Claim Services
PO Box 385018
Birmingham, AL 35238-5018

PROSTHETIC COMPONENTS AND DEVICES.

Pre-Authorization is Required for All Services.

Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components.

Definitions:

"Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.

RECONSTRUCTIVE BREAST SURGERY.

Pre-Authorization is Required.

Coverage under this section will be in a manner determined in consultation with the attending Physician and the Member. For Members who have had a mastectomy We will cover:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedema.

SKILLED NURSING SERVICES.

Pre-Authorization is Required.

We cover care given in a licensed Skilled Nursing Facility. The care must be ordered by a Physician. We cover semi-private room and board charges and other facility services and supply charges. See Your Face Sheet for the maximum number of days per year. Custodial Care is not covered.

SMOKING AND TOBACCO CESSATION.

The plan includes coverage of smoking and tobacco cessation counseling according to United States Preventive Task Force Guidelines under "PPACA Recommended Preventive Care Services".

Covered Food and Drug Administration (FDA) cessation medications (including both prescription and over-the-counter medications) are covered under the Plan's approved tobacco prescription drug benefits limited to two 90-day treatment regimens per calendar/contract year when prescribed by a health care provider. Generic medications will be covered with no Member out-of-pocket cost sharing.

TELEMEDICINE SERVICES.

Telemedicine services, as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided. Telemedicine services does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. We will not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

We do not cover technical fees or costs that result from the treating or consulting provider's provision of telemedicine services. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment. Covered Services will include the use of telemedicine technologies as it pertains to Medically Necessary remote patient monitoring services to the full extent that these services are available.

THERAPY AND REHABILITATION SERVICES.

Pre-Authorization is Required.

We cover the following therapy and rehabilitation services:

- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Cardiac rehabilitation;

- Pulmonary rehabilitation;
- Vascular rehabilitation; and
- Vestibular rehabilitation.

See Your Face Sheet for benefit limits. All services must be Medically Necessary and done by a provider licensed to do the services.

We cover physical therapy only to the extent of restoration to the level of the pre-trauma, pre-Illness, or pre-condition level.

We cover occupational therapy services which assist the Member to restore self-care and improve functionality in activities of daily living.

We cover speech therapy that is Medically Necessary to correct an organic impairment of organic origin due to accident or Illness. We cover speech therapy following surgery to correct a congenital defect. Speech therapy is covered only to the extent of restoration to the level of the pre-trauma, pre-Illness, or pre-condition speech function. We do not cover any therapy services related to developmental delay except for covered Early Intervention services.

All therapy and rehabilitation services must be provided by a Physician, or by a licensed or certified physical, occupational or speech therapist. We cover therapy and rehabilitation services furnished to a Member on an outpatient or inpatient basis according to a specific written treatment plan that:

1. Details the treatment to be rendered, its frequency, duration, and goals; and
2. Provides for ongoing review.

TRANSPLANT SERVICES.

Pre-Authorization is Required.

All transplant services will be covered at contracted Plan facilities only.

We cover Medically Necessary human organ and tissue transplants for members who meet Medical Necessity criteria established by the Plan. We do not cover transplants that are experimental. We cover the following transplants:

- Kidney;
- Heart;
- Cornea;
- Liver;
- Lung;
- Heart-lung;
- Kidney-pancreas;
- Heart-kidney;
- Other combination transplants;
- Bone marrow transplants for leukemia, hodgkin's disease, non-hodgkin's lymphoma, severe combined immunodeficiency disease, aplastic anemia and wiskott-aldrich syndrome; and
- Dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for the treatment of breast cancer.

At the discretion of the Plan, this list may be amended to include coverage of additional transplants in accordance with accepted medical and community standards.

Donor Searches

Donor search charges will be covered as routine diagnostic tests. The donor search request will be reviewed for Medical Necessity and may be approved. However, such an approval for donor searches is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Organ Donor Benefits

When both the person donating the organ and the person receiving the organ are covered Optima Health Members each will get benefits under their Plan.

When the person receiving the organ is Our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source including but not limited to other insurance, grants, foundations, and government programs. Medically Necessary charges, not covered by any other source, for getting an organ from a live donor, including complications from the donor procedure for up to six weeks from the date of procurement, are covered under this Plan.

If Our covered Member is donating the organ to someone who is not a covered Member benefits are not available and not Covered under this Plan.

TRAVEL EXPENSES

For organ and tissue transplants listed as a Covered Service under Your Plan We may cover the cost of reasonable and necessary travel and lodging costs if We have Pre-Authorized the costs and You need to travel more than 50 miles from your home to reach the Hospital where the authorized transplant procedure will be done. For Members receiving a covered transplant, or for the donor when both the donor and recipient are Members, benefits are limited to travel costs to and from the facility and lodging for the patient and one companion or two companions if the patient is a minor. You must provide Us with itemized receipts for all travel and lodging costs and We will determine if Your expenses are covered. Nothing in this statement shall prevent a Member from appealing Optima Health's decision. Covered Services will not include Child care; rental cars, buses, taxis or other transportation not approved in advance by Us; frequent flyer miles, or any other travel services not related to the transplant.

We will not pay or reimburse You, for any other travel expenses unless We have approved them in advance as a Covered Service.

VIRTUAL CONSULTS.

Virtual Consults will be covered when furnished by providers who are approved by Optima Health to provide services.

Virtual Consult means a medical consult using a secure platform (as determined by Optima Health in its sole discretion) with interactive video, and telephone to connect a provider and a patient.

Virtual Consult services do not include electronic mail message, facsimile transmission or online questionnaire.

Section 6
What is Covered

OUTPATIENT PRESCRIPTION DRUG COVERAGE

Your Plan Formulary

This Plan has an open formulary. Please use the following link to see a list of drugs on the open formulary: www.optimahealth.com. You can also call Member Services at the number on Your Optima Health ID Card to find out if a drug is on Our formulary.

You can also call Member Services at the number on Your Optima Health ID Card to find our if a drug is on Our formulary.

Choosing a Pharmacy to Fill Your Prescription

All drugs must be FDA approved and You must have a prescription. You will need to pay Your Copayment or Coinsurance when You fill your prescription at the pharmacy. If Your Plan has a Deductible You must meet that amount before Your Coverage begins. Your drug Coverage has specific Exclusions and Limitations listed in Section 7.

Retail Pharmacy

You can fill Your prescription at a Plan retail pharmacy. Your participating network of retail pharmacies include both national, chain and local, independent pharmacies.

Mail Order Pharmacy Benefit

Most outpatient prescription drugs are available through the Plan's Mail Order Provider. This does not include Specialty Drugs. You may call Express Scripts at 1-888-899-2653 to find out if a drug is available.

Specialty Pharmacy

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

Non-Plan Out of Network Pharmacies

You may use a Non-Plan Out-of-Network Pharmacy, including a specialty pharmacy, or its intermediary that has previously notified the Plan or its Pharmacy Benefit Manager of its agreement to accept reimbursement for its services at rates applicable to Our In-Network pharmacies including accepting Your applicable Copayment, Coinsurance and/or Deductible (if any) amounts as payment in full to the same extent as Coverage for outpatient prescription drug services provided to You by an In-Network provider. This provision will not apply to any pharmacy which does not execute a participating pharmacy agreement with the Plan or its Pharmacy Benefit Manager within thirty days of being requested to do so in writing by the Plan or its Pharmacy Benefit Manger unless and until the pharmacy executes and delivers the agreement.

Pharmacy and Therapeutics Committee

Our formulary is a list of FDA-approved medications that We cover. At its sole discretion, the Optima Health Pharmacy and Therapeutics Committee reviews medications for placement onto the formulary. The Plan's Pharmacy and Therapeutics Committee is composed of Physicians and pharmacists. For all drugs, including new drugs, the committee looks at the medical literature and then evaluates whether to add or remove a drug from the formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration.

Pharmacy Tiers and Determining Your Cost Sharing

The formulary covers drugs on the Tiers defined below. You will pay Your Copayment or Coinsurance depending on which Tier Your Drug is in.

- **Preferred Generic (Tier 1)** includes commonly prescribed Generic Drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in Illness.
- **Preferred Brand & Other Generic (Tier 2)** includes brand-name drugs and some Generic Drugs with higher costs than Tier 1 generics that are considered by the Plan to be standard therapy.
- **Non-Preferred Brand (Tier 3)** includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a generic equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers.
- **Specialty Drugs (Tier 4)** includes those drugs classified by the Plan as Specialty Drugs. Tier 4 also includes therapeutic biological products. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional. Specialty Drugs include the following:

    - Medications that treat certain patient populations including those with rare diseases;
    - Medications that require close medical and pharmacy management and monitoring;
    - Medications that require special handling and/or storage;
    - Medications derived from biotechnology and/or blood derived drugs or small molecules;
    - Medications that can be delivered via injection, infusion, inhalation, or oral administration;
    - Medications subject to restricted distribution by the U.S. Food and Drug Administration;
    - Medications that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

  Tier 4 also includes covered compound prescription medications.

Compound Medications

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

Medications Requiring Pre-Authorization

The Plan uses a number of tools to determine if Your drug should be covered. Optima Health may limit the amount of some drugs You receive. Some drugs require Pre-Authorization to make sure proper use and guidelines are followed. Your Physician is responsible for Pre-Authorization. We will notify You and Your Physician of Our decision. If Pre-Authorization is denied You have the right to file an appeal. Please see Section 5 on Pre-Authorization and Section 13 on filing an internal or external appeal.

Step Therapy Protocols and Exception Requests

For some prescription drugs, Optima Health has established step therapy protocols. A Step Therapy Protocol means a protocol setting the sequence in which prescription drugs are determined medically appropriate for a specified medical condition for a particular Member, and covered under the Plan.

Optima Health has a process in place to review requests for an exception to our step therapy requirements. Our determination will be based on a review of the Member's or prescribing Provider's request, supporting rationale and documentation for an exception.

A step therapy exception request may be granted if the prescription drug is covered under the Member's current health Plan; and the prescribing Provider's submitted justification and supporting clinical documentation are determined to support the prescribing Provider's statement that:

- The required prescription drug is contraindicated;
- The required drug would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
- The patient has tried the step therapy-required prescription drug while under their current or a previous health benefit plan, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or
- The patient is currently receiving a positive therapeutic outcome on a prescription drug recommended by his Provider for the medical condition under consideration while on a current or the immediately preceding health benefit plan.

Optima Health will respond to a step therapy exception request within 72 hours of receipt, including hours on weekends. We will confirm that the request is approved, denied, or requires supplementation or additional information. In cases where exigent circumstances exist, We will respond with Our decision within 24 hours of receipt, including hours on weekends. A Member may appeal any step therapy exception request denial under the Plan's existing appeal procedures.

Quantity Limits

Quantity limits are drug-specific and limit the amount of certain drugs that can be dispensed during a specified period of time. These limits are based on FDA guidelines, clinical literature, and manufacturer's instructions. Your physician can request an exception to the quantity limit.

Refills

Your Plan has refill limitations. In most cases You must use 75% of Your medication based on the day supply of Your prescription before You can get a refill. There are several ways to refill Your prescription. In most cases contact the retail, mail order, or specialty pharmacy where You originally filled Your prescription and request a refill. Sometimes Your doctor will prescribe a set amount of refills for Your prescription. If You have run out of refills You will need a new prescription from Your doctor. In some cases Your pharmacist may be able to call Your doctor to get more refills for You.

Prescription Cancer Drugs

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, for the treatment of cancer that is approved by the United States Food and Drug Administration for the following reasons:

- For at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

- On the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of a specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
- For use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

Flu Shots and Other Covered Vaccines

We cover flu shots and other vaccines listed on the formulary, including administration at authorized pharmacies.

Special Food Products or Supplements

We cover special food products or supplements when prescribed by a Doctor and Medically Necessary. Nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription are not Covered Services.

Self-Administered Injectable Drugs

We cover self-administered injectable drugs and related supplies and equipment that You pick up at a retail pharmacy or receive from the Plan's mail order benefit or specialty pharmacy. These are drugs that do not need administration or monitoring by a Provider in an office or facility. Prescription medications and supplies ordered and administered by Your Provider as part of a doctor's visit, home health care visit or at an outpatient or inpatient facility are Covered Services under the Plan's medical benefits.

Diabetic Insulin, Testing Supplies, Equipment, and Education

Covered Services include the following. Member cost sharing is shown on the Schedule of Benefits.

- Self-injected insulin and related supplies for insulin administration including syringes;
- Diabetic testing supplies including home blood glucose monitors, test strips, lancets, lancet devices, and control solution. Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands.
- In-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law may be received at a Plan Pharmacy authorized to provide these services. Contact Your pharmacy to see if they are certified to perform these services. Members may call 1-800-SENTARA for additional information on educational classes.

Services, equipment and supplies for Diabetes Care Management other than those listed in this section are covered under the Plan's medical benefit.

Women's Contraceptives

Covered Services under the pharmacy benefit include FDA approved contraceptive drugs, injectables, patches, rings and devices such as diaphragms for women. This does not include abortifacient drugs. A twelve month supply of hormonal contraceptives is available at one time if Members pay all applicable cost sharing.

"Hormonal contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration for such purpose.

Requests for Coverage of Drugs or Medications not Included on the Plan's Formulary

We consider these types of requests to be standard exception requests. Please note that this exception process only applies to drugs not included on the formulary. If You have been denied Coverage for a drug included on the formulary, You have the right to a full and fair appeal of Our decision and should follow the Plan's appeal process described later in the Evidence of Coverage.

The Plan makes available to Members, Providers and pharmacists the complete, current drug formulary and any updates We make to the formulary. The formulary list includes a list of the prescription drugs on the formulary by major therapeutic category and specifies whether a particular prescription drug is preferred over other drugs. We will provide to each affected individual health benefit Plan policyholder or Contract Holder not less than 30 days prior written notice of a modification to a formulary that results in the movement of a prescription drug to a tier with higher cost sharing requirements. This notice does not apply to modifications that occur at the time of Coverage renewal.

We have a process in place to allow a Member, a designated representative, the prescribing physician or other prescriber to ask Us to approve Coverage of a non-formulary drug:

- If the formulary drug is determined by Us, after reasonable investigation and consultation with the prescribing Physician, to be an inappropriate therapy for the medical condition of the Member; or
- When the Member has been receiving the specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and the prescribing physician has determined that the formulary drug is an inappropriate therapy for the specific Member or that changing drug therapy presents a significant health risk to the specific Member.

We will make a decision on a standard exception request and notify the Member, representative, or physician no later than one business day following receipt of the request. If the request is approved, Coverage of the non-formulary drug will be provided for the duration of the prescription including refills and without additional cost sharing beyond that provided for formulary prescription drugs in the Member's covered benefits.

Any exception request for Coverage of non-formulary drugs can be made by the Member, a designated representative, the prescribing physician or other prescriber. Requests can be made in writing, electronically and telephonically. To request a non-formulary drug, have Your doctor send a medical necessity form to Our pharmacy authorization department at 4456 Corporation Lane, Suite 210, Virginia Beach, VA 23462 or call Us at 757-552-7540 or 1-800-229-5522.

Expedited Exception Request Based on Exigent Circumstances

Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function, or when a Member is undergoing a current course of treatment using a non-formulary drug. The Plan will make a decision on an expedited exception request and notify the Member, representative, or Physician no later than 24 hours following receipt of the request. If the request is approved Coverage of the non-formulary drug will be provided for the duration of the exigency and without additional cost sharing beyond that provided for formulary prescription drugs in the Member's covered benefits.

External Exception Request Review

If the Plan denies a standard or expedited request, We have a process in place to allow the request to be reviewed by an independent review organization. Notification of a decision on an external exception request will be given to the Member, representative, or Physician no later than 72 hours following receipt of the request if the original request was a standard request. If the original request was an expedited request notification will be given no later than 24 hours following receipt of the request. If an external exception request is approved, the Plan will provide Coverage for the non-formulary drug for the duration of the prescription and without additional cost sharing beyond that provided for formulary prescription drugs in the Member's covered benefits. For expedited exception requests Coverage of the non-formulary drug will be provided for the duration of the exigency and without additional cost sharing beyond that provided for formulary prescription drugs in the Member's covered benefits.

Synchronization of Medication

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

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

Lost or Stolen Medication

Pre-Authorization is required.

Your applicable Copayment, Coinsurance and/or Deductible amounts (if any) would apply. In the following circumstances, You can obtain an additional 30-day supply from Your pharmacist:

- You've lost Your medication;
- Your medication was stolen; or
- Your physician increases the amount of Your dosage.

Section 7
What is Not Covered (Exclusions and Limitations)

This chapter lists services that are not covered. Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

A

Abortion is covered in the first 12 weeks of pregnancy. After 12 weeks abortion is covered if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

Administrative Charges or fees are not Covered including charges or costs for:

- Completion of claim or other forms;
- Transfer or copy of medical records or reports;
- Access or concierge fees;
- Missed appointments;
- Routine telephone calls;
- Other clerical charges.

Alternative Medicine services are not Covered including:

- Acupuncture;
- Holistic medicine
- Homeopathic medicine;
- Hypnosis;
- Aromatherapy;
- Massage and massage therapy;
- Reiki therapy;
- Herbal, vitamin or dietary products or therapies;
- Naturopathy;
- Thermography;
- Orthomolecular therapy;
- Contact reflex analysis;
- Bioenergial synchronization technique (BEST);
- Iridology-study of the iris;
- Auditory integration therapy (AIT);
- Colonic irrigation.

Non-emergency **air, ground, water, or other Ambulance transport** services are not Covered unless authorized by Us.

Non-medical **Ancillary Services** are not Covered including:

- Vocational rehabilitation services;
- Employment counseling;
- Relationship counseling for unmarried couples;
- Pastoral counseling;

- Expressive therapies;
- Health education.

General **Anesthesia** in a Physician's office is not Covered.

Autopsies are not Covered.

B

Batteries are not Covered except for use in:

- Motorized wheelchairs;
- Left ventricular assist device (LVAD);
- Cochlear implants.

Biofeedback and neurofeedback therapies and related testing are not Covered unless We authorize services.

Birthing Center Services are Covered at contracted facilities only.

Searches for **Blood Donors** are not Covered.

Transportation or storage of **blood** is not Covered.

Bone Densitometry Studies more than once every two years are not Covered unless We authorize additional services.

Bone or Joint treatment is not Covered unless Medically Necessary to restore normal function of the joint or bone.

Botox injections are not Covered unless We have approved them.

Breast Augmentation (enlargement) or Breast Mastopexy (reduction) is not Covered unless We authorize services. Cosmetic procedures or surgery for breast enlargement or reduction are not Covered. Procedures for correction of cosmetic physical imperfections are not Covered. Breast implants are not Covered. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Breast Ductal Lavage is not Covered.

Breast Milk from a donor is not Covered.

C

Chelation Therapy is not Covered except as treatment for arsenic, copper, iron, gold, mercury or lead poisoning.

Chiropractic Care is not a Covered Service unless Your Plan includes a rider. Chiropractic care means diagnosis, correction, and management of vertebral subluxations or neuromusculoskeletal conditions.

Section 7
What is Not Covered (Exclusions and Limitations)

Complications of Non-Covered Services are not Covered. This includes care needed as a direct result of a non-covered service when without the non-covered service, care would not have been needed.

Contact Lenses are not Covered Services. Fitting of lenses or eyeglasses is not Covered. However, the first pair of lenses following cataract surgery including contact lens, or placement of intraocular lens or eyeglass lens only are Covered Services.

Cosmetic Surgery and Cosmetic Procedures are not Covered. Medical, surgical, and mental health services for, or related to, cosmetic surgery or cosmetic procedures are not Covered. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **The following are also not Covered Services:**

- Services to preserve, change or improve how a person looks;
- Services to change the texture or look of skin, the size, shape or look of facial or body features;
- Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Any service or supply that is a direct result of a non-covered service;
- Non-medically necessary treatment or services resulting from complications due to cosmetic experimental procedures;
- Breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following mastectomy;
- Tattoo removal;
- Keloid treatment as a result of the piercing of any body part;
- Consultations or office visits for obtaining cosmetic or experimental procedures;
- Penile implants; or
- Vitiligo **or other cosmetic skin condition** treatments by laser, light or other methods.

Costs of Services paid for by Another Payor are not Covered Services. We do not cover the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of covered services in those cases where You received services in accordance with the Plan's authorization procedures. We will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

Court ordered examinations or treatments and Temporary Detention Orders (TDOs) are not Covered Services unless they are determined to be Medically Necessary and are listed as a Covered Service under the Plan.

Custodial Care is not a Covered Service including, but not limited to the following:**:**

- Residential care;
- Rest cures;
- Care from institutions or facilities licensed solely as residential treatment centers, intermediate care facilities, or other non-skilled sub-acute inpatient settings; or
- Examination or care ordered by a court of law not authorized by the Plan to be provided at a Plan Provider.

D

Dentistry/Oral Surgery/Dental Care.

- Treatment of natural teeth due to disease;
- Routine dental care;
- Routine dental X-rays;
- Dental supplies;
- Extraction of erupted or impacted wisdom teeth except to prepare the mouth for medical services and treatments;
- Oral surgeries or periodontal work on the hard and/or soft tissue supporting the teeth to help support structures;
- Periodontal, prosthodontal, or orthodontic care;
- Cosmetic services to restore appearance;
- Restorative services and supplies necessary to treat, repair or replace sound natural teeth;
- Dental implants or dentures and preparation work;
- Dental services performed in a Hospital or any outpatient facility. This does not include Covered Services listed under "Hospitalization and Anesthesia for Dental procedures."
- Oral surgery which is part of an orthodontic treatment program;
- Orthodontic care.

Driver Training is not a Covered Service.

Drugs for certain clinical trials are not Covered Services. This includes drugs paid for directly by the clinical trial or another payor.

E

Electron Beam Computer Tomography (EBCT) is not a Covered Service. Other diagnostic imaging tests where there is insufficient scientific evidence of the test's safety or efficacy in improving clinical outcomes are not Covered Services.

The following **Educational services** are not Covered Services:

- Self-training services;
- Vocational training;
- Tutorial services or testing required to complete Educational, degree or residency requirements;
- Testing or screening services for classroom performance except when services qualify as Early Intervention Services.

Enteral or Parenteral Feeding supplements are not Covered Services unless included under the Plan's benefit for Medically Necessary Formula and Enteral Nutrition Products. Over-the-counter supplements, over-the-counter infant formulas, or over-the-counter medical foods are not Covered Services.

Examinations, testing or treatment required for employment, insurance, or judicial or administrative proceedings are not Covered Services.

Experimental or Investigative drugs, devices, treatments, or services are not Covered Services.
Experimental or Investigative means any of the following situations:

- The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable value as reported by current scientific literature and/or regulatory agencies; or
- The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
- The drug or device is not approved for marketing by the United States Food and Drug Administration (FDA); or
- The drug, device, medical treatment or procedure is currently under study in a **Non-FDA approved** Phase I or Phase II clinical trial, an experimental study/investigational arm of a Phase III clinical study, or otherwise under study to determine safety and efficacy or to compare its safety and efficacy to current standards of care; or
- The drug, device, medical treatment or procedure is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment or procedure.

Eye examinations, surgery, and other services are not Covered Services including:

- Corrective or protective eyewear required for work;
- Eye exercise training;
- Eye Movement Desensitization and Reprocessing Therapy;
- Eye Corrective Surgery such as Radial Keratotomy, PRK, or LASIK.

Eye Glasses and contact lenses are not Covered Services unless the plan includes a rider for vision materials. Fitting of lenses or eyeglasses is not a Covered Service except for the first pair of lenses following cataract surgery including contact lenses, or placement of intraocular lenses or eyeglass lenses only.

F

Services provided, prescribed, ordered, or referred by Yourself or by a member of Your immediate **family,** including Your spouse, child, brother, sister, parent, in-law are not Covered Services.

The following **Foot Care Services are not Covered Services** except for Members with Diabetes or severe vascular problems:

- Removal of corns or calluses;
- Nail trimming;
- Treatment and services for or from flat-feet, fallen arches, weak feet, or chronic foot strain;
- Foot Orthotics of any kind;
- Customized or non-customized shoes, boots, and inserts.

G

Genetic Testing and Counseling are not Covered Services unless We have authorized the services. Counseling is a Covered Service only as part of the approved genetic test unless considered preventive care.

Growth Hormones are only Covered Services under the Plan's Outpatient Prescription Drug Rider. Growth hormones for the treatment of idiopathic short stature are not Covered Services**.**

H

Hearing Aids and related services are not covered unless Your Plan has a rider. Non-covered services include:

- Examinations for fitting and molds;
- Hearing aid batteries except for cochlear implants;
- Other hearing aid supplies or repair services.

Home Births are not a Covered Service.

Home Health Care Skilled Services are not Covered Services unless You are homebound, physically unable to seek care on an outpatient basis, or service is provided in lieu of inpatient hospitalization. Services or visits are limited as stated on Your Plan's Face Sheet or schedule of benefits. We do not cover any services after You have reached Your Plan's limit. We only cover services or supplies listed in Your home health care plan. Custodial Care is not a Covered Service.

Hospital Services listed below are not Covered Services:

- Guest meals;
- Telephones, televisions, and other convenience items;
- Private inpatient Hospital rooms unless You need a private room because You have a highly contagious condition or are at greater risk of contracting an infectious disease because of Your medical condition;
- Care by interns, residents, house Physicians, or other facility employees that are billed separately from the facility.

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not Covered Services.

Incarceration - Services and treatments done during **Incarceration** in a Local, State, Federal or Community Correctional Facility or prison are not Covered Services.

Unless listed as a Covered Service in this EOC, or under a Rider, **Infertility Services** listed below are not Covered Services:

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as a Covered Service;
- Services, tests, medications, and treatments for the enhancement of conception;
- In-vitro Fertilization programs;
- Artificial insemination or any other types of artificial or surgical means of conception;
- Drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- Reproductive material storage;
- Treatment or testing related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage,
- Sperm washing;

- Services to reverse voluntary sterilization;
- Infertility Treatment or services from reversal of sterilization;
- Drugs used to treat infertility;
- Surrogate pregnancy services when the person is not covered under Your Plan.

J

K

Keloids from body piercing or pierced ears are not Covered Services.

L

Laboratory Services from Non-Plan providers or laboratories are not Covered Services. This exclusion does not apply to Covered Services provided by a Non-Plan provider during an Emergency, or during an authorized Admission to an Plan Facility.

Long-Term Custodial Nursing Home Care is not a Covered Service.

M

Massage Therapy is not a Covered Service unless provided as part of an approved medical therapy program.

Matristem Extracellular Wound Care System is not a Covered Service.

Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not a Covered Service.

Medical Equipment, Services, Exercise equipment, Devices and Supplies that are disposable, available over the counter, or mainly for convenience are not Covered Services. **The following are not Covered Services:**

- Adaptations to Your home, car, van, other vehicle or office;
- Bicycles, treadmills, stair climbers, and other exercise equipment;
- Free weights, exercise videos and other training equipment;
- Air conditioners, purifiers, humidifiers and dehumidifiers;
- Whirlpool baths;
- Hypoallergenic pillows or bed linens;
- Under pads and diapers;
- Telephones;
- Televisions;
- Handrails, ramps, elevators, escalators, and stair glides;
- Orthotics not approved by Us;
- Adaptive feeding devices;
- Adaptive bed devices;
- Water filers or purification devices;
- Disposable Medical Supplies such as medical dressings and disposable diapers;
- Over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, and peroxide;
- Heating pads, thermometers, pulse ox meters;

- Raised toilet seats;
- Shower chairs;
- Waterbeds;
- Pools, hot tubs, or spas;
- Pool, gym or health club membership fees;
- Personal trainers or other fitness instruction;
- Ice bags;
- Chairs or recliners;
- Other personal comfort or over the counter hygienic items.

Mobile Cardiac Outpatient Telemetry (MCOT) is not a Covered Service.

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not Covered Services unless Your plan includes a rider, and services have been **authorized by the Plan for Members who meet established criteria.**

Motorized or Power Operated Vehicles or chair lifts are not Covered Services unless authorized by the Plan. This does not include wheelchairs or scooters.

N

Neuro-cognitive therapy is not a Covered Service.

Newborns or other children of a Covered Dependent Child are not Covered Persons under the Plan unless mutually agreed to by the Plan and the Group.

Nutritional and/or dietary supplements, except as required by law, are not Covered Services. Nutritional formulas and dietary supplements that are available over-the-counter and do not require a written prescription are not Covered Services.

O

Orthoptics or vision or visual training and any associated supplemental testing are not Covered Services except when Medically Necessary for treatment of convergence and insufficiency. Pre-authorization is required.

Services or treatment You receive from **Out-of-Network Non-Plan Providers** will not be Covered except in the following situations:

- During treatment at an In-Network Hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider;
- You receive Emergency Care from an Out-of-Network Non-Plan Provider.

P

PARS System (Physical Activity Reward System) is not a Covered Service.

Pass Devices (Patient Activated Serial Stretch) are not a Covered Service.

Paternity Testing is not a Covered Service.

Penile implants are not a Covered Service.

Physician Examinations <u>are limited as follows</u>:

- Physicals for employment, insurance or recreational activities are not Covered Services.
- Executive physicals are not Covered Services.
- A second opinion from a Non-Plan Provider is a Covered Service only when authorized by the Plan. A second opinion by a Plan Provider does not require authorization.
- Services or supplies ordered or done by a provider not licensed to do so are not Covered Services.

Outpatient **Prescription Drugs** are not Covered Services unless Your Plan includes a rider.

Private Duty Nursing is not a Covered Service.

Prosthetics for sports or cosmetic purposes are not a Covered Service.

Non-covered **Providers** and services including massage therapists, physical therapist technicians, and athletic trainers.

Pulsed Irrigation Evacuation System is not a Covered Service.

Q

R

Reconstructive surgery is not a Covered Service unless Medically Necessary and surgery follows trauma which causes anatomic functional impairment, or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is a Covered Service.

Remedial Education and Programs are not Covered Services. Services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities **are not Covered Services.**

Residential treatment center care or care in another non-skilled setting are not Covered Services unless the treatment setting qualifies as a substance use disorder treatment facility licensed to provide continuous, structured, 24-hour a day program of drug or alcohol treatment and rehabilitation including 24-hour a day nursing care, and services are not merely custodial, residential, or domiciliary in nature.

S

Second Opinions from Plan providers do not require authorization. A second opinion from a Non-Plan provider is a Covered Service only when a Plan provider is not available and authorized by the Plan.

Services – <u>The following are not Covered Services:</u>

- Services that are not Medically Necessary;
- Services not listed as Covered under the Plan;
- Services not described, documented or supported in Your medical records;

- Services required for employment or continued employment;
- Services prescribed, ordered, referred by or given by an immediate family member;
- Services for which a charge is not normally made;
- Services or supplies prescribed, performed or directed by a provider not licensed to do so;
- Services provided before Your Plan effective date;
- Services provided after Your Coverage ends;
- Services after a benefit limit has been reached;
- Virtual Consults except when provided by Optima Health approved providers;
- Services or supplies that are a direct result of a non-covered service.

Skilled Nursing Facility (SNF) stays are not covered unless authorized by the Plan. The following services are not Covered:

- Custodial or domiciliary care;
- Rest care;
- Education or similar services;
- Private rooms unless Medically Necessary.

Spinal Manipulation is not a Covered Service unless covered under a Chiropractic Care Rider.

T

Charges for non-interactive **Telemedicine Services** such as fax, telephone only conversations, email, or online questionnaire are not Covered Services under the Plan's Telemedicine benefits.

Temporomandibular Joint Treatment fixed appliances or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures) are not Covered Services.

Therapies. Physical, Speech, and Occupational **Therapies** are limited as stated on Your schedule of benefits. Therapies will be Covered Services only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. **The following are not Covered Services except for those services that are listed under Early Intervention Services or under Autism Spectrum Disorder:**

- Therapies for developmental delay or abnormal speech pathology;
- Therapies which are primarily educational in nature;
- Special education services;
- Treatment of learning disabilities;
- Group speech therapy programs;
- Lessons for sign language;
- Therapies to correct an impairment resulting from a functional or developmental nervous disorder (i.e. stuttering, stammering);
- Therapies to maintain current status or level of care;
- Restorative therapies to maintain chronic level of care;
- Therapies available in a school program;
- Therapies available through state and local funding;
- Recreational or nature therapies;
- Art, craft, dance, or music therapies;
- Exercise, or equine therapies;
- Sleep therapies;
- Driver evaluations as part of occupational therapy;
- Driver training;
- Functional capacity testing needed to return to work;

- Work hardening programs; or
- Remedial education and programs.

Total Body Photography is not a Covered Service.

Transplant Services -<u>The following are not Covered Services</u>:

- Organ and tissue transplant services not listed as a Covered Service;
- Organ and tissue transplants not Medically Necessary;
- Organ and tissue transplants considered Experimental or investigative;
- Services from non-contracted providers unless pre-authorized by the Plan;
- Travel and lodging services not approved by the Plan including child care, mileage, and rental cars;
- Services and supplies for organ donor screenings, searches and registries; or
- Services related to donor complications following an approved transplant are limited to Medically Necessary charges, not covered by any other source, for up to six weeks from the date of procurement;
- **Donor Benefits** are not Covered Services if the covered individual is donating an organ to a non-covered member.

Transportation services that are not Emergency Services are Covered Services only when approved and authorized by Us.

Travel, Lodging and other Transportation expenses are not Covered Services unless approved and authorized by Us.

Treatment and services, other than Emergency Services, received while **traveling outside of the United States of America** are not Covered Services.

U

Urea Breath Testing is not a Covered Service.

V

Treatment of **varicose veins** or **telangiectatic dermal veins** (spider veins) for cosmetic purposes are not Covered Services.

Video Recording or Video Taping of any service or procedure is not a Covered Service.

Virtual Colonoscopy is not a Covered Service unless approved by the Plan.

Virtual Consults do not include the following:

- Electronic mail message;
- Facsimile transmission; or
- Online questionnaire.

Vitiligo Treatment by laser, light or other methods is not a Covered Service.

W

Wigs or cranial prostheses for hair loss for any reason are not Covered Services.

Wisdom Teeth extraction is not a Covered Service unless under a rider**.**

Work-related injuries or diseases when the employer must provide benefits or when that person has been paid by the employer are not Covered Services.

X

Y

Z

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

The following is a list of Exclusions, Limitations and other conditions that apply to Your drug benefit. Please also see the Plan Schedule of Benefits for Member cost sharing and other Coverage terms.

Limitations

- Amounts You pay for any outpatient prescription drug after a benefit Limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.
- Over-the-Counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded form Coverage. However, the Plan may approve Coverage of limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs.
- Unless required by law, certain Prescription Drugs may not be Covered under the Plan if You could use a "clinically equivalent drug." "Clinically equivalent drug" means a drug that for most individuals will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered by the Plan please call the Member Services number on the back of Your Optima Identification card. If You or Your doctor believes You need to use a different Prescription Drug, please have Your doctor contact Us. If We agree that it is Medically Necessary and appropriate We will cover the other Prescription Drug instead of the "clinically equivalent drug" at the non-preferred tier.
- Our formulary is a list of FDA-approved medications that We cover. At its sole discretion, the Optima Health Pharmacy and Therapeutics Committee reviews medications for placement onto the formulary. The Plan's Pharmacy and Therapeutics Committee is composed of Physicians and pharmacists. For all drugs, including new drugs, the committee looks at the medical literature and then evaluates whether to add or remove a drug from the formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration.
- Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under the Plan's prescription drug benefit or the Plan's medical benefit.

- Synchronization of Medication. For prescription drugs Covered under the Plan We will permit and apply a prorated daily cost sharing rate to prescriptions that are dispensed by an In-Network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the Member, and the Member requests or agrees to a partial supply for the purpose of synchronizing the Member's medications. Proration will not occur more frequently than annually. The Plan will not deny Coverage for the dispensing of a medication by an In-Network pharmacy on the basis that the dispensing is for a partial supply if the prescribing provider or the pharmacist determines the fill or refill is in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the Member's medications.
- Intrauterine devices (IUDs), implants, and cervical caps and their insertion are covered under the Plan's medical benefits.
- Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.

Prescription Drug Coverage Exclusions

The following is a list of exclusions that apply to Your drug benefit.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications with no approved FDA indications are excluded from Coverage.
3. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
4. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
6. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage, unless authorized by the Plan.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage, unless authorized by the Plan.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded form Coverage.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. Therapeutic devices or appliances, including but not limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded form Coverage.
13. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded form Coverage.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded form Coverage.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded form Coverage.

18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage.
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country.
20. Flu symptom drugs are excluded form Coverage unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage.
22. Over the counter medical foods are excluded from Coverage under the pharmacy benefit.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following standard reference compendia are not Covered Services:
    a. American Hospital Formulary Service Drug Information;
    b. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
    c. Elsevier Gold Standard's Clinical Pharmacology.
24. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
25. Non-Sedating antihistamines are excluded from Coverage.
26. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage.
27. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
28. Prescriptions written by a licensed dentist are excluded from Coverage, except for the prevention of infection or pain in conjunction with a Covered dental procedure.
29. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription.
30. Sexual dysfunction drugs are excluded from Coverage.
31. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
32. Infertility drugs are excluded from Coverage.
33. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
34. Abortifacient drugs that cause abortions are not covered.

Section 8
When You Are Covered By More Than One Health Plan

If You are covered by more than one health plan Your benefits under the plans will be coordinated so that the same services don't get paid for twice. This section explains coordination of benefits (COB).

You must tell Optima Health if You or a covered family member has coverage under any other health plan. When You have double coverage, one plan normally pays its benefits in full as the primary payor. The other plan pays a reduced benefit as the secondary payor. When We are the primary payor, We will pay the benefits described in this brochure. When We are the secondary payor, We will determine Our allowance. After the primary plan pays, We will pay what is left of Our allowance, up to Our regular benefit. We will not pay more than Our allowance.

DETERMINING WHICH PLAN IS PRIMARY AND WHICH PLAN IS SECONDARY (ORDER OF BENEFIT DETERMINATION RULES).

When a Member is covered under more than one insurance Plan, the Plan that covers the Member as the Subscriber (not a spouse or Dependent) is normally the primary Plan. If the Plan that covers the person as the Subscriber is a government Plan, the law may require the other Plan to pay first.

Depending on the circumstance We use the following rules to determine which plan is primary and which plan is secondary.

- **If a person is covered as a Subscriber under one plan and as a Dependent under another plan:**

  1. The Plan that covers the person as a Subscriber pays its covered benefits first.
  2. The Plan that covers the person as a Dependent then pays any of its covered benefits that the first Plan did not pay.

- **If Children are covered as dependents under both the mother's and the father's plan and the parents <u>are not</u> Separated or Divorced**:

  1. The Plan that covers the parent whose birthday falls earlier in a year pays its benefits first. The Plan that covers the other parent then pays any of its covered benefits that the first Plan did not pay. (If the other Plan has a rule based on the parent's sex instead of this rule, the other Plan's rule applies.)
  2. If both parents have the same birthday, the Plan that has covered one of the parents the longest pays its benefits first. The other Plan then pays any of its covered benefits that the first Plan did not pay.

- **If Children are covered as dependents under both the mother's and the father's plan and the parents are Separated or Divorced, the Plans pay in the following order**:

  1. The Plan of the parent with custody of the child pays its benefits.
  2. The Plan of the spouse of the parent with custody of the child, if any, pays its covered benefits not paid by the spouse's Plan.
  3. Finally, the Plan of the parent not having custody of the child pays any of its covered benefits left over.

     If a court decree specifically states that one of the parents is responsible for the health care expense of the child, and that parent's health insurance company actually knows that parent is responsible, then the responsible parent's insurance pays its benefits first. The other parent's Plan is the secondary Plan. If the responsible parent's health insurance company does not have actual knowledge of the court decree terms, this paragraph does not apply.

Section 8
When You Are Covered By More Than One Health Plan

- **For Active and Inactive Employees the Plans pay in the following order:**

    1. The health benefits Plan of an active employee (one not laid off or retired) and his or her Dependents pays its benefits first.
    2. The Plan which covers a laid off or retired employee and his or her Dependents is the secondary Plan. Both Plans must have this rule for it to apply.

- **If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee longer are determined first.**

    1. Two consecutive Plans are treated as one Plan if the person starts the second Plan within 24 hours of the termination of the first Plan.
    2. The start of a new Plan does not include:

        a) A change in the amount or scope of a Plan's benefits; or
        b) A change in the entity paying, providing or administering Plan benefits; or
        c) A change from one type of Plan to another (e.g., single employer to multiple employer Plan).

EFFECT ON THE BENEFITS OF THIS PLAN WHEN WE ARE A SECONDARY PLAN.

If this Plan is not the Primary Plan, We will coordinate benefits with the Primary Plan. We will pay the difference between what the Primary Plan(s) pay the provider and what We would pay if We were the primary Plan.

When the benefits of this Plan are coordinated as described in the rules above, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of this Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

We require certain information to apply these COB rules. Each Member must submit to Us any completed consents, releases, assignments and/or other documents that are necessary for Us to coordinate benefits.

We may get information from other organizations or persons. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan all facts it needs to pay the claim. We may release information to other persons and organizations in accordance with the Insurance Information and Privacy Protection regulations as set forth in the Code of Virginia 38.2-613. If You have questions about how We can get and use information please refer to the information on Our privacy practices notice in this document.

FACILITY OF PAYMENT.

A payment made by another plan may include an amount which We should have paid. If it does, We may pay the other Plan that amount. We will then treat that amount as if it were a benefit paid under this Plan. If the "payment made" was in the form of services, "payment made" means the reasonable cash value of those services.

RIGHT OF RECOVERY.

If We pay more than We should have paid under COB, We may recover the excess from one or more of:

- The person(s) it paid; or
- Health insurance companies and health maintenance organizations (HMOs).

Section 8
When You Are Covered By More Than One Health Plan

We are not required to reimburse a Member in cash for the value of services provided.

WE DO NOT COVER ANY OF THE FOLLOWING:

- Benefits available under **Worker's Compensation**. If We provide services covered under Worker's Compensation, Worker's Compensation will pay the provider of the services directly for those services. The Plan will coordinate benefits with the provider of the service. Any money received by Us belongs to Us.
- Benefits available under **Medicare Parts A, B, C, or D** unless required to do so by federal law. If We provide services covered under Medicare, Medicare will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us.
- Benefits available under **any other government program**, unless required to do so by law. If We provide services under a government program, the government program will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us.

THE FOLLOWING DEFINITIONS APPLY TO THIS SECTION.

"Plan" is any of the following which provide health benefits or services:

1. Group health insurance or group-type health coverage, whether insured or self-insured. This does not include Worker's Compensation.
2. A government health Plan, or coverage required or provided by law. This does not include a state Plan under Medicaid.

Each contract or other arrangement for Coverage is a separate Plan. If a Plan has more than one part and COB rules apply to less than all of the parts, each of the parts is a separate Plan.

"This Plan" or "We" is the part of this Evidence of Coverage that provides benefits for health care expenses.

"Primary Plan/Secondary Plan". When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits may be coordinated with any other health insurance or health care benefits or services that are provided by any other group policy, group contract, or group health care Plan so that no more than 100% of the eligible incurred expenses are paid. This Plan may recover from the primary Plan the reasonable cash value of services provided by this Plan.

"Allowable Expense" means an expense for which the Plan will pay. It is the usual and customary charge for an item or service covered at least in part by the Member's insurance. The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an allowable expense unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an allowable expense. For example, services obtained without a required Pre-Authorization or referral are not allowable expenses.

"Claim Determination Period" means a contract year. However, it does not include any part of a year during which a person has no Coverage under this Plan, or any part of a year before the date of this COB provision or a similar provision takes effect.

Section 9
Your Out-Of-Pocket Cost Sharing

This section explains the amounts that You must pay out-of-pocket when You receive covered services. See Your Face Sheet Schedule of Benefits for the specific out-of-pocket amounts You must pay for each Covered Service.

COPAYMENT AND COINSURANCE

Copayment and Coinsurance are out-of-pocket amounts You pay directly to a Provider for a Covered Service. You will usually have to pay Your out-of-pocket amount when You receive a service.

A Copayment is a flat dollar amount.

A Coinsurance is a percent of Optima Health's Allowable Charge for the Covered Service You receive.

Tiered Benefits and Cost Sharing.

This Plan has tiered Copayment or Coinsurance amounts listed for some In-Network benefits. For tiered benefits You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals or other Facilities or providers. When you use Tier 2 Physicians, Hospitals or other Facilities or other providers Your out of pocket costs will be higher. You can access Tier 1 or Tier 2 Primary Care Physicians (PCP) or Specialist providers without a referral.

> **Tier 1 Physician, Facility or other provider** means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 1 cost sharing amounts listed on the Plan Face Sheet Schedule of Benefits. Tier 1 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 1 Physicians, Facilities, and other providers and their locations is available to each enrollee during enrollment and anytime upon request.
>
> **Tier 2 Physician, Facility, or other provider** means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 2 cost sharing amounts listed on the Plan Face Sheet Schedule of Benefits. Tier 2 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 2 Physicians and Facilities and other providers and their locations is available to each enrollee during enrollment and anytime upon request.

DEDUCTIBLE

A Deductible is a dollar amount that You must pay out-of-pocket for health plan benefits before We begin to pay for benefits. If Your Plan has a Deductible it will be listed on the Face Sheet Schedule of Benefits. Your plan may have separate Deductibles for individuals and for families. Your plan may have a separate Deductible for outpatient prescription drugs.

Any applicable Deductible, Coinsurance, or Copayment You pay for a Covered Service will be included as part of the payment of the Allowable Charge.

Services or treatment You receive from Out-of-Network Non-Plan Providers will not be Covered under the Plan except in the following situations:

- If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits;

- You have received advance approval from Us to use an Out-of-Network Non-Plan Provider; and We have authorized the service to be Covered under Your In-Network Benefits;

- Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket amounts.

MAXIMUM OUT-OF-POCKET LIMIT or MAXIMUM OUT-OF-POCKET AMOUNT.

Maximum Out-of-Pocket Limit or Amount means the total amount You or Your Dependents pay, or that are paid on behalf of You or Your Dependents by another person, during a year as specified on Your Plan's Face Sheet or Schedule of Benefits. Deductible, Copayment and Coinsurance amounts for certain services will be accumulated and will apply toward the maximum dollar amount listed on the Face Sheet.

We maintain a record of Your payments. When You have reached the maximum out-of-pocket amount, no further payments will be required for that year, except for those services listed on Your Face Sheet that do not apply toward the maximum out-of-pocket amount. We will notify You within 30-days after You have reached Your maximum. We will promptly refund any payments charged after You reach Your maximum.

EMERGENCY DEPARTMENT COPAYMENT.

If Your plan requires a Copayment for an Emergency Department visit and You are admitted to the hospital from the Emergency Department the Plan waives the Emergency Department Copayment. The Member will be responsible for all applicable Deductibles and inpatient hospital Copayments or Coinsurances as specified on the Face Sheet.

INPATIENT HOSPITAL COPAYMENT.

The Plan will waive the inpatient Hospital Copayment if the Member is readmitted for the same diagnosis within 30-days of the original Admission.

A newborn that remains in the Hospital after the mother is discharged will be admitted as a patient under the newborn's own name, and a separate Copayment, Coinsurance, and Deductible may be applied to the newborn's Covered Services.

BALANCE BILLING PROTECTION FOR OUT-OF-NETWORK SERVICES.

Beginning January 1, 2021, Virginia state law protects You from "balance billing" if You receive Emergency Services from an Out-of-Network Provider or non-emergency surgical or ancillary services provided by an Out-of-Network Provider at an In-Network facility.

Please also see the complete Member notice on Balance Billing Protection for Out-of-Network Services in the notices section of this EOC.

What is balance billing?

Providers and facilities that do not directly contract with Your health plan are referred to as Out-of-Network Providers. Your health plan is generally not required to cover non-emergency care that You get from Out-of-Network Providers. Under Your health plan, You are responsible for certain cost sharing amounts such as Copayments, Coinsurance and Deductibles for Covered Services. Balance billing occurs

when an Out-of-Network Provider bills You for covered charges above Your cost sharing amounts that Your Plan didn't pay.

When You cannot be balance billed:

An Out-of-Network Provider cannot balance bill or attempt to collect costs from You that exceed Your Plan's In-Network cost sharing requirements, such as Copayments, Coinsurance and Deductibles, for the following services:

- Emergency Services provided by an out-of-network provider. This also includes post-stabilization services including any additional Covered Services furnished by a an out of network provider or emergency facility (regardless of the department of the hospital in which the items and services are furnished) after a Member is stabilized as part of outpatient observation, or as part of an inpatient or outpatient stay with respect to the visit in which Emergency Services are furnished.

- Emergency air ambulance services provided by an out of network provider.

- Nonemergency services provided by an out of network provider at an in-network facility if the nonemergency services involve otherwise covered Surgical or Ancillary Services, or other Covered Services provided by an out-of-network provider

Your In-Network cost sharing requirement will be based on what Optima Health usually pays an In-Network provider. Emergency Services will be covered at the highest tier (Tier). Non-emergency services provided at a Network Facility involving Surgical or Ancillary Services provided by an Out-of-Network Provider will be paid at the same Tier level as the network Facility. If You have a high Deductible or catastrophic health plan, Your Deductible will be based on any additional amounts Your Plan must pay to the Provider. Any amounts You are responsible for under this protection must count toward the Maximum Amount You must pay for In-Network services. If You pay an amount that exceeds this, the Provider must refund that amount with interest.

When You receive services, We will provide an Explanation of Benefits (EOB) that will show the out-of-pocket amount You are responsible for.

Your health plan contracts with certain health care professionals and facilities. These are called "In-Network" Providers. Optima Health is required to advise You, via Our website or on request, which Providers and facilities are in Your Plan's network. Health care professionals and facilities must also tell You which health plan provider networks they participate in either on their website or on request. Using In-Network Providers may help You avoid additional costs.

Other Out-of-Network Services:

Covered Services or treatment You receive from Out-of-Network Non-Plan Providers will not be Covered except in the following situations:

- Emergency Services provided by an out-of-network provider. This also includes post-stabilization services including any additional Covered Services furnished by a an out of network provider or emergency facility (regardless of the department of the hospital in which the items and services are furnished) after a Member is stabilized as part of outpatient observation, or as part of an inpatient or outpatient stay with respect to the visit in which Emergency Services are furnished.

- Emergency air ambulance services provided by an out of network provider.

- Nonemergency services provided by an out of network provider at an in-network facility if the nonemergency services involve otherwise covered Surgical or Ancillary Services, or other Covered Services provided by an out-of-network provider.

- We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

MONTHLY PREMIUM.

The Application to the Group Contract lists the monthly premium. If Members must contribute toward the cost of Coverage, the Application to the Group Contract and the Face Sheet of the Evidence of Coverage will indicate so. If a Member fails to pay, or arrange for payment of, any amount due under the Plan, including failure to pay a premium required by the Plan, Coverage will terminate upon 31 days written notice.

GRACE PERIOD.

The Group contract holder is entitled to a grace period of 31 days for the payment of any premium due except the first premium. During the grace period coverage shall continue in force unless the contract holder has given the Plan written notice of discontinuance in accordance with the terms of the contract and in advance of the date of discontinuance. The contract holder shall be liable to the Plan for the payment of a pro rata premium for the time the contract was in force during the grace period.

OFFICE VISIT COPAYMENTS FOR PREVENTIVE CARE

Recommended Preventive Care under PPACA will be covered with no Member cost-sharing when received from Plan Providers. However You may still have to pay Your office visit cost sharing including any Copayments, Coinsurance and Deductibles listed on the Face Sheet of Your Evidence of Coverage in certain circumstances:

1. You will pay office visit cost sharing if Your preventive care item or service is billed separately, or is tracked as individual encounter data separately from the office visit.
2. You should not pay a cost sharing for an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit, and the primary purpose of the office visit is the delivery of the preventive item or service.
3. You will pay office visit cost sharing if an item or service is not billed separately, or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.
4. You will pay all charges for any preventive care and office visits You receive from Out-of-Network Non-Plan Providers.

Section 10
Claims And Payments

WHEN YOU HAVE TO FILE A CLAIM FOR BENEFITS.

Plan Providers will usually file claims for You. You may have to file a claim if Your Provider is unable to file for You, or if You see a Non-Plan Provider. We do not use claim forms, but You must send Us complete written proof of loss. Proof of loss means that We have all the information We need to process Your claim. You can provide proof of loss by sending Us an itemized bill for services You received. An example would be a bill from a doctor's office or hospital listing the cost of services or tests You had done.

- **The bill must be in English and include all of the following:**

  - The name and address of the provider; and
  - The name and Member number of the Member who received services; and
  - The date of the services; and
  - The diagnosis and type of services received; and
  - The charge for each type of service.

- **Send the itemized bill and any other information You have about Your claim to**:

  MEDICAL CLAIMS
  Lason Systems
  P.O. Box 5028
  Troy, MI 48007-5028

TIMELY FILING OF CLAIMS AND WRITTEN PROOF OF LOSS.

Proof of loss means that We have all the information We need to process Your claim. You must submit written proof of loss to the Plan within 90 days after You receive the covered services. If You do not send written proof of loss within 90 days Your claim will not be reduced or invalid as long as You send it to Us as soon as reasonably possible.

Unless You are not legally competent to act, We require that You send Us proof of loss no later than one year after the date of service or We will not provide benefits.

CLAIMS FROM NON-PLAN PROVIDERS.

Non-Plan Providers must submit claims for Covered Services provided to Members to:

MEDICAL CLAIMS
Lason Systems
P.O. Box 5028
Troy, MI 48007-5028

MENTAL HEALTH CLAIMS
Lason Systems
P.O. Box 1440
Troy, MI 48009-1440

Claims must be received by the Plan within 365 days of the date the Member received the Covered Service. We will not be liable for, or pay a claim We receive from a Non-Plan Provider more than 365 days from the date of service.

Section 10
Claims And Payments

PROCESSING A CLAIM.

We process claims, make coverage decisions, and provide notice according to the procedures and timeframes described in Section 5. All of Our requirements for Pre-Authorization apply. All of the Member's coverage exclusions and limitations apply.

If We deny a Claim for benefits the Member has the right to a full and fair review of the Plan's determination according to Our appeal process in Section 13.

CLAIMS PAYMENT.

We usually pay the provider or the facility that provided the covered service. If a Member has provided proof that they paid the provider directly for a covered service We will reimburse the Member less any amounts We have already paid the provider for the claim. We will pay the estate of the Member if the Member is dead.

RIGHT OF EXAMINATION AND AUTOPSY.

While We are processing a claim We have the right to have the Member examined when and as often as reasonably required. We will pay the cost of examination. We also have the right, at Our expense, to investigate a Member's death or request an autopsy unless prohibited by law.

CLAIMS PAID DIRECTLY TO MEMBERS FOR SERVICES FROM NON-PARTICIPATING PHYSICIANS.

If We send payment directly to a Member for a claim for covered services from a non-plan physician or osteopath, the Member must apply the plan payment to the claim from the non-plan provider. We will include the name and any last known address of the physician or osteopath with any payment sent directly to the Member.

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

Section 11
When Your Coverage Will End

WHEN YOUR COVERAGE WILL END.

Under certain circumstances Your coverage under Your employer group plan will end. Your coverage will not be canceled based on Your health. Your coverage will not be canceled because You have exercised Your right to file a complaint under Our grievance system. If Your coverage ends We will no longer pay for any services You receive after the date Your coverage ends.

A Subscriber or Employee's Coverage ends on:

- The date the employer group plan ends, upon 31 days written notice; or
- The date the subscriber fails to meet the plan's eligibility requirements; or
- The date the grace period for payment of premiums to the plan ends; or
- The date the subscriber t fails to pay any amounts due under the plan, including failure to pay a premium required under the plan; or
- The date the subscriber dies.

A Dependent's Coverage ends:

- The date the employer group plan ends, upon 31 days written notice; or
- The date the dependent fails to meet the plan's eligibility requirements; or
- The date the grace period for payment of premiums to the plan ends; or
- The date the subscriber fails to pay any amounts due under the plan, including failure to pay a premium required under the plan; or
- The date the subscriber's coverage under the plan ends unless otherwise agreed to by the plan and the employer group; or
- The date a dependent spouse or child becomes covered as an employee under the plan; or
- The date the dependent dies.

RESCISSION OF COVERAGE

Rescission means a cancellation or discontinuation of coverage that is retroactive. Rescission does not mean cancellation or discontinuance of coverage in accordance with the Plan's Grace Period for non-payment of premium.

Optima Health will not rescind coverage after an individual is covered under the Plan unless the individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

Optima Health will provide at least 30 days' advance written or electronic notice to any Covered Person who would be affected by the proposed rescission of coverage before coverage under the Plan may be rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group. The written or electronic advance notice will at a minimum include the following:

1. Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

2. An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

3. Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

4. A description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and

5. The date when the advance notice ends and the date back to which the coverage will be rescinded.

If coverage is rescinded a Covered Person losing coverage is entitled to a refund of any paid premiums from the date coverage is voided or rescinded.

REASONS YOUR GROUP COVERAGE WILL END.

We have a contract or Group Contract with Your employer to provide Your benefits. We will not end or cancel a Member's coverage under the Group Contract except for one or more of the following reasons:

- Failure to pay the amounts due under the Plan, including failure to pay a premium required by Our contract with the Group;
- Fraud or material misrepresentation in enrollment, or in the use of services or facilities;

  Fraud or Misrepresentation. We may cancel Coverage of any Subscriber or Member who knowingly gives incorrect, incomplete or deceptive information about themselves or their Dependents eligibility for coverage. This applies if the information is given to Us or to Your employer. This also applies whether the Member gives the information or has others give it on their behalf. The incomplete, incorrect or deceptive information must be material. The Member is responsible for all costs incurred by the Plan because of the incorrect, incomplete, or deceptive information, including legal fees.

  Misuse of Plan Identification Card. No one but the Member may use their Optima Health ID card. Use by anyone else is fraud. The Plan may prosecute the Member and the person using the card. Both the Member and the person using the Member's card are liable to the Plan for all costs resulting from the misuse of the identification card.

- Material violation of the terms of the Plan Group Contract.
- Failure to meet the eligibility requirements under the Plan Group Contract.
- Termination of the Group Contract under which the Member was covered.

NOTICE THAT COVERAGE HAS ENDED.

We will not end Coverage for services provided under the employer Group Contract without giving the Subscriber written notice effective at least 31 days from the date of mailing or, if not mailed, from the date of delivery, except that:

- For cancelation due to nonpayment of premium the Plan's grace period will apply. The contract holder is entitled to a grace period of 31 days for the payment of any premium due except the first premium. During the grace period coverage will continue in force unless the contract holder has given the Plan written notice of discontinuance in accordance with the terms of the contract and in advance of the date of discontinuance. The contract holder will be liable to the Plan for the payment of a pro rata premium for the time the contract was in force during the grace period.
- For cancelation due to nonpayment of premium by an employer, the following additional provisions apply:

  1. Any employer who (i) assumes part or all of the cost of providing group accident and sickness insurance or a group health services plan or group health care plan for his employees under a group insurance policy or subscription contract or other Evidence of Coverage; (ii) provides a facility for deducting the full amount of the premium from employees' salaries and remitting such premium to the insurer, health services plan, or health maintenance organization; or (iii)

provides for health and medical care or reimbursement of medical expenses for his employees as a self-insurer, shall give written notice to participating employees in the event of termination or upon the receipt of notice of termination of any such policy, contract, coverage, or self-insurance not later than fifteen days after the termination of a self-insured plan or receipt of the notice of termination.

2. Any employer who collects from his employees or covers any part of the cost of any of the policies, contracts, or coverages specified in subsection 1 above and who knowingly fails to remit to the insurer or plan such funds required to maintain coverage in accordance with the policy or contract provisions under which the employees are covered shall be guilty of a Class 1 misdemeanor and shall be subject to civil suit for any medical expenses the employee may become liable for as a result of the employer letting such coverage be terminated.
3. In the event coverage under the Plan is canceled due to nonpayment of premium by the employer, no such coverages shall be terminated by the Plan with respect to a covered individual unless and until the employer has been provided with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least fifteen days after such notice has been mailed. The Plan shall make reimbursement on all valid claims for services incurred prior to the date coverage is terminated.

- For cancelation due to change of eligibility status of a Member, immediate notice may be given.
- Optima Health will provide at least 30-days' advance written or electronic notice to any Covered Person who would be affected by the proposed rescission of coverage before coverage under the Plan may be rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group. The Covered Person or their authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission.

CONTINUATION OF CARE EXTENSION OF BENEFITS FOR TOTAL DISABILITY.

If Coverage ends under the Group Contract members who become totally disabled while enrolled under the Plan and who continue to be totally disabled when the Group Contract ends are entitled to an extension of benefits for total disability. Upon payment of premium, coverage shall remain in full force and effect for a period of time not less than 180 days, or until the Member is no longer totally disabled, or a succeeding carrier elects to provide replacement coverage to that Member without limitation as to the disabling condition. Upon termination of the extension of benefits, the enrollee shall have the right to convert or continue coverage as provided herein.

REINSTATEMENT OF COVERAGE FOLLOWING ABSENCE FROM EMPLOYMENT.

Unless otherwise agreed to by the Employer and the Plan the following provisions apply to employees following an absence from employment:

- An employee who is re-hired after 90 days will be considered a new employee and will be subject to all Plan eligibility requirements, including any waiting periods, and effective date of Coverage requirements, as described in **Section 3 Who is Eligible to Enroll and Section 4 When You Can Enroll and When Coverage Begins.**
- An employee who returns to work within 90 days after a layoff or an approved leave of absence will keep the same employment and eligibility status as before.

**To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.**

Section 11
When Your Coverage Will End

TERMINATION OF THE GROUP CONTRACT.

Unless otherwise stated, and in accordance with all notice requirements, on the date the Group Contract is ended:

- Coverage of Subscribers and Dependents will end immediately. The Group must notify Members promptly that We are no longer required to provide any service in connection with the Group Contract.
- All Covered Services under the Plan, including treatment for ongoing conditions and care for hospitalized Members may stop immediately. This does not include those Members who have become totally disabled while a Member of the Plan and remain totally disabled at the time of the termination of the Group Contract.

If the Group Contract ends We will refund the difference between fees paid to Us after the termination date and amounts otherwise due to Us. Refunds will go to the Group unless the premiums are billed directly to and paid by the Member.

To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.

Section 12
Continuing Coverage Options When Eligibility Ends

When Your Coverage or Your dependent's coverage ends Your employer must tell You and Your dependents in writing what options are available to continue coverage.

The following options may be available:

- Continue group coverage under federal Consolidated Omnibus Budget Reconciliation Act (COBRA); or
- Continue group coverage under Virginia state law for 12 months.

REQUIRED EMPLOYER NOTICE OF CONTINUATION OPTIONS.

Your employer must provide each employee, or other enrollee covered under Your Plan, written notice of the availability of COBRA or, if Your group is not subject to COBRA, written notice of the availability of Virginia's twelve month continuation of group coverage option. The employer notice must include all of the procedures and timeframes for continuation of coverage. The notice must be provided within 14 days of the employer group contract holder's knowledge of the enrollee or other covered person's loss of eligibility under the group contract.

COBRA CONTINUATION HEALTH COVERAGE.

When group health plan coverage ends the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most group health plans to provide a temporary continuation of group health coverage for certain qualifying events. COBRA generally applies to all group health plans maintained by private-sector employers (with at least 20 employees) or by state and local governments. The law does not apply, however, to plans sponsored by the Federal government or by churches and certain church-related organizations.

COBRA requires continuation coverage to be offered to covered employees, their spouses, their former spouses, and their dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce, or legal separation from a covered employee, a covered employee's becoming entitled to Medicare, and a child's loss of dependent status (and therefore coverage) under the plan.

Employers may require individuals who elect continuation coverage to pay the full cost of the coverage, plus a 2 percent administrative charge. For more information about COBRA please read the General Notice of COBRA Continuation Coverage Rights in the back of this document. Your employer and not Optima Health is responsible for administering COBRA benefits.

STATE CONTINUATION OF GROUP PLAN COVERAGE.

This section will apply to You only if Your employer's group plan is not subject to COBRA continuation.

If Coverage under the Group Plan ends Members are entitled to continuation of coverage under the existing group contract for a period of 12 months immediately following the date of termination of the enrollee's eligibility for coverage under the Group Plan. Coverage shall be provided without additional evidence of insurability. The premium for continuing group coverage shall be at the current rate applicable to the group contract subject to the following requirements:

1. The application and payment for the extended coverage is made to the group contract holder within 31 days after issuance of the written notice by the employer, but in no event beyond the 60 day period following the date of the termination of the person's eligibility;
2. Each premium for the extended coverage is timely paid to the group contract holder on a monthly basis during the 12 month period; and
3. The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy plus any applicable administrative of 2% of the current rate.

Members will not be eligible for Continuation of Coverage if any conditions below are true.

- The Member is covered by, or is eligible for benefits under Title XVIII, under the United States Social Security Act.
- The Member is covered by, or is eligible for substantially the same level of Hospital, medical, and surgical benefits under state or federal law.
- The Member is covered by substantially the same level of Hospital, medical, and surgical benefits under any policy, contract, or Plan for individuals in a group.
- The Member has not been continuously covered during the three-month period immediately preceding the Member's termination of Coverage.
- The Member was terminated by the Plan for any of the following reasons**:**

    1. Failure to pay the amounts due under the contract, including failure to pay a premium required by the contract as shown in the contract or Evidence of Coverage;
    2. Fraud or material misrepresentation in enrollment or in the use of services or facilities; or
    3. Material violation of the terms of the contract.

**To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.**

Section 13
How To File A Complaint, Grievance, Or Appeal An Adverse Benefit Determination

YOUR RIGHT TO FILE A COMPLAINT OR APPEAL.

We want You to be satisfied with Your health plan services. If You are not satisfied We have a formal complaint process to handle Your concerns. We also have an Internal and an External Appeal Process to resolve benefit disputes and respond to requests to reconsider coverage decisions You find unacceptable.

Some examples of typical complaints or grievances are:

- You are unhappy with a doctor or hospital;
- You feel You received poor care at a hospital; or
- You are unhappy with Our services.

Some examples of when You are entitled to an appeal are:

- We did not approve a request for Pre-Authorization;
- We did not cover a treatment because it is experimental;
- We did not cover a service because it is not medically necessary;
- We did not pay for a treatment or service according to Your benefits; or
- We have notified you that Your coverage is being rescinded for fraud or material misrepresentation.

We suggest You call Member Services first and one of Our customer service representatives will assist You with the problem. Most problems can be handled in this manner. If You are still not satisfied You can file a formal written complaint or an appeal by following one of processes below.

Remember, You have the right to file a complaint or an appeal. We will not penalize You or cancel Your coverage because You exercise Your rights.

If You have any questions regarding an appeal, grievance, or complaint concerning the health care services that You have been provided which have not been satisfactorily addressed by Your Plan, You may contact the Office of the Managed Care Ombudsman. The Managed Care Ombudsman is available to help Virginia consumers who experience problems with, or have questions about managed care. The Managed Care Ombudsman can assist Plan members in understanding and exercising their rights of appeal of adverse decisions. There are several ways to contact the Office of the Managed Care Ombudsman:

Write:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Telephone:

Toll-Free: 1-877-310-6560
Richmond Metropolitan Area: 1-804-371-9032

E-Mail:

ombudsman@scc.virginia.gov

**To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.**

Section 13
How To File A Complaint, Grievance, Or Appeal An Adverse Benefit Determination

HOW TO FILE A COMPLAINT.

You can file a complaint anytime within 180 days from the date of Your concern with Your care or services. Remember to include any additional documentation that will help Us resolve Your concern. You may have someone else, such as a doctor or family member, file a complaint for You. We may ask that You sign a form authorizing the other person to act for You.

Call Member Services and ask for a complaint form, or download the forms from Our Web site optimahealth.com. Mail or fax the completed forms and any additional documentation to:

Optima Health
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232
Toll Free: 866-472-3920

We will write to You and let You know We have received Your complaint. We will also tell You how long We think it will take Us to investigate Your complaint. When We have finished Our investigation We will write to You and let You know how We have resolved Your complaint.

If You have been unable to contact Us or obtain satisfaction here are some other places You can go for help.

- **Contact the Virginia Bureau of Insurance**:

  Life & Health Division
  Bureau of Insurance
  P. O. Box 1157
  Richmond, VA 23218
  Phone: 804-371-9741
  In-State Toll Free 1-800-552-7945

- **Contact the Virginia Department of Health**:

  Virginia Department of Health
  Center for Quality Health Services and Consumer Protection
  3600 W. Broad Street, Suite 216
  Richmond, VA 23230-4920
  Toll-free Telephone: 1-800-955-1819

- **The Managed Care Ombudsman**:

  Write:
  Office of the Managed Care Ombudsman
  Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218

  Telephone:
  Toll-Free: 1-877-310-6560
  Richmond Metropolitan Area: 1-804-371-9032

**To be Covered all services must be Medically Necessary and listed as a Covered Service.
See Your Face Sheet for Deductibles, Copayments or Coinsurance You must pay out-of-pocket.
Call Member Services if You have any questions.**

Section 13
How To File A Complaint, Grievance, Or Appeal An Adverse Benefit Determination

E-Mail: ombudsman@scc.virginia.gov

APPEALS OF AN ADVERSE BENEFIT DETERMINATIONS.

An Adverse Benefit Determination means that We have made a decision not to pre-authorize, cover, or pay (in whole or in part) for a service because:

- You are not eligible for benefits under the plan; or
- The service does not meet Our requirements for:
  - Medical necessity;
  - Appropriateness;
  - Health care setting;
  - Level of care;
  - Effectiveness; or
- The service is Experimental or Investigational; or
- Optima Health has notified You that Your Coverage is being rescinded.

You have the right to a full and fair appeal of an Adverse Benefit Determination. You have 180 days from Our notice to You of an Adverse Benefit Determination to ask for an appeal.

You can have someone else, such as a doctor or family member file an appeal for You. We may ask You to sign a form to authorize this person to act for You.

When We review Your appeal We will look at all comments, documents, records, and other information submitted to Us. We will do a new review without regard to the first review of Your case. Make sure You send Us any new information You want Us to review. You can submit new information to Us in writing or in person.

The person reviewing Your appeal will not have participated in the original coverage decision.

Appeals involving a medical judgment, including whether a particular treatment, drug, or other service is experimental, investigational, or not Medically Necessary will be reviewed by a clinical peer reviewer who did not participate in the first coverage decision.

Before We make Our final decision on Your appeal We will provide you free of charge any new information We relied on; and We will give you time to provide comments.

Appeals of Pre-Service Claims.

A **Pre-service Claim** is a claim for a benefit or service that requires Pre-Authorization before You receive care. An example would be obtaining Pre-Authorization for a diagnostic test or medical procedure.

For Pre-Service Claims, We will make a decision and notify You within 30 calendar days of receipt of Your written request for the appeal.

Reconsideration of an Adverse Decision

Your treating provider my request a reconsideration of an Adverse Decision on Your behalf. A request for reconsideration is optional, and available only to Your treating health care provider. You or Your Authorized Representative may file an appeal regardless of whether your provider requests a reconsideration. We will make a decision on a reconsideration and notify the provider and the member in writing within ten (10) working days of the date of receipt of the request. If we deny the reconsideration

request the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate recommendation, and the Member's right to appeal the decision.

Appeals of Post-Service Claims.

A Post-Service Claim is any claim for a benefit that is not a Pre-Service Claim. An example would be a claim for payment for a diagnostic test or other services You have already had done.

If Your appeal involves a Post-Service Claim, We will make a decision and notify You within 60 calendar days of receipt of Your written request for the appeal.

Appeals of Concurrent Claims or Review Decisions.

A **Concurrent Care Claim** is a claim for a benefit where We are reducing or ending a service previously approved. It can also be a request to extend a course of treatment. An example would be a review of an inpatient hospital stay approved for five days on the third day to determine if the full five days is appropriate. Another example would be a request for additional outpatient therapy visits.

For Concurrent Care Claims, We will make a decision and notify You as soon as possible; and prior to the benefit being reduced or terminated.

We will continue to provide coverage during Your appeal of a concurrent review.

Expedited Appeals for Urgent Claims.

You can request an expedited appeal if Your claim for medical care or treatment is urgent and using Our normal appeal process would:

- Seriously jeopardize Your life or health; or
- Seriously jeopardize Your ability to regain maximum function; or
- In the opinion of a Physician with knowledge of Your medical condition, subject the Member to severe pain that cannot be adequately managed without the care or treatment.

You or Your treating physician can request an expedited appeal by telephone, fax, or letter. Please make sure to explicitly state "expedited appeal" in the request to initiate this process.

We will make a decision on an expedited appeal and notify You as soon as possible, but no later than:

- One business day after We receive all information necessary to make a decision; or
- Not later than 72 hours from the receipt of the request.

Expedited appeals relating to a prescription to alleviate cancer pain will be decided not more than twenty-four hours from receipt of the request.

You also have the right to file an external review at the same time as Your request for an expedited internal appeal. **Please see the section below "YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR A FINAL ADVERSE BENEFIT DETERMINATION."**

Adverse Determinations Involving The Treatment of Cancer

Section 13
How To File A Complaint, Grievance, Or Appeal An Adverse Benefit Determination

If You receive an Adverse Determination involving the treatment of Cancer You are not required to exhaust Our internal appeal processes before requesting a standard or expedited independent external review. **Please see the section below "YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR A FINAL ADVERSE BENEFIT DETERMINATION."**

HOW TO BEGIN YOUR APPEAL.

- **You can ask for forms to start a written appeal by:**

  1. Calling Member Services at the number on Your ID card; or
  2. Downloading the forms at Optimahealth.com ; or
  3. Sending Us a fax at 757-687-6232 or 1-866-472-3920; or
  4. Sending Us a letter by mail at:

     Optima Health
     APPEALS DEPARTMENT
     P.O. Box 62876
     Virginia Beach, VA 23466-2876

- **For an Urgent care appeal You or Your treating physician can request an expedited appeal by telephone, fax, or letter. Please make sure to explicitly state "expedited appeal" in the request to initiate this process.**

- **When You have completed the forms return them to Us. Remember to include all of the following with Your appeal forms:**

  1. Your name, address, and telephone number;
  2. Your Member number and group number;
  3. The date of service, and place of service;
  4. The name of the doctor or other service provider;
  5. The charge related to the service; and
  6. Any new additional written comments, documents, records, or other information You want Us to consider.

- **When We complete Your appeal We will send written notification of Our decision. If We don't change Our initial decision Our notice will include**:

  1. The specific reason for Our decision; and
  2. The specific plan provisions We based Our decision on; and
  3. Information on any external appeal rights available to You.

- **You can also request the following free of charge:**

  1. Reasonable access to, and copies of, all documents, records, and other information relevant to Your appeal; and
  2. Copies of any internal rule, guideline, protocol, or other criteria We relied on for Our decision; and
  3. For denials due to medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to Your medical circumstances.

Section 13
How To File A Complaint, Grievance, Or Appeal An Adverse Benefit Determination

YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR A FINAL ADVERSE BENEFIT DETERMINATION.

If We have denied Your request for the provision of or payment for a health care service or course of treatment You may have the right to have Our decision reviewed by health care professionals who have no association with Us if Our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested by submitting a request for external review to the Virginia State Corporation Commission's Bureau of Insurance.

State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
Phone: 1-877-310-6560 Fax: (804)371-9915
Email: externalreview@scc.virginia.gov

We will send You copies of the forms and instructions that You need to file an external review or an expedited external review with Our notice of an adverse benefit determination or final adverse determination. You can also get copies of the forms and instructions that You need by calling Member Services at the number on Your Optima Health ID card or on Our web site at optimahealth.com.

Depending on Your situation You or Your authorized representative can ask for an external review of an adverse or final adverse determination.

You may file a request for an External Review of an adverse determination in the following situations:

- If We have denied Your request for a covered service, or We have denied payment for a covered service or course of treatment, and Our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested;
- If the adverse determination involves the treatment of cancer, or You have a medical condition where the time frame for completion of an expedited internal appeal of an adverse determination would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, You, or Your authorized representative may file a request for an expedited external appeal;
- If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and Your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, You or Your authorized representative may file a request for an expedited external review;
- If You or Your authorized representative files a request for an expedited internal appeal with Us, You may file at the same time a request for an expedited external review of an adverse determination. The independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited internal appeal prior to conducting the expedited external review;
- If You or Your authorized representative files a standard appeal with Our internal appeal process, and We do not issue a written decision by either 30 days from the date of filing for a pre-service claim or by 60 days from the date of filing for a post-service claim, and You or Your authorized representative did not request or agree to a delay, You or Your authorized representative may file

a request for external review, and will be considered to have exhausted Our internal appeal process.

You or Your authorized representative can request an external review of a final adverse benefit determination in the following situations:

- You have a medical condition where the time frame for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, You or Your authorized representative may file a request for an expedited external.
- If the final adverse determination involves an admission, availability of care, continued stay, or health care service for which You received emergency services, but have not been discharged from a facility, You or Your authorized representative may request an expedited external review.
- If the final adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, You or Your authorized representative may file a request for a standard external review; or if Your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, You or Your authorized representative may request an expedited external review.

You have 120 days from the date You receive notice of Your right to request an External appeal from the Bureau of Insurance (BOI).

You must have exhausted Our internal appeal process. Exhaustion of the internal appeal process will not be required if the adverse determination is related to the treatment of cancer. Depending on Your situation exhausted means:

1. You have filed an internal appeal and We have notified You of Our final adverse benefit decision; or
2. You filed an internal appeal, and We have not given You a response on Our determination by either 30 days from the date of filing for a pre-service claim or by 60 days from the date of filing for a post-service claim. This does not apply if You agreed to give Us more time to work on Your appeal; or
3. You filed an expedited or urgent appeal with Us. At the same time You can request an External review; or
4. We have agreed to waive the exhaustion requirement for Your appeal.

How Your External Appeal will be handled.

When the BOI receives Your appeal, they will ask Us to verify that Your case is eligible for external appeal, and that Your appeal request is complete.

You will have to authorize the release of any medical records needed to reach a decision on the external review.

If any additional information is needed to complete Your request or verify eligibility, We will ask You to provide the specific information needed. We will give You a timeframe to submit this information. If You do not submit this information to Us a timely manner, Your request for an external review may be concluded.

If We determine that Your request is not eligible for an external appeal, You may appeal that determination to the BOI.

You will be notified that Your request is complete and eligible for external review. The BOI will randomly select an Independent Review Organization (IRO) to perform Your appeal. The IRO performing Your appeal will not be affiliated with Optima Health so that there is no conflict of interest with Your case. You will have 5 business days from notification to submit any additional information You would like the IRO to review about Your case. We will also submit all of Our documents and information We used to make Our decision on Your internal appeal to the IRO for review.

The IRO will notify You and Optima Health of its decision on Your external appeal. The decision is binding on Us. The decision is also binding on You except to the extent the covered person has other remedies available under applicable federal or state law.

If a request for an expedited External Review is submitted at the same time as a request for an expedited internal appeal request has been made, the IRO will make a determination as to whether the internal expedited appeal process must be completed prior to the expedited External Review process beginning.

We may reconsider any final Adverse Benefit Determination that is the subject of an external review at any time. Reconsideration by Us will not delay or end the external review.

SOURCES FOR ADDITIONAL HELP.

If You have been unable to contact Us or obtain satisfaction here are additional places You can go for help:

- Virginia State Corporation Commission
  Life & Health Division, Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  (877) 310-6560
  http://www.scc.virginia.gov/boi
  bureauofinsurance@scc.virginia.gov

- You may contact the Office of the Managed Care Ombudsman to seek assistance in understanding and exercising Your right to appeal an adverse determination at:

  Office of the Managed Care Ombudsman
  Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  Toll Free Telephone Number: 877-310-6560
  Email Address: ombudsman@scc.virginia.gov

- You may Contact the Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection at 1-800-955-1819.

- You may have the right to bring civil action under Section 502 (a) of the Employee Retirement Income Security Act if all required reviews of Your appeal have been completed and Your appeal has not been approved. Members of government or church-sponsored groups do not have this right. Additionally, You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency. Contact the nearest

office of the U.S. Department of Labor, Pension and Welfare Benefits Administration Toll-free at 1-866-275-7922 or visit their website at www.dol.gov.

Section 14
General Provisions

MAJOR DISASTERS AND OTHER CIRCUMSTANCES BEYOND THE PLAN'S CONTROL.

In the event that circumstances not within the Plan's control including, but not limited to, a major disaster, epidemic, or civil insurrection, result in the facilities, personnel or resources used by the Plan being unable to provide or arrange for the care and services the Plan has agreed to provide, the Plan shall make a good faith effort to arrange for an alternative method of providing such care and services insofar as practical and according to its best judgment. In such circumstances, however, neither the Plan nor participating providers shall incur any liability or obligation for delay, or failure to provide or arrange for such services.

INCONTESTABILITY.

All statements made by a Member shall be considered representations and not warranties and no statement shall be the basis for voiding Coverage or denying a claim after the contract has been in force for two years from its effective date, unless the statement was material to the risk and was contained in a written application.

SEVERABILITY.

In the event that any provision of this Evidence of Coverage is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this EOC or the Group Contract, which shall continue in full force and effect in accordance with its remaining terms.

POLICIES AND PROVISIONS.

The Plan may develop and adopt policies, procedures, rules, and interpretations to promote orderly, equitable, and efficient administration of Coverage.

MODIFICATIONS.

Alterations to the Group Contract and its attachments may be made, in accordance with the terms of the Group Contract between the Plan and group. This may be done without the Subscriber's consent or concurrence.

ENTIRE CONTRACT.

The Group Contract and this Evidence of Coverage together with all exhibits and amendments thereto, the individual Enrollment Applications of Members, and any other questionnaire, form or other document provided in execution with the Group Contract shall constitute the entire agreement between the parties. No statements or representations may be used in any legal dispute regarding the terms of Coverage or any exclusions or limitations hereunder unless contained in such documents. No alteration of the Group Contract and no waiver of any of its provisions shall be valid unless evidenced by a written endorsement or amendment signed by a duly authorized officer of the Plan. Any insurance agent or broker licensed through the Plan who may have assisted in the contract for this Plan is not an authorized officer of the Plan for this or any other purpose.

OMISSIONS.

Neither the group nor any Member is an agent or representative of the Plan, and neither shall be liable for any acts or omissions of the Plan, its agents or employees, or of any provider, or any other person or organization with which the Plan, its agents or employees, has made or hereafter shall make arrangements for the performance of services under this agreement. Certain Members may, for reasons personal to themselves, refuse to accept procedures or courses of treatment recommended by a Plan provider. Providers shall use their best efforts to render all necessary and appropriate professional services in a

manner compatible with the Member's wishes, insofar as this can be done consistently with the provider's judgment as to the requirements of proper medical practice. If a Member refuses to follow a recommended treatment or procedure, and a provider believes that no professionally acceptable alternative exists, such Member shall be so advised; and if upon being so advised the Member still refuses to follow the recommended treatment or procedure, then the Member shall be given no further treatment for the condition under treatment, and neither the Plan provider nor the Plan shall have any further responsibility to provide care for such condition or related ailment nor financial responsibility for payment of such care or complications arising from failure to follow the medical advice of Plan providers. However, the Member shall have the right to a consultation (second opinion) regarding his/her medical condition. This second opinion must be pre-authorized by the Member's Primary Care Physician using participating Plan providers.

RELATIONSHIP BETWEEN THE PLAN AND HOSPITALS.

The relationship between the Plan and Hospitals is that of an independent contractor. Hospitals are not agents or employees of the Plan nor is the Plan or any employee of the Plan an employee or agent of Hospitals. Hospitals shall maintain the Hospital-patient relationship with Members and are solely responsible to Members for all Hospital services.

RELATIONSHIP BETWEEN THE PLAN AND HEALTH PROFESSIONALS.

The relationship between the Plan and health professionals is that of an independent contractor except in such cases whereby the health professional is employed by the Plan. Independently contracted health professionals are not agents or employees of the Plan nor is the Plan, or any employee of the Plan, an employee or agent of its health professionals. Health professionals shall maintain professional patient relationships with Members in accordance with the terms hereof and applicable law, and are solely responsible to Members for all medical services.

PRESCRIPTION DRUG BENEFITS.

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

The Plan will not exclude coverage for any prescription drug solely on the basis of the length of time since the drug obtained FDA approval.

Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy or its intermediary that has agreed to accept as payment in full reimbursement from the Plan or its Pharmacy Benefit Manager at the same level as the Plan or its Pharmacy Benefit Manager gives to participating pharmacies.

Step Therapy Protocols.

For some prescription drugs, Optima Health has established step therapy protocols. A Step therapy protocol means a protocol setting the sequence in which prescription drugs are determined medically appropriate for a specified medical condition for a particular patient, and covered under the Plan.

Optima Health has a process in place to review requests for an exception to our step therapy requirements. Our determination will be based on a review of the Member's or prescribing provider's request, supporting rationale and documentation for an exception.

A step therapy exception request may be granted if the prescription drug is covered under the Member's current health plan; and the prescribing provider's submitted justification and supporting clinical documentation are determined to support the prescribing provider's statement that:

- The required prescription drug is contraindicated;
- The required drug would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
- The patient has tried the step therapy-required prescription drug while under their current or a previous health benefit plan, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or
- The patient is currently receiving a positive therapeutic outcome on a prescription drug recommended by his provider for the medical condition under consideration while on a current or the immediately preceding health benefit plan.

Optima Health will respond to a step therapy exception request within 72 hours of receipt, including hours on weekends. We will confirm that the request is approved, denied, or requires supplementation or additional information. In cases where exigent circumstances exist, We will respond with our decision within 24 hours of receipt, including hours on weekends. A Member may appeal any step therapy exception request denial under the Plan's existing appeal procedures.

NOTICE IN WRITING.

From the Plan to You.

A notice sent to You by the Plan is considered "given" when received by the Subscriber's employer at the address listed in the Plan's records or, if sent directly to You, the notice is considered "given" when mailed to the subscriber's last known address as shown in the Plan's enrollment records. Notices include any information which the Plan may send You, including identification cards.

From You or Your employer to the Plan.

Notice by You or the subscriber's employer is considered "given" when actually received by the Plan. The Plan will not be able to act on this notice unless the subscriber's name and identification number are included in the notice.

LIMITATIONS OF DAMAGES.

In the event a Member or his representative sues the Plan, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any exist under this Evidence of Coverage, the damages shall be limited to the amount of the Member's claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. This policy does not provide coverage for punitive damages, or damages for emotional distress or mental anguish; provided, however, this provision is not intended, and shall not be

construed, to affect in any manner any recovery by You or Your representative of any non-contractual damages to which You or Your representatives may otherwise be entitled.

TIME LIMITS ON LEGAL ACTION.

No action at law or suit in equity shall be brought against the Plan more than one year after the date the cause of action first accrued with respect to any matter relating to this Evidence of Coverage, the Plan's performance under this Evidence of Coverage, or any statements made by an employee, officer, or director of the Plan concerning the Evidence of Coverage or the benefits available.

THE PLAN'S CONTINUING RIGHTS.

On occasion, We may not insist on Your strict performance of all terms of this Evidence of Coverage. This does not mean We waive or give up any future rights We have under this Evidence of Coverage.

CONTINUITY OF CARE.

If a provider leaves the Plan's network, except for cause, the Member may continue to receive care from that provider with a valid referral or authorization from the Plan:

1. For a period of 90 days from the date of the notice of a provider's termination for Members who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider;
2. Through the provision of postpartum care directly related to the delivery for Members who have entered the second trimester of pregnancy at the time of a provider's termination; or
3. For the remainder of the Member's life for care directly related to the treatment of terminal Illness. "Terminally ill" is defined under §1861(dd)(3)(A) of the Social Security Act.
4. The Plan will pay a provider according to the Plan's agreement with the provider existing immediately before the provider's termination of participation.

CONSIDERATION OF MEDICAID ELIGIBILITY PROHIBITED.

The Plan shall not, in determining the eligibility of an individual for coverage, consider the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

The Plan shall not, in determining benefits payable to, or on behalf of an individual covered under the Plan, take into account the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

STANDING REFERRALS FOR SPECIAL CONDITIONS.

For those individuals with special conditions the Plan may, after consultation with the PCP, issue a standing referral to a Plan Specialist, (i) authorized to provide Covered Services and (ii) selected by the individual, to be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral.

Special condition means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, the specialist will be permitted to authorize referrals, procedures, tests, and other medical services related to the initial referral as the individual's PCP would be permitted to provide or authorize.

STANDING REFERRALS FOR CANCER PAIN.

Individuals who have been diagnosed with cancer may be issued a standing referral to a board-certified Physician in pain management or oncologist who is authorized to provide services under the Plan. Some services may require Pre-Authorization by the Plan.

DISCRIMINATION.

The Plan will not unfairly discriminate against an enrollee on the basis of the age, sex, gender identity or status as a transgender individual, health status, race, color, creed, national origin, ancestry, religion, marital status, or lawful occupation of the enrollee, or because of the frequency of utilization of services by the enrollee. However, nothing shall prohibit the Plan from setting rates or establishing a schedule of charges in accordance with relevant actuarial data.

The Plan will not unreasonably discriminate against physicians as a class or any class of providers listed in § 38.2-4312 and § 38.2-3449.1 of the Code of Virginia when contracting for specialty or referral practitioners, provided the plan covers services that the class of providers are licensed to render. Nothing in this section shall prevent a health maintenance organization from selecting, in the judgment of the health maintenance organization, the number of providers necessary to render the services offered by the health maintenance organization, or from limiting certain specialty services to particular types of practitioners, provided these services are within the scope of their license.

THIS IS THE END OF YOUR EVIDENCE OF COVERAGE.

Attachments

Under state and federal law Optima Health Members are entitled to certain information about their health plan benefits. Your employer may be required to provide You additional notices or information about Your coverage rights. On the following pages You will find the following:

Notice of Maternity Coverage (NMHPA)

Under Federal and state law You have certain rights and protections regarding Your maternity benefits under the Plan.

Notice of Coverage for Reconstructive Breast Surgery (WHCRA)

This notice provides information on the Member's rights and availability of benefits for the treatment of mastectomy related services, including reconstructive surgery, prostheses, and physical complications, including lymphedemas under the Plan.

Information on COBRA Continuation of Coverage

This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it. Your employer and not Optima Health is responsible for giving You all the required information and notices about COBRA coverage.

Your Rights Under ERISA

As a participant in the Plan You may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If You or Your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

Notice Of Privacy Practices

Optima Health is part of the Sentara Healthcare integrated health care system. This system is made up of companies owned by Sentara Healthcare. Every member of the Sentara Healthcare family, including Optima Health, must comply with the basic privacy principles found in the "Notice of Privacy Practices." A copy of the notice is attached to this booklet. In the notice there is an explanation of how Optima and Sentara use and safeguard Your personal and medical record information.

Notice Of Protection Provided By Virginia Life, Accident And Sickness Insurance Guaranty Association

This notice provides **a brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

Notice of Insurance Information and Financial Information Practices

This notice will help You understand how We may collect information about You, the type of information that may be collected, and what information may be disclosed about You to the Plan's affiliates and to non-affiliated third parties.

Balance Billing Consumer Rights

This notice will help You understand balance billing protection for Out-of-Network Services.

Notice of Maternity Coverage (NMHPA)

Under Virginia law and under federal law You have certain rights and protections regarding Your maternity benefits under the Plan.

Under federal law known as the **"Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act)** group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Under Virginia State law Your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally.

Notice of Coverage for Reconstructive Breast Surgery (WHCRA)

In the Commonwealth of Virginia and under a federal law known as The Women's Health and Cancer Rights Act of 1998 (WHCRA) We are required to notify You of Your rights related to benefits provided by the Plan in connection with a mastectomy. This notice provides information on the Member's rights and availability of benefits for the treatment of mastectomy related services, including reconstructive surgery, prostheses, and physical complications, including lymphedemas under the Plan.

You should keep this information with Your important health care records. If You have any questions regarding this Notice or the benefits You are entitled to under the Plan please call Member Services at the number listed on Your Plan insurance identification card.

As a Member of the Plan You have rights to coverage to be provided in a manner determined in consultation with Your attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the exclusions, limitations, and conditions including Copayments, Coinsurances, and/or Deductibles set forth in this document. Coverage shall have durational limits, dollar limits, Deductibles and Coinsurance factors that are no less favorable than for physical illness generally.

COBRA Continuation of Coverage

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do *not* need to include this instruction page with the model general notice.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0123.

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or

- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.
How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying

event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Your Rights Under ERISA

ERISA NOTICE

As a participant in the Plan You may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA does not apply to You if Your insurance is through a government, county, church, or school employer. Under ERISA, You are entitled to:

Receive Information about Your Plan and Benefits

You may examine, without charge, at the plan administrator's office and at other specified locations, the plan administrator's documents, including insurance contracts, and a copy of the latest annual report filed by the plan administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. You may obtain, upon written request to the plan administrator, copies of all the plan administrator's documents and other plan information. The plan administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Your spouse or Your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or Your spouse or Your dependents may have to pay for such coverage. Please Review the Continuation of Coverage section in this document for the rules governing Your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in Your interest and in the interest of other plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a group health plan benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your claim for a group health plan benefit is denied or ignored, in whole or in part, You have a right within certain time schedules to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan administrator's office and do not receive them within 30-days, You may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, if for example, it finds Your claim is frivolous.

Assistance with Your Questions

Your Rights Under ERISA

If You have any questions about Your plan, You should contact the plan administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the plan administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

[Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: : https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid Phone 1-800-457-4584
CALIFORNIA – Medicaid	
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 1-916-445-8322 Email: hipp@dhcs.ca.gov	

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

COLORADO – Medicaid	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	W ebsite: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618- 5488 (LaHIPP)	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/indexes.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP P Phone: 1-800-694-3084	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medica l/HIPP-Program.aspx Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
VIRGINIA – Medicaid and CHIP	
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

References to "Sentara," "we," "us," and "our" means the members of the Sentara Healthcare ACE, which is an affiliated covered entity. An affiliated covered entity is a group of organizations under common ownership or control who designate themselves as a single affiliated covered entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The Sentara Healthcare ACE, and its employees and workforce members who are involved in providing and coordinating your health care, are all bound to follow the terms of this Notice. The members of the Sentara Healthcare ACE will share federally protected health information (i.e., your medical information) with each other for treatment, payment, and health care operations as permitted by HIPAA and this Notice. A complete list of the members of the Sentara Healthcare ACE is provided at the end of this Notice.

Our Pledge Regarding Your Protected Health Information

Sentara is committed to safeguarding protected health information about you. We create a record of certain health information related to your health benefit plan administered by certain Sentara entities. We need this information to provide you with quality services and to comply with certain legal requirements.

This Notice applies to all the health information records related to your health benefit plan administered by certain Sentara Health Plans.

We are required by law to:

- Maintain the privacy of your medical information;
- Provide you this Notice describing our legal duties and privacy practices with respect to your medical information;
- Notify you following a breach of your unsecured medical information; and
- Follow the terms of this Notice.

How We May Use and Disclose Protected Health Information About You Without Your Authorization (Permission)

The following sections describe different ways that we may use and disclose your protected health information without your authorization (permission). For each category of uses or disclosures, we will describe them and give some examples. Some medical information, such as certain genetic information, certain drug and alcohol information, HIV information, and mental health information, may be entitled to special restrictions by state and federal laws. We abide by all applicable state and federal laws related to the protection of such medical information. Not every use or disclosure will be listed, but all of the ways we are permitted to use and disclose protected health information about you will fall within one of the following categories.

Treatment: We may use or disclose medical information about you to provide you with medical treatment and/or coordinate with health care providers on treatment for you.

Payment: We may use and disclose your protected health information to make coverage determinations, to coordinate benefits, and to help pay your medical bills submitted to us for payment. For example, we may use your medical information from a surgery you received at a hospital so that the hospital can be paid.

Health Care Operations: We may use and disclose protected health information about you for our health care operations and for certain health care operations of other providers who furnish care to you. These uses and disclosures are necessary to operate our health plans and to make sure that all of our members receive quality services. We may use and disclose protected health information to provide customer services. For example, we may use protected health information about you to review our services, to evaluate the performance of our staff, and to survey you on your satisfaction with our services. We may review and/or aggregate member information to decide what additional services or benefits our health plans should offer, what services are not needed, and whether certain new services are effective. We may combine the protected health information we have about you with other members' protected health information to compare how we are doing and see where we can make improvements in the services we offer.

Business Associates: We may share your protected health information with certain third parties referred to as "business associates." Business associates provide various services to or for Sentara. Examples include billing services, transcription services, and legal services. We require our business associates to sign an agreement requiring them to protect your protected health information and to use and disclose your protected health information only for the purposes for which we have contracted for their services.

Individuals Involved in Your Care or Payment for Your Care: Unless you tell us not to, we may release protected health information about you to individuals involved in your medical care such as a friend, a family member, or any individual you identify. We also may give your protected health information to someone who helps pay for your care. Additionally, we may disclose protected health information about you to your legal representative, meaning generally, a person who has the authority by law to make healthcare decisions for you. Sentara typically will treat your legal representative the same way as we would treat you with respect to your medical information.

Communications with You: We, or our Business Associates, may contact you via telephone, email, or text message about your treatment, care, or payment related activities. As an example, we may remind you that you have an appointment for medical care and provide information about treatment. We or our Business Associate may also use your protected health information to communicate with you about health-related benefits or services that may be of interest to you, such as available immunizations.

If you provide us with your email address and/or phone number, you acknowledge that we, or our Business Associates, may exchange protected health information with you by email, text, or phone call. These messages may be sent using automated dialing and/or pre-recorded messages. You agree we can communicate with you through these methods via phone calls, emails, text messages, or other means based on the contact information you have on file with us. You also understand and agree that communication via email and text or are inherently unsecure and that there is no assurance of confidentiality of information communicated in this manner. You agree that you are the user and/or subscriber of the e-mail address and/or phone number provided to us, and you accept full responsibility for e-mails, phone calls, and/or text

messages made or sent to or from this e-mail address or phone number. If you prefer not to exchange protected health information via email, text or over the phone, you can choose not to communicate with us via those means by notifying the Privacy Officer (see contact information at the end of this Notice).

As Required or Permitted by Law: We will disclose medical information about you when required to do so by federal and/or state law. This includes sharing information with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Legal Proceedings, Lawsuits and Other Legal Actions: We may disclose protected health information about you to courts, attorneys, court employees, and others when we receive a court order, subpoena, discovery request, warrant, summons, or other lawful instructions. We also may disclose protected health information about you to those working on Sentara's behalf in a lawsuit or action involving Sentara. We may also disclose information for law enforcement purposes as required by law or in response to a valid subpoena, summons, court order, or similar process.

Incidental Disclosures: There are certain disclosures of protected health information that may occur while we are providing service to you or conducting our business. We will make reasonable efforts to limit these incidental disclosures.

Additional Uses and Disclosures of Your Protected Health Information Without Your Authorization (Permission)

We may use and disclose your protected health information in the following special situations:

- **Disaster-Relief Efforts:** We may disclose protected health information about you to an organization assisting in a disaster-relief effort so that your family can be notified about your condition, status, and location. If you do not want us to disclose your protected health information for this purpose, you must tell your caregivers so that we do not disclose this information unless we must do so to respond to the emergency.

- **To Avert a Serious Threat to Health or Safety:** We may use and disclose protected health information about you to help prevent a serious and imminent threat to your health and safety or the health and safety of the public or another person.

- **Military:** If you are a member of the armed forces, domestic (United States) or foreign, we may release protected health information about you to the military authorities as permitted or required by law.

- **Workers' Compensation:** We may disclose protected health information about you for workers' compensation or similar programs as permitted or required by law.

- **Coroners, Medical Examiners and Funeral Directors:** We may disclose protected health information about you to a coroner, medical examiner, or funeral director as necessary for them to carry out their duties.

- **National Security and Intelligence Activities:** We may disclose protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities as permitted or required by law.

- **Protective Services for the President of the United States and Others:** We may disclose protected health information about you to authorized federal officials so they may conduct special investigations or provide protection to the President of the United States, other authorized persons, or foreign heads of state as permitted or required by law.

- **Inmates:** If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release protected health information about you to the correctional institution or law enforcement officials as permitted or required by law.

How We May Use and Disclose Protected Health Information About You Upon Your Written Authorization (Permission)

Marketing: We must obtain your written permission to use or disclose your protected health information for marketing purposes except in certain circumstances. For example, written permission is not required for face-to-face encounters involving marketing, or where we are providing a gift of nominal value (for example, a coffee mug), or a communication about our own services or products (for example, we may send you a postcard announcing the arrival of a new surgeon or x-ray machine).

Sale of Protected Health Information: We must obtain your written permission to disclose your protected health information in exchange for remuneration (payment).

Other Uses and Disclosures of Your Protected Health Information Without Your Authorization (Permission): Other uses and disclosures of your protected health information not covered by the categories included in this Notice or applicable laws, rules, or regulations will be made only with your written permission. If you provide us with such written permission, you may revoke it at any time. We are not able to take back any uses or disclosures that we already made in reliance on your written permission.

Your Rights Regarding Protected Health Information About You

You have the following rights regarding your protected health information:

Right to Inspect and Copy: With certain exceptions, you have the right to inspect and/or receive a copy of the protected health information that is used by us to make decisions about your benefits. The exceptions to this are any psychotherapy notes, information collected for certain legal proceedings, and any protected health information restricted by law.

To inspect and/or receive a copy of your medical information, we require that you submit your request in writing to the Health Plan's Members Services. If you are unsure where to submit your request, please contact the Sentara Health Plans Privacy Officer (contact information below). If you request a copy of your medical information, we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. Your request will be fulfilled in a timely manner not to exceed 30 days.

Under certain circumstances, we may deny your request to inspect or copy your protected health information, such as if we believe it may endanger you or someone else. If you are denied access to your protected health information, you may request that another licensed health care professional review the denial. We will comply with the outcome of the review.

Right to Request Confidential Communications: You have the right to request that we use a certain method to communicate with you about Sentara Health Plan matters or that we send Sentara Health Plan information to you at a certain location if the communication could endanger you. For example, you may ask that we send your information by a specific means, such as by U.S. mail only, or to a specified address. If you want us to communicate with you in a certain way, you will need to give us specific details about how you want to be contacted including a valid alternative address. We will not ask you the reason for the request, and we will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have. We require that you submit your request in writing to the Health Plan's Members Services. If you are unsure where to submit your request, please contact the Sentara Health Plan Privacy Officer (contact information below).

Right to Request an Amendment: If you feel that the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the protected health information. To request an amendment, we require that you submit your request in writing and that you provide the reason for the request. You should direct your request to the Health Plan's Members Services. If you are unsure where to submit your request, please contact the Sentara Health Plans Privacy Officer (contact information below). If we agree to your request, we will amend your record(s) and notify you of such. In certain circumstances, we cannot remove what was in the record(s), but we may add supplemental information to clarify. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to an Accounting of Disclosures: You have a right to make a written request to receive a list of the disclosures we have made of your protected health information in the six years prior to your request. The accounting of disclosures you receive will not include disclosures made for treatment, payment, or healthcare operations activities of Sentara Health Plans. Additionally, it will not include disclosures made to you. To request an accounting of disclosures, we require that you submit your request in writing to the Sentara Health Plans Privacy Officer (contact information below). You must state the time period for which you want to receive the accounting, which may not be longer than six years and which may not date back more than six years from the date of your request. You must indicate whether you wish to receive the list of disclosures electronically or on paper.

The first accounting of disclosures you receive in a 12-month period will be free. We may charge you for responding to additional requests in that same period. We will inform you of the costs involved before any costs are incurred. You may choose to withdraw or modify your request at that time.

Right to Request Restrictions: You have the right to request a restriction, or limitation, on the protected health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request. If we agree to your request, we

will comply with your request unless the protected health information is needed to provide you with emergency treatment, or we are required by law to not disclose it.

To request a restriction, you must make your request in writing to the Sentara Health Plans Privacy Officer (contact information provided below) and tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) to whom you want the limits to apply (for example, disclosures to your spouse). We are allowed to end the restriction by providing you notice. If we end the restriction, it will only affect the medical information that was created or received after we notify you.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you have previously agreed to receive this Notice electronically. Copies of this Notice are available by contacting the Sentara Health Plans Privacy Officer (contact information below). This notice is posted on our website and can be downloaded at: www.optimahealth.com.

Right to Receive Notification of a Breach: You have the right to receive written notification of any breach of your unsecured protected health information.

Changes to This Notice: We reserve the right to change this Notice from time to time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any medical information we receive about you in the future. We will post a copy of the current notice on the Sentara Health Plans website at www.optimahealth.com and provide the revised notice, or information about the material change and how to obtain the revised notice in our next annual mailing to members then covered by the plan. Please review the Notice from time to time to ensure you are familiar with our HIPAA privacy practices.

Questions, Requests, or Complaints: If you have questions or believe that your privacy rights have been violated, you may file a complaint with Sentara Health Plans or with the Secretary of the Department of Health and Human Services. To file a complaint with Sentara Health Plans, contact the Sentara Health Plans Privacy Officer. ***You will not be penalized or retaliated against for filing a complaint.***

Sentara Health Plans
Attn: Privacy Officer
4417 Corporation Lane
Virginia Beach, VA 23462
757-552-7485

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

This Notice is effective 01/01/2022 and replaces all earlier versions.

Notice of Privacy Practices

APPENDIX A

AFFILIATES

This Notice of Privacy Practices covers an Affiliated Covered Entity or "ACE". When this Notice refers to the Sentara Healthcare ACE, it is referring to Sentara Healthcare and each of the following subsidiaries and affiliates:

Optima Health Insurance Company
Optima Health Plan
Sentara Health Plans, Inc.
Optima Behavioral Health Services, Inc.
Optima Health Group, Inc.
Virginia Premier Health Plan, Inc.

Virginia Life, Accident and Sickness Insurance Guaranty Association

This notice provides **a brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 In cash surrender and withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 In other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts. is $350,000, except for health benefit plans, for which the limit is Increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.0. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945 http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia]

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Our Privacy Policy

The Plan takes our responsibility to protect the privacy and confidentiality of Your Personal, Privileged, Medical Record, and Financial information very seriously. Our commitment to protecting Your privacy is not new. We have specific policies in place to safeguard information about You and Your family.

We are providing this notice to You to help You understand how we may collect information about You, the type of information that may be collected, and what information may be disclosed about You to the Plan's affiliates and to non-affiliated third parties.

What We Mean By Personal, Privileged, Medical Record, And Financial Information

"Personal Information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical-record information, but does not include (i) privileged information or (ii) any information that is publicly available.

"Privileged Information " means any individually identifiable information that (i) relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual, and (ii) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual.

"Medical-record Information " means personal information that:

1. Relates to an individual's physical or mental condition, medical history, or medical treatment; and
2. Is obtained from a medical professional or medical-care institution, from the individual or from the individual's spouse, parent, or legal guardian.

"Financial Information" means personal information other than medical record information or records of payment for the provision of health care to an individual.

How We Protect Your Information

We treat Your information in a confidential manner. We restrict access to nonpublic personal and financial information about You to those employees and other persons hired by us who need to know the information to provide services to You. Our employees are required to protect the confidentiality of Your information. We maintain physical, electronic and procedural safeguards that comply with applicable laws and regulations to store and secure information about You from unauthorized access, alteration and destruction.

We may enter into agreements with other companies to provide services to us to make services available to You. Under these agreements, the companies must safeguard information about You and they may not use it for purposes other than helping us to improve our service to You.

Why We Collect Information About You

Your Plan needs to know general information about You, such as Your name and the names of Your dependents, Your address, Your age, Your marital status, and other more specific medical information for business purposes, including, but not limited to, processing claims, evaluating eligibility for covered services, administering health benefit plans, educational programs, disease management programs, and other transactions related to Your health care services.

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We may collect and use certain financial information about You such as name, birth date, mailing address, employment, social security number, marital status, and checking account information. We need this type of information to administer Your health benefits, process claims and/or premium payments and collections, market products, and/or as part of our enrollment process.

We get most of this information directly from You on Your Application or other forms. When You completed and signed Your Application for coverage, You authorized Your physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of Your health or Your dependents' health to give to the Plan any such personal medical information for the purpose of underwriting and claims payment.

We may also receive information about You from Your employer, from Your or Your employer's insurance broker, or, if You receive insurance coverage through a governmental program, from local, state or federal agencies or their representatives. In some instances, we may receive coverage information about You from another insurance carrier with which You have insurance (this is done to coordinate payment of Your medical bills.)

Medical Record information and financial information about You in our files is private. We will not give this data or privileged or personal information about You collected or received in connection with an insurance transaction unless You have provided written authorization or as permitted by law.

How We Disclose Personal, Privileged, Medical And Financial Information

To administer Your health coverage we may need to disclose information about You. According to law we may disclose information about an individual collected or received in connection with an insurance transaction, without written authorization, if the disclosure is:

1. To insurers, agents, or insurance support organizations. Data must be reasonably needed for them or us: (a) to detect or prevent a crime, fraud or material misrepresentation or nondisclosure; or (b) to perform our or their function relating to Your insurance such as determining an individual's eligibility for benefits or payment of claims.
2. To a medical care institution or medical professional for the purpose of: (a) verifying insurance coverage or benefits; or (b) informing You of a medical problem of which You may not be aware; or (c) conducting an operations or services audit.
3. To a state or federal insurance regulatory authority.
4. To a law enforcement authority or other government authority to prevent or prosecute fraud or other unlawful activities.
5. In response to facially valid administrative or judicial order, including a search warrant or subpoena.
6. To those engaged in actuarial or research studies, provided: (a) no names will be used in their report; (b) all data is destroyed or returned to us after use; and (c) no data will be disclosed unless it is authorized by law.
7. To a nonaffiliated third party whose only use of such information will be in connection with the marketing of a nonfinancial product or service, provided: (a) no medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from the information is disclosed (b) the individual has been given the opportunity to indicate that he or she does not want financial information disclosed for marketing purposes and has given no indication that he does not want the information disclosed and (c) the nonaffiliated third party receiving the information agrees not to use it except in connection with the marketing of the product or service.
8. To a group policyholder for reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit.

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9. To a government authority in order to determine eligibility for health benefits for which it may be liable.
10. To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction.
11. Pursuant to any federal Health Insurance Portability and Accountability Act privacy rules promulgated by the United States Department of Health and Human Services.
12. To others as permitted or required by law.

Your Right Of Access To Information

1. You have the right to request access to data about You in our files. Your request must: (a) be sent to us or our agent; (b) be in writing; (c) clearly describe the data You want; (d) clearly describe the purpose for which You want the data; and (e) be for data which we or our agent can reasonably locate and retrieve.
2. We will respond to Your request within 30 business days from the date Your request is received. Our response will: (a) inform You of the nature and substance of the recorded personal information in writing, by telephone, or by other oral communication; (b) permit You the right to see and copy, in person, the recorded personal information pertaining to You or to obtain a copy of the recorded personal information by mail, whichever You prefer, unless the recorded personal information is in coded form, in which case an accurate translation in plain language will be provided in writing; and (c) disclose the identity, if recorded, of those persons to whom we have disclosed the personal information within two years prior to the request, and if the identity is not recorded, the names of those insurance institutions, agents, insurance-support organizations or other persons to whom such information is normally disclosed; (d) give You the rights, as described below, regarding correction, amendment, or deletion of recorded personal information.
3. Medical Record Information supplied by a medical care institution or medical professional and requested by You, together with the identity of the medical professional or medical care institution that provided the information, will be provided to the medical professional designated by You and licensed to provide medical care with respect to the condition to which the information relates. We will notify You, at the time of disclosure, that we have provided the information to the medical professional.
4. We may charge a reasonable fee for providing copies of data in our files.

Your Rights Regarding Correction, Amendment Or Deletion Of Information

1. If You feel data about You in our files is wrong, you can request correction, amendment or deletion. You must make Your request in writing.
2. We will have 30 business days from receipt of Your request to respond. Our response will either: (a) confirm that we have made the changes You asked for; or (b) inform You of our refusal to change our records.
3. If we correct, amend or delete recorded personal information about You we will notify You in writing and furnish the corrections, amendment, or fact of deletion to: (a) any person specifically designated by You who, within the preceding two years, may have received the recorded personal information; (b) any insurance-support organization whose primary source of personal information is insurance institutions if the insurance-support organization has systematically received the recorded personal information from the insurance institution within the preceding seven years. The correction, amendment, or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and (c) any insurance-support organization that furnished the personal information that has been corrected, amended or deleted.
4. If we refuse to change our records, You can send us a written statement for our files. In it, You can state: (a) what You think is the correct, relevant or fair information; and/or (b) why You disagree with our refusal. If You send us such a statement, we will (a) keep it with Your file so that it will be seen by any-one reviewing the file; (b) include it with any data sent to others about You; and (c) send it to anyone described in subsection 3, above.

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5. The above rights do not extend to data connected with or in preparation for a claim or civil or criminal proceeding involving You.

Whom You Should Contact If You Have Additional Questions About This Notice

If You have any questions or comments concerning this Privacy Statement, please contact us by mail at:
Optima Health Member Services
4417 Corporation Lane
Virginia Beach, VA 23462

Balance Billing Consumer Rights

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at in in-network facility, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs,such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference betweenwhat your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocketlimit.

"Surprise billing" or "balance billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stablecondition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network facility
When you get services from an in-network facility, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, laboratory, surgeon and assistant surgeon services, and professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers can't balance bill you and can't ask you to give up your protectionsnot to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balancebill you, unless you give written consent and give up your protections.

You're <u>never required</u> to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Balance Billing Consumer Rights

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you believe you've been wrongly billed, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**.

Visit cms.gov/nosurprises for more information about your rights under federal law.
Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.