Portsmouth Public Schools

Equity Vantage 3300/0% - HDHP

Health Maintenance Organization (HMO) Group Health Plan

Summary Plan Description

January 1, 2025

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Administrative Information

Important Plan Information:

This Summary Plan Description (SPD) describes Covered Services available to You and Your Dependents as Covered Persons under the Plan. It is Your responsibility as a Covered Person to be familiar with the Plan's Covered Services and other terms and conditions of the Plan. Please refer to the Plan Schedule of Benefits in this SPD for information on Your out-of-pocket Copayment or Coinsurance amounts. These are the amounts that You will need to pay directly to providers when you receive Covered Services.

Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the Covered Person is entitled to them. Except in an Emergency, In-Network Benefits under the Plan are available only when Covered Services are provided by Plan Providers.

When Pre-Authorization is required for a Covered Service it is Your responsibility to make sure all requirements are met prior to receiving the service.

This SPD is intended to help You understand the main features of the Plan. The SPD should not be considered as a substitute for the Plan Document, which governs the operation of the Plan. The Plan Document sets forth all of the details and provisions concerning the Plan and is subject to amendment. If any questions arise that are not covered in this SPD or if this SPD appears to conflict with the Plan Document, the Plan Document will determine how questions will be resolved.

Name of Plan:

Portsmouth Public Schools Equity Vantage 3300/0% - HDHP Plan

Original Plan Effective Date:

January 1, 2015

Restated Plan Effective Date:

January 1, 2025

Type of Plan:

Welfare group health plan

Name and Address of Company or "Plan Sponsor":

Sharon Plummer, Benefits Supervisor
Portsmouth Public Schools
801 Crawford Street, 3rd Floor
Portsmouth, VA 23704
757-398-8488 ext. 14148

Administrative Information

Name, Address and Business Telephone Number of Plan Administrator:

Sharon Plummer, Benefits Supervisor
Portsmouth Public Schools
801 Crawford Street, 3rd Floor
Portsmouth, VA 23704
757-398-8488 ext. 14148

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

Employer Identification Number (EIN):

54-6001517

Plan Number:

3232

Who Pays for Coverage Provided by the Plan (Contribution Source):

The health care coverage under the Plan is paid partly by funds contributed by the Employer or Company and partly by contributions from You as Employee of Company.

Method of Contribution:

Combination of employer and employee.

Plan Year: 2025

The financial records of the Plan are kept on a Plan year basis, which is the twelve month period beginning 01/01/2025 and ending 12/31/2025.

Plan Provider Coordinator and Claims Processing:

The Plan has contracted with Sentara Health Plan ("Sentara"), a Virginia corporation doing business as Sentara Health and located at 1300 Sentara Park, Virginia Beach, Virginia 23464, (757) 552-7100, to provide certain claims processing, health care utilization review, and health care provider coordination services for the Plan Administrator.

Agent for Legal Process:

For disputes arising under the Plan, service for legal process may be made to the Plan Administrator at the address shown above.

Sharon Plummer, Benefits Supervisor
Portsmouth Public Schools
801 Crawford Street, 3rd Floor
Portsmouth, VA 23704
757-398-8488 ext. 14148

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757-398-8488 ext. 14148

Funding For Accumulation of Plan Assets:

The Plan utilizes a fund for the accumulation of assets through which benefits are provided. Benefits are payable directly from assets from a fund established and maintained solely by the Plan Sponsor.

Notice of Opportunity to Enroll with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Portsmouth Public Schools Group Health Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1, 2015 that is the first day of the first plan year beginning on or after September 23, 2010. For more information contact the plan administrator, Sharon Plummer, Benefits Supervisor, Portsmouth Public Schools, 801 Crawford Street, 3rd Floor, Portsmouth, VA 23704, 757-398-8488 ext. 14148.

Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under Portsmouth Public Schools Group Health no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the plan administrator, Sharon Plummer, Benefits Supervisor, Portsmouth Public Schools, 801 Crawford Street, 3rd Floor, Portsmouth, VA 23704, 757-398-8488 ext. 14148.

Patient Protection Disclosure/Choice of a Health Care Provider

Sentara Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Sentara Health Plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator, Sharon Plummer, Benefits Supervisor, Portsmouth Public Schools, 801 Crawford Street, 3rd Floor, Portsmouth, VA 23704, 757-398-8488 ext. 14148.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Portsmouth Public Schools 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 the plan administrator, Sharon Plummer, Benefits Supervisor, Portsmouth Public Schools, 801 Crawford Street, Portsmouth, VA 23704, 757-398-8488 ext. 14148.

Newborns' and Mothers' Health Protection Act of 1996

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).

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires the Plan to notify You of Your rights related to benefits provided by the Plan in connection with a mastectomy. Please retain this notice 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 you Plan insurance identification card.

As a Covered Person under 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; and
- 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.

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 July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

Additional Notices

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
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/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
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.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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.

MB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Privacy Practices Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Privacy Notice which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the Plan Sponsor, will not use or further disclose information ("personal health information or PHI") that is protected by HIPAA except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan Sponsor will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit plan of the Plan Sponsor.

Under HIPAA you have certain rights to see and copy protected health information about you. You have the right to request an accounting of certain disclosures of the information and under certain circumstances, amend the information. You have the right to file a complaint with the Plan Sponsor or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have any questions regarding your rights under HIPAA's privacy rules please consult the Privacy Notice. For a copy of the notice please contact the following:

If you have questions about the privacy of your health information please contact Sharon Plummer, 757-393-8488 ext. 14148

If you wish to file a complaint under HIPAA, please contact Sharon Plummer, 757-393-8488 ext. 14148.

In-Network and Out-of-Network Covered Services

This section explains how the Plan treats Covered Services received from In-Network and Out of Network providers and facilities and includes the following:

- Consumer Notice - "Your Rights and Protections Against Surprise Medical Bills";
- Accessing In and Out of Network Covered Services under the Plan;
- Commonwealth of Virginia Balance Billing Protections for Out-of-Network Services;
- Federal "No Surprises Act" Provisions;
- Continuity of Care With Respect to Termination of Certain Provider or Facility Network Contract Relationships Resulting In Changes in Provider Network Status

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-pocket limit.

"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 stable condition, 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 protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required 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.

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.

ACCESSING IN-NETWORK AND OUT OF NETWORK COVERED SERVICES

Sentara Health Plan 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. Access to a list of the In-Network Plan Providers is provided to Subscribers at the time of enrollment. Members 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 sentarahealthplans.com. All services must be deemed to be, or have been, Medically Necessary and all benefits are subject to the exclusions, limitations, and conditions including Copayments, Coinsurance and/or Deductibles in the Summary Plan Description (SPD) and on the Plan's Schedule of Benefits.

This Plan is a Health Maintenance Organization (HMO) and except in limited situations health care is only Covered when received from an In-Network Plan Provider. In the following situations Covered Services from Out-of-Network Providers are covered under In-Network benefits; and in general 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 Covered Services listed above that are protected from balance billing Members are responsible for In-Network Copayments, Coinsurance and Deductibles which will be applied to In-Network Maximum Out of Pocket amounts. Please see the SPD notice in this section "Your Rights and Protections Against Surprise Medical Bills Plan's" for more information on protections against balance billing.

In all other situations if there is no In-Network Provider available to provide a Covered Service Members must contact the Plan before receiving the service or treatment from an Out-of-Network Provider. We may be able to help find an In-Network Provider; or We may approve a Covered Service 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 a Member sees an Out-of-Network provider without advance approval from the Plan We may deny the claim and the Member may be responsible for the entire cost or all charges for services. Advance approval is not required for Out-of-Network Emergency Services.

COMMONWEALTH OF VIRGINIA BALANCE BILLING PROTECTIONS FOR OUT-OF-NETWORK SERVICES

Your Plan Administrator or employer has completed an attestation with the Virginia State Corporation Commission Bureau of Insurance (the “Commission”) stating that Your Plan has elected to participate in and be bound by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia as well as Chapter 405 of the Virginia Administrative Code “Rules Governing Balance Billing For Out-of-Network Health Care Services.” The attestation opts Your Group Health Plan into Virginia State Balance Billing Protections effective on the first day of Your Plan Year. Please also see the attached Consumer Notice describing balance billing protections. Additionally, note that not all out-of-network providers are subject to these requirements. These protections only apply to those providers that are subject to these Virginia requirements.

These balance billing protections will continue until Your employer chooses to terminate or not renew its election.

The sections related to these balance billing protections are intended to summarize the Virginia law and regulations. In the event there is any difference, including updated guidance by the Commission, the benefits described in these sections shall be interpreted to meet the Virginia law and regulations, and Commission’s guidance.

The following definitions apply when used in this section unless the context clearly indicates otherwise.

"Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable cost-sharing requirements, for a covered service or item rendered by a participating provider or by a nonparticipating provider.

"Arbitrator" means an individual included on a list of arbitrators approved by the commission pursuant to14VAC5-405-50.

"Balance bill" means a bill sent to an enrollee by an out-of-network provider for health care services provided to the enrollee after the provider's billed amount is not fully reimbursed by the carrier, exclusive of applicable cost-sharing requirements.

"Child" 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.

"Clean claim" means a claim (i) that has no material defect or impropriety, including any lack of any reasonably required substantiation documentation, that substantially prevents timely payment from being made on the claim; and (ii) that includes required Internal Revenue Service documentation for the carrier to process payment. A carrier shall notify the person submitting the claim of any defect or impropriety.

"Commercially reasonable payment" or "commercially reasonable amount" means payments or amounts a carrier is required to reimburse a health care provider for out-of-network services pursuant to §§ 38.2-3445.01 and 38.2-3445.02 of the Code of Virginia.
"Commission" means the State Corporation Commission.

"Cost-sharing requirement" means an enrollee's deductible, copayment amount, or coinsurance rate.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

Elective group health plan" means (i) a self-funded group health plan providing or administering an employee welfare benefit plan as defined in § 3(1) of ERISA, 29 USC § 1002(1), that is self-insured or self-funded with respect to such plan and that establishes for its enrollees a network of participating providers, or a self-funded group health plan for local government employees, local officers, teachers, and retirees, and the dependents of such employees, officers, teachers, and retirees; and (ii) elects to participate in the requirements of §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia by notifying the commission in accordance with 14VAC5-405-80.

"Emergency medical condition" means, regardless of the final diagnosis rendered to an enrollee, 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 (i) a medical screening examination as required under § 1867 of the Social Security Act (42 USC § 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 (ii) 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 § 1867 of the Social Security Act (42 USC § 1395dd (e)(3)) to stabilize the patient.

"Enrollee" means a policyholder, subscriber, covered person, participant, or other individual covered by a health benefit plan.

"ERISA" means the Employee Retirement Income Security Act of 1974 (29 USC § 1001 et seq.).

"Facility" means an institution providing health care related services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies,

and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. Health benefit plan" also includes an elective group health plan. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431 of the Code of Virginia.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider" means a health care professional or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Initiating party" means the health carrier or out-of-network provider that requests arbitration pursuant to § 38.2-3445.02 of the Code of Virginia and 14VAC5-405-40.

"In-network" or "participating" means a provider that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing requirements.

"Managed care plan" means a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Network" means the group of participating providers providing services to a managed care plan.

"Offer to pay" or "payment notification" means a claim that has been adjudicated and paid by a carrier or determined by a carrier to be payable by an enrollee to an out-of-network provider for services described in subsection A of § 38.2-3445.01 of the Code of Virginia.
"Out-of-network" or "nonparticipating" means a provider that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.
"Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing requirements for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

"Provider group" means a group of multispecialty or single specialty health care professionals who contract with a facility to exclusively provide multispecialty or single specialty health care services at the facility.

Receipt" means five calendar days after mailing or the date of electronic transmittal.

"Surgical or ancillary services" means any professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

"Written" or "in writing" means a written communication that is electronically transmitted. Paper communication is discouraged.

Balance billing for out-of-network services.

No out-of-network provider will balance bill or attempt to collect payment amounts from an enrollee other than in-network cost sharing amounts show on the Plan Schedule of Benefits for the following Covered Services:

1. Emergency services provided to an enrollee by an out-of-network provider; or
2. Nonemergency services provided to an enrollee at an in-network facility if the nonemergency services involve otherwise covered surgical or ancillary services provided by an out-of-network provider.

An enrollee who receives services described above must pay the in-network cost-sharing requirements shown on the Plan Schedule of Benefits. In-network cost sharing will be determined using the Plan's median in-network contracted rate for the same or similar service in the same or similar geographic area. An enrollee who is enrolled in a high deductible health plan associated with a Health Savings Account or other health plan that prohibits providing first-dollar coverage prior to the enrollee meeting the deductible requirement under 26 USC § 223(c)(2) or any other applicable federal or state law may be responsible for any additional amounts necessary to meet deductible requirements beyond those described under the Plan's in-network benefits, but only to the extent that the deductible has not yet been met and not to exceed the deductible amount.

When a clean claim under this section is received, the Plan will be responsible for:

1. Providing an explanation of benefits to the enrollee and the out-of-network provider that reflects the enrollee cost-sharing requirement;
2. Applying the enrollee's in-network cost sharing requirement and any cost-sharing requirement paid by the enrollee for such services toward the in-network maximum out-of-pocket payment obligation;
3. Making commercially reasonable payments for services other than cost-sharing requirements directly to the out-of-network provider without requiring the completion of any assignment of benefits or other documentation by the provider or enrollee;
4. Paying any additional amounts owed to the out-of-network provider through good faith negotiation or arbitration directly to the out-of-network provider; and
5. Making available to a provider through electronic or other method of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether an enrollee's health benefit plan is subject to the requirements of this section.

If the enrollee pays the out-of-network provider an amount that exceeds in-network cost sharing amounts the out-of-network provider will be responsible for:

1. Refunding to the enrollee the excess amount that the enrollee paid to the provider within 30 business days of receipt of the later of payment or notice that the enrollee's managed care plan is subject to the requirements of this section; and
2. Paying the enrollee interest computed daily at the legal rate of interest stated in § 6.2-301 of the Code of Virginia beginning on the first calendar day after the 30 business days for any un-refunded payments.

Payment to Out-of-Network Providers for Health Care Services

The amount paid to an out-of-network provider for health care services described in this section will be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within 30 calendar days of receipt of a clean claim from an out-of-network provider, the Plan will offer to pay the provider a commercially reasonable amount. Disputes between the out-of-network provider and the Plan regarding the commercially reasonable amount will be handled as follows:

1. If the out-of-network provider disputes the carrier's payment, the provider shall notify the carrier in writing and negotiate in good faith no later than 30 calendar days after the earlier of receipt of payment or payment notification from the carrier; and
2. If the carrier and provider do not agree to a commercially reasonable payment amount within the good faith negotiation period and either party acts within the required timeframes to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration as provided in § 38.2-3445.02 of the Code of Virginia and 14VAC5-405-40. A carrier may not require a provider to reject or return claim payment as a condition of pursuing further arbitration.

FEDERAL NO SURPRISES ACT PROVISIONS

The Plan acknowledges that some provisions of the No Surprises Act of the Consolidated Appropriates Action, 2021 and its associated regulations are proposed, interim final, delayed in enforcement, and/or forthcoming and that they may impact services related to this Group Health Plan. Services under this section of the SPD are subject to final regulation under 29CFR Part 2590 including the following sections of the No Surprises Act:

§ 2590.716-1 Basis and scope.
§ 2590.716-2 Applicability.
§ 2590.716-3 Definitions.
§ 2590.716-4 Preventing surprise medical bills for emergency services.
§ 2590.716-5 Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities.
§ 2590.716-6 Methodology for calculating qualifying payment amount.
§ 2590.716-7 Complaints process for surprise medical bills regarding group health plans and group health insurance coverage.
§ 2590.716-8 Independent dispute resolution process
§ 2590.716-9 [Reserved]
§ 2590.717-1 Preventing surprise medical bills for air ambulance services.
§ 2590.717-2 Independent dispute resolution process for air ambulance services

§ 2590.722 Choice of health care professional.

Surprise Billing Protections

Provisions of the federal No Surprises Act protect participants, beneficiaries, and enrollees in group health plans and group and individual health insurance coverage from surprise medical bills for certain covered services from nonparticipating providers including the following under certain circumstances:

- Emergency services in connection with an emergency medical condition, screening, examination and treatment within capabilities of the provider or facility. This also includes post-stabilization and observation (subject to transferability and notice and consent exception;)
- Non-emergency services provided by non-participating providers at participating health care facilities;
- Air ambulance services provided by non-participating providers

Definitions

Definitions in the No Surprises Act Regulations under 29 CFR Part 2590 § 2590.716-3 Definitions will apply to this section and the Plan as applicable.

Cost-Sharing Amounts:

The No Surprises Act also limits cost sharing for out-of-network services subject to these protections to no higher than in-network levels, requires such cost sharing to count toward any in-network deductibles and out-of-pocket maximums, and prohibits balance billing.

Plan cost-sharing amounts for emergency services provided by out-of-network emergency facilities and out-of-network providers, and certain non-emergency services furnished by out-of-network providers at certain in-network facilities, must be calculated based on one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
- If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law.
- If neither of the above apply, the lesser amount of either the billed charge or the qualifying payment amount, which is generally the plan's or issuer's median contracted rate.

Similarly, cost-sharing amounts for air ambulance services provided by out-of-network providers must be calculated using the lesser of the billed charge or the plan's or issuer's qualifying payment amount, and the cost sharing requirement must be the same as if services were provided by an in-network air ambulance provider.

Members will receive an Explanation of Benefits (EOB) following receipt of Covered Services that will show the amount they must pay out of pocket. The EOB will also include information on

specific services that are protected from balance billing and information on internal and external appeal rights for services where payment is denied.

Determining Out-of-Network Rates and Payment to Providers:

The Plan will make payment, less any cost sharing amounts paid by the member, for Covered Services directly to providers of services under this section. The total amount to be paid to the provider or facility, including any cost sharing, is based on:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
- If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law.
- If there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility.
- If none of the three conditions above apply, an amount determined by an independent dispute resolution (IDR) entity.

Independent Dispute Resolution

The Plan has processes in place to administer the Independent Dispute Resolution process specified under 29CFR Part 2590 sections § 2590.716-8 Independent dispute resolution process and § 2590.717-2 Independent dispute resolution process for air ambulance services as applicable.

Notice and Consent To Be Treated By A Nonparticipating Provider Or Nonparticipating Emergency Facility.

In limited cases, a provider or facility may provide notice to a person regarding potential out-of-network care, and obtain the individual's consent for that out-of-network care and extra costs including balance billing. However, this exception does not apply in certain situations when surprise bills are likely to happen, like for specified ancillary services connected to non-emergency care, such as anesthesiology or radiology services provided at an in-network healthcare facility.

Complaint Process For Balance Billing Regarding Providers And Facilities

Please see the Balance Billing Notices included in this SPD for additional information for assistance with a complaint against a provider or facility.

Continuity of Care With Respect to Termination of Certain Provider or Facility Network Contract Relationships Resulting In Changes in Provider Network Status

The Plan will allow certain patients the opportunity to continue care if their provider or facility is "terminated" from the Plan's provider network. Members who are a "continuing care patient" will have an opportunity to request to continue to have services provided under the same terms and conditions as they would have been covered had no change occurred. If approved coverage will continue until the earlier of 90 days following the Plan's notice to the Member or the date on which the Member is no longer a "continuing care patient" of the provider or facility.

The following definitions apply to this section:

Continuing care patient. The term ‘continuing care patient’ means an individual who, with respect to a provider or facility— ‘‘(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility; ‘‘(B) is undergoing a course of institutional or inpatient care from the provider or facility; ‘‘(C) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; ‘‘(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or ‘‘(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Serious and complex condition. The term ‘serious and complex condition’ means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage— ‘‘(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or ‘‘(B) in the case of a chronic illness or condition, a condition that is— ‘‘(i) is life-threatening, degenerative, potentially disabling, or congenital; and ‘‘(ii) requires specialized medical care over a prolonged period of time.

Terminated. The term ‘terminated’ includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.’’

HDHP
Sentara Health Administration, Inc.
Sentara Vantage Equity 3300/0%
Portsmouth Public Schools
Plan Effective Date: 01/01/2025
Large Group Benefit Summary

This document is not a contract or health plan policy from Sentara. If there are any differences between this Benefit Summary and the Plan coverage documents issued when You are enrolled, the provisions of the coverage documents will prevail for all benefits, conditions, cost sharing, and limitations and exclusions.

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. 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 or an air ambulance 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.

For the services above, Members are only responsible for applicable In-Network Copayments, Coinsurance and Deductibles which will be applied to In-Network Maximum Out-of-Pocket Amounts. Members are protected from balance billing for these services.

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.

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

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

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	**Out-of-Network**
Deductible Plan Year	$3,300/Individual; $6,600/Family	Not Covered

Most amounts You pay for 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.

	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$6,000/Individual; $12,000/Family	Not Covered

Most amounts You pay for In-Network Covered Services will count toward meeting the In-Network Maximum Out-of-Pocket Amount.

The following will not count toward the 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 Drug 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.

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

Benefit	In-Network	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 approved Plan providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	After Deductible No Charge	Not Covered
Virtual Consult	After Deductible No Charge	Not Covered
Specialist Visit	After Deductible No Charge	Not Covered
Vaccines and Immunotherapeutic Agents This does not include routine immunizations Covered under Preventive Care.	After Deductible No Charge	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	Not Covered
Outpatient Therapies and Services You pay a Copayment or Coinsurance amount for each visit at a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home. For home visits the Home Health Visit limit will apply instead of the Therapy Services limits listed below. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services if You get that care as part of the Hospice or Early Intervention benefit, or as part of a treatment plan for Autism Spectrum Disorder. Visit limits do not apply to outpatient or home health habilitative or rehabilitative therapy services for mental health conditions or substance use disorders. For Mental Health conditions or Substance Use Disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Plan year. Habilitative Services limited to 30 combined visits per Plan year.	After Deductible No Charge	Not Covered
Speech Therapy* Services limited to 30 visits per Plan year. Habilitative Services limited to 30 combined visits per Plan year.	After Deductible No Charge	Not Covered
Cardiac Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered

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

Benefit	In-Network	Out-of-Network
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
Vascular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
Vestibular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
IV Infusion Therapy	After Deductible No Charge	Not Covered
Respiratory/Inhalation Therapy	After Deductible No Charge	Not Covered
Chemotherapy and Chemotherapy Drugs*	After Deductible No Charge	Not Covered
Radiation Therapy	After Deductible No Charge	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.	After Deductible No Charge	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	After Deductible 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*	After Deductible No Charge	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. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Diagnostic Procedures	After Deductible No Charge	Not Covered
X-Ray **Ultrasound** **Doppler Studies**	After Deductible No Charge	Not Covered
Lab Work	After Deductible No Charge	Not Covered

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

Benefit	In-Network	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. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
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 No Charge	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	After Deductible No Charge for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
Inpatient Services		
Inpatient Hospital Services*	After Deductible No Charge	Not Covered
Transplants* Covered at contracted facilities only.	After Deductible No Charge	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Plan year.	After Deductible No Charge	Not Covered
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay a Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Water and Ground Services Non-Emergent Transportation*	After Deductible No Charge	Not Covered
Air Ambulance Services Non-Emergent Transportation*	After Deductible No Charge	After Deductible No Charge

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

Benefit	In-Network	Out-of-Network
Emergency Services Includes medical and mental health and substance use disorder 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 and independent freestanding Emergency Department, In-Network or Out-of-Network.		
Emergency Services	After Deductible No Charge	After Deductible No Charge
Emergency Ambulance	After Deductible No Charge	After Deductible No Charge
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. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	After Deductible No Charge	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 Plan providers. ***Pre-Authorization is required for Inpatient Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**		
Inpatient Hospital Services*	After Deductible No Charge	Not Covered
Residential Treatment Services*	After Deductible No Charge	Not Covered
Outpatient Office Visits (PCP and Specialist)	After Deductible No Charge	Not Covered
Outpatient Office Visits (Virtual Consult)	After Deductible No Charge	Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	After Deductible No Charge	Not Covered
Other Outpatient Services	After Deductible No Charge	Not Covered
Autism Spectrum Disorder* Covered Services include diagnosis and treatment of Autism Spectrum Disorder in children from age two through ten.	Cost sharing determined by the type and place of service.	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 5 visits from Plan Employee Assistance providers per presenting issue as determined by treatment protocols.	

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

Benefit	In-Network	Out-of-Network
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating Vision Services Plan (VSP) provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps*	After Deductible No Charge	Not Covered
Pump Infusion Sets and Supplies*	After Deductible No Charge	Not Covered
Testing Supplies Includes test strips, lancets, lancet devices, Blood Glucose Meters and control solution, and Continuous Blood Glucose Monitors, sensors, and supplies. ***Pre-Authorization is required for talking Blood Glucose Meters**	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	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	After Deductible No Charge	Not Covered
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible No Charge	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 No Charge	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.	Not Covered
Home Health Care Includes skilled home health care services. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services for mental health conditions and substance use disorders.		
Home Health Care* Limited to a maximum of 100 visits per Plan year.	After Deductible No Charge	Not Covered

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

Benefit	In-Network	Out-of-Network
Private Duty Nursing		
Private Duty Nursing* Includes services provided by an RN or LPN in the home. Limited to 16 hours per Plan year.	After Deductible No Charge	Not Covered
Hospice Care		
Hospice Care*	After Deductible No Charge	Not Covered
Vision Care The Plan contracts with Vision Services Plan (VSP) to administer this benefit. Services must be received from Vision Services Plan (VSP) providers.		
Vision Exams Limited to one routine eye exam every 12 months from a participating VSP provider.	No Charge	Members will be reimbursed up to $30 for one routine eye exam only
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.	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.	Not Covered
Allergy Care		
Allergy Care, Testing, and Serum	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.	Not Covered

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

Prescription Drugs
LG_MDA_15_40_50_20%

This document describes Your Plan's outpatient prescription drug Coverage for medical and mental health and substance use disorder treatment. 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 31-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 31-day supply and can be delivered to Your home address from the Plan's specialty mail order drug pharmacy.

This formulary is organized into the following tiers which will 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;
6. Medications subject to restricted distribution by the U.S. Food and Drug Administration; and

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

7. Medications that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

Specialty Drugs are only available through a Plan Specialty Pharmacy including specialty pharmacy Proprium Pharmacy at 1-855-553-3568 and are limited to a 31-day supply. 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 Plan ID Card. You can also log onto sentarahealthplans.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 number 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. If Your doctor increases the amount of Your dosage, you will be able to refill Your prescription at the newly prescribed dosage.

Deductibles, Maximum Out of Pocket Amount (MOOP), and Benefits	
Deductibles	You must meet the medical Deductible listed on Your Plan document before Coverage for Tier 1, Tier 2, Tier 3, and Tier 4 drugs begin.
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	You pay the cost sharing for the applicable Tier. A Member's cost sharing payment for a covered insulin drug will not exceed $50 per 31-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. Deductible does not apply.
Diabetic Testing Supplies including Blood Glucose Meters, test strips, lancets, lancet devices, and control solution	After Deductible 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.
Continuous Blood Glucose Monitors, Sensors and Supplies	After Deductible No Charge
Formulary	This Plan has a closed formulary and Covers a specific list of drugs and medications. If Your drug is not on Our formulary, We have a process in place to request Coverage. Please use the following link to see a list of drugs on the Plan's formulary: sentarahealthplans.com/members/manage-plans/employer-group-prescription-drug-lists. 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.

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

Retail Pharmacy Cost Sharing When You pick up Your drug at a retail pharmacy You will pay the Copayment (one Copayment for each 31-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 31-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 a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 31-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.
Other Preventive Drugs HSA Includes outpatient prescription drugs that are considered by the Plan to be preventive care. Please use this link for a list of drugs under this benefit: Equity Preventive Drug Lists - Preventive Class.	You pay the cost sharing for the applicable Tier. Deductible does not apply.
Preferred Generic Drugs **Tier 1**	After Deductible You Pay $15
Preferred Brand & Other Generic Drugs **Tier 2**	After Deductible You Pay $40
Non-Preferred Brand Drugs **Tier 3**	After Deductible You Pay $50
Specialty Drugs **Tier 4**	After Deductible You Pay 20% up to a maximum Copayment of $200.

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 a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 31-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.
Other Preventive Drugs HSA Includes outpatient prescription drugs that are considered by the Plan to be preventive care. Please use this link for a list of drugs under this benefit: Equity Preventive Drug Lists - Preventive Class.	You pay the cost sharing for the applicable Tier. Deductible does not apply.
Preferred Generic Drugs **Tier 1**	After Deductible You Pay $45
Preferred Brand & Other Generic Drugs **Tier 2**	After Deductible You Pay $120
Non-Preferred Brand Drugs **Tier 3**	After Deductible You Pay $150
Specialty Drugs **Tier 4**	After Deductible You Pay 20% up to a maximum Copayment of $200.

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 month 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.

Section 1 Definitions

For purposes of this Summary Plan Description (SPD) and any enrollment application, questionnaire, form or other document provided or executed in connection with Coverage under this document, the following terms shall have the meanings given them in this section unless the context requires otherwise:

ACCIDENT/INJURY means physical damage to a Covered Person'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. However, if proof, acceptable to the Plan, is furnished to the Plan that a Covered Person covered under a Workers' Compensation law, or similar law, is not covered for a particular accident or injury under such law, then such accident or injury shall be considered "non-occupational," regardless of its cause.

ADMISSION means registration as a patient at a Hospital. For purposes of determining the applicability of Deductibles and Copayments, successive inpatient admissions for the same or a related cause will be considered one admission unless separated by a period of at least 30 days.

ADVERSE BENEFIT DETERMINATION means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. Adverse Benefit Determination also means a Rescission of Coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.)

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 should be paid to a Provider for a Covered Service. When a Covered Person uses In-Network benefits from Plan Providers the Allowable Charge is the Provider's contracted rate with the Plan or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.

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 mean individual review and follow-up for ongoing services.

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, and any subsequent amendments thereto. COBRA provisions apply to groups of more than 20 employees.

COINSURANCE means amounts required to be paid by the Covered Person for certain services covered under this Plan. 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 Covered Person's care while hospitalized.

COORDINATION OF BENEFITS means those provisions by which the Plan Provider or the Plan either together or separately seek to recover costs of health care services provided to a Covered Person in connection with an incident of sickness or Accident, 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 this Summary Plan Description.

COPAYMENT means a specific dollar amount which may be collected directly from a Covered Person as payment for Covered Services covered under this Plan. 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 of the Covered Person to receive those health care benefits of the Plan he or she has chosen, as set forth herein.

COVERED PERSON/MEMBER/ENROLLEE means the Employee, and his/her Dependent(s) who meet the eligibility requirements of the Plan Sponsor, and who are enrolled hereunder.

COVERED SERVICE or COVERED SERVICES means those health services and benefits to which Covered Persons are entitled under the terms of this Summary Plan Description which may be amended by the Plan Sponsor from time to time, and which are rendered while the Covered Person is under the direct care of a Physician.

CUSTODIAL CARE means treatment or services which could be rendered safely and reasonably by a person not medically skilled, 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 spoon, tube or gastrostomy, exercising, dressing;
2. Preparing meals or special diets;
3. Moving the patient;
4. Acting as a companion or sitter;
5. Supervising or administering medication which can usually be self-administered.

"Custodial Care" includes the following care: (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 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 to live outside an institution; and (3) rest cures, respite care and home care provided by family members. The Plan or its designee will determine if a service or treatment is Custodial Care.

DEDUCTIBLE means the dollar amount which a Covered Person is responsible to pay before benefits are payable under the Plan for Covered Services. Such amount will not be reimbursed under the Plan. After any applicable Deductible amount has been paid, benefits for Covered Services will be payable in accordance with the Copayment/Coinsurance rates shown on the Schedule of Benefits.

DEPENDENT(S) means those members of the Employee's family who meet the eligibility requirements of the Plan, and that have been enrolled in the Plan by the Employee, and for whom any required contribution have been received by the Plan.

DIAGNOSTIC SERVICES means services ordered by a provider because of specific symptoms, to diagnose a definite condition or disease. Diagnostic Services include, but are not limited to: a) radiology, ultrasound, nuclear medicine, computer axial tomography (CT scan), and magnetic resonance imaging (MRI); b) laboratory and pathology; and c) EKGs, EEGs, and other electronic diagnostic tests. Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination.

DRUG FORMULARY means a listing of prescription medications which are approved for Coverage by the Plan, subject to the Plan's established procedure, when dispensed by Plan Pharmacies to a Covered Person. When designated by the Plan, a generic equivalent shall be dispensed. The Drug Formulary shall be subject to periodic review and modification by the Plan.

DURABLE MEDICAL EQUIPMENT (DME) means equipment which is a) able to withstand repeated use; b) primarily and customarily used to serve a medical purpose; and c) not generally useful to a person in the absence of an illness or injury. Durable Medical Equipment includes, but is not limited to, renal dialysis equipment, hospital type beds, traction equipment, wheelchairs and walkers.

EMERGENCY MEDICAL CONDITION means a medical condition or behavioral health 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 a condition described in clause (i), (ii), or (iii) of section 1867(e) (1) (A) of the Social Security Act (42 U.S.C. 1395dd (e) (1) (A)). That provision of the Social Security Act, refers to the following conditions: clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

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.

EMPLOYEE means a person who meets all applicable eligibility requirements of the Plan, and whose enrollment has been accepted by the Plan, and whose employee contribution, if any, has been received by the Plan.

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 than an evaluation of safety and efficacy cannot be made; or
4. The drug or device is not approved for marketing by the U.S. Food and Drug Administration (FDA); or
5. The drug, device, or medical treatment is approved as Category B Non-experimental/Investigational by the U.S. 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, alcohol or drug rehabilitation facilities, mental health treatment centers;
5. Diagnostic, laboratory, and imaging centers; and

6. Rehabilitation and other therapeutic health settings.

GENERIC DRUG/GENERIC PRODUCT LEVEL means a drug is approved by the United States Food Drug Administration (U.S. FDA) as having the same active ingredient as the brand name drug. U.S. 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.

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 patient's home;
2. Is duly licensed, if required, by the appropriate licensing facility;
3. Has policies established by a professional group associated with the agency or organization, including at least one physician and one registered graduate nurse (R.N.) to govern the services provided;
4. Provides full-time supervision of such services by a Physician or by a R.N.;
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 Covered Person in his or her home;
2. Established and approved in writing by his or her attending Physician;
3. Certified, by the attending Physician, as required for the proper treatment of the injury or illness, and
4. In place of inpatient treatment in a Hospital or in a Skilled Nursing Facility.

HOME HEALTH SERVICES shall mean part-time or intermittent care or service provided by a Home Health Care Agency. Such services shall consist primarily of medical or therapeutic caring for the patient and shall provide for the care and treatment of the Covered Person in his or her home under a Home Health Care Plan.

HOSPICE SERVICES means a coordinated program of home and inpatient care including palliative and supportive physical, psychological, psychosocial and other Covered 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 Health Care Organizations; or
2. Is licensed as a hospital under the laws of the jurisdiction where it is located;
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;
4. Provides 24-hour nursing service rendered or supervised by a an R.N.; and
5. 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 in the Summary Plan Description and/or as mandated by state or Federal law. It does not mean

any institution in which the Covered Person receives treatment for which he or she is not required to pay.

ILLNESS means a bodily disorder or infirmity that is not work-related, or a pregnancy. Only a non-occupational Illness (i.e., one that 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 Covered Person covered under a Workers' Compensation law, or similar law, is not covered for a particular illness under such law, then such illness may be considered "non-occupational," regardless of its cause.

IN-NETWORK SERVICES means the level of benefits a Covered Person uses when he or she seeks Covered Services from a Plan Provider.

MAXIMUM OUT OF POCKET AMOUNT or MAXIMUM OUT OF POCKET LIMIT, MAXIMUM, INDIVIDUAL MAXIMUM, or FAMILY MAXIMUM means the total amount a Member and/or eligible Dependent(s) pay during a calendar year as specified on the Plan Schedule of Benefits.

MEDICAL DIRECTOR means a duly licensed Physician or his/her designee who has been appointed by the Plan to monitor the quality and delivery of health care to Covered Persons in accordance with the Summary Plan Description and the accepted medical standards of the 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;
2. In accordance with recognized standards of care for the Member's condition, disease, ailment or injury;
3. Appropriate with regard to standards of good medical practice;
4. Not solely for the convenience of the Member or 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.

MEDICARE means Title XVII of the Act and all amendments thereto.

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

OPEN ENROLLMENT PERIOD means a period of time occurring at least once annually during which time any eligible Employee may join or transfer from once type of health care plan to another.

OUT-OF-NETWORK OR OUT-OF-NETWORK SERVICES means the level of benefits a Member uses when he or she received Covered Services from Non-Plan Providers.

PHYSICIAN means a doctor of medicine or osteopathy who is duly licensed under the laws of the state where the health care service 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. "Physician" does not include (1) an intern; or (2) a person in training.

PLAN means this group health plan which arranges to provide to Covered Persons the health care services that are set forth herein.

PLAN ADMINISTRATOR means the individual or entity identified who is responsible for the operation of the Plan.

PLAN DOCUMENT means a document maintained by the Plan Administrator which describes the terms and conditions of the health care benefits provided by the Plan.

PLAN PHARMACY means a pharmacy which is licensed by the State and is under contract to provide covered prescription drugs to Covered Persons.

PLAN PROVIDER 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 Covered Persons

PLAN SPONSOR/COMPANY means the employer, employee organization or other entity that established and maintains the Plan.

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 to determine that the treatment is being provided at the appropriate level of care.

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 PHYSICIAN (PCP) means the Plan Physician selected by a Covered Person to provide and/or coordinate medical care. Primary Care Physicians include Internists, Pediatricians, Family Practitioners, and other physician specialties as the Plan may designate.

RESCISSION or RESCIND means a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. 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.

RESIDENTIAL TREATMENT SERVICES mean inpatient services for treatment of mental health, and/or substance use disorder, eating disorders and the like provided in a Hospital or treatment facility that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-day nursing care. Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly, and rehabilitation, therapy, education, and recreational or social activities provided by Psychiatrist, Psychologist, Neuropsychologist, Licensed Clinical Social Worker (L.C.S.W.), clinical nurse specialist. Licensed Marriage and Family Therapist (L.M.F.T.), Licensed Professional Counselor (L.P.C.) or any agency licensed by the state to give these services, when we have to cover them by law. Residential Treatment Services will not be covered if the services are merely custodial, residential, or domiciliary in nature.

RETROSPECTIVE REVIEW means the review of the Covered Person's medical records and other supporting documentation by the Plan after services have been rendered to determine whether such services are Covered Services.

SENTARA (SHP) means Sentara Health Plans, Inc., doing business as Sentara Health, which has been contracted by the Plan Sponsor to arrange and coordinate access to health benefits for Covered Persons of the Plan as set forth in the Summary Plan Description.

SERVICE AREA means the geographic area within which the Plan shall arrange for the provision of Covered Services through Plan Providers. Make Consistent with definition of Service Area under the Purchaser Services Agreement.

The Plan Service Area only include the following cities and counties:

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

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 Healthcare 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, an R.N. ; 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.

SUMMARY PLAN DESCRIPTION (SPD) means this document which includes a summary of Covered Services under the Plan.

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 sever 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 outpatient Covered Services which are Medically Necessary in order to prevent a serious deterioration of the Covered Person's health that results from an unforeseen non-life threatening Illness or Injury. Urgent Care Services are subject to Retrospective Review.

USUAL AND CUSTOMARY CHARGES means the lower of the rate which a Provider usually charges for furnishing a treatment, service or supply; or the charge determined to be the general rate charged by others 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 Charges" means the compensation agreed to by the Plan Provider in its contract with respect to Covered Persons. Usual and Customary Charges shall be determined by the Plan.

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

WE/US means Sentara Health Plans, Inc., doing business as Sentara Health Plans, which has been contracted by the Plan Sponsor to arrange and coordinate access to health benefits for Covered Persons of the Plan as set forth in this Summary Plan Description (SPD.)

YOU/YOUR means the Covered Person.

ELIGIBILITY FOR COVERAGE

Eligibility for Covered Services under this Plan is to be determined by the Plan Sponsor/Company in accordance with the terms in this SPD.

Employees. Employees are eligible for Covered Services under this Plan if they are employed by the Plan Sponsor/Company on a regular full-time basis, which is at least twenty-seven and ½ (27.5) hours per week, and reside or work in the Service Area or any grandfathered employee that works 22.5 scheduled hours per week.

Employees must be "actively at work" to receive Covered Services. An Employee is considered actively at work on any day he or she is employed by the Plan Sponsor/Company, meets all the eligibility requirements of the Plan, and premiums are being paid to the Plan on behalf of the eligible Employee. Employees who, for any reason, are not actively at work on the Plan's effective date must wait until they return to being actively at work to receive Covered Services. Absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the Plan as being actively at work. Retired employees, COBRA beneficiary, or Employees receiving Workers' Compensation will be considered actively at work on any day that all of the Plan's eligibility requirements are met and premiums are being paid to the Plan.

If an eligible Employee is no longer actively at work because of one of the following circumstances, and the Plan's Coverage remains in effect, Coverage may continue if premiums are being paid on the Employee's behalf according to the following:

1. For an approved short term leave of absence coverage will continue for not longer than 3 months.
2. For an employee who is totally disabled, coverage will continue for a period of not longer than 6 months. The Plan may require certification of disability from the employee.
3. Also if an employee is part-time yet has qualified for coverage as part of the annual ACA lookback period, they would qualify for coverage under federal law as well.
4. The Family and Medical Leave Act (FMLA). FMLA requires employers of 50 or more employees to give up to 12 weeks of unpaid, job-protected leave to eligible employees for the birth, or adoption of a child or for the serious illness of the employee or a spouse, child or parent.
   Reference the group's FMLA Policy
5. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). According to USERRA any employee called to Active Duty can continue the health care coverage they have for themselves and/or any family members covered under the Plan for up to 24 months.
   Reference the group's USERRA Policy
   Coverage for Employees is effective on the first day of the month following a waiting thirty-day period of one(1) full month of full-time employment, provided that completed enrollment information has been received by the Plan from the Employee or on the Employee's behalf.

Dependents. Dependents must be chiefly dependent upon the Employee for support. The following persons may be eligible to enroll for coverage as a Dependent:

- An Employee's lawful spouse;
- Children up to the age 26. Eligible Children include:
  - Natural or step Children;
  - Legally adopted Children;
  - Children placed with You for adoption;
  - Other Children for whom the subscriber 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 Employee or any other person;
  - Residency with the Employee or any other person;
  - Student status;
  - 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 receiving Dependent coverage.

  Eligibility to age 26 does not extend to a child of a Child receiving dependent coverage unless grandchildren are eligible under the terms of the Plan.

  Coverage will continue for Dependents currently enrolled in the Plan who are twenty six (26) years or older but incapable of self-sustaining support because of mental or physical handicap and is dependent upon the Employee for support and maintenance. A subsequent recertification may be required by the Plan, but not more frequently than annually following the Dependent's twenty first birthday. Such certification is subject to review and approval by the Plan and consists of a statement by a licensed psychologist, psychiatrist, or other Physician to the effect that such Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap. The Plan uses Social Security's definition for “disability” in determining eligibility under this subsection . A Covered Person will be considered disabled if he or she is unable to perform any gainful work found in the national economy. The Covered Person's inability to work is also expected to last for at least a year or to result in death. If for any reason, voluntary or involuntary, the Employee disenrolls, and the incapacitated Dependent reaches the limiting age during the period of disenrollment, then the incapacitated Dependent is no longer eligible upon re enrollment of the Employee.

  Coverage for a newborn Child of an Employee will begin at birth if the newborn is added to the Employee's coverage within thirty-one (31) days of birth. The Employee must submit a completed enrollment form for the newborn and the full applicable contribution, if any, for the month in which the Child is born. If an enrollment application and applicable fees are not submitted within thirty-one (31) days of birth, the newborn may not be enrolled until the Plan's next Open Enrollment Period unless other special enrollment rights apply.

CHANGES IN ELIGIBILITY.

Verification of Eligibility. It is the responsibility of the Employee to verify their eligibility and the eligibility of any Dependents enrolled in the Plan or applying for coverage under the Plan. The Plan and/or SHP reserve the right to request or review at any time, at its sole and absolute discretion, proof of eligibility of any Employee or Dependent. Should SHP or the Plan discover at any time that any Subscriber or Dependent is not eligible for Coverage, never was eligible for Coverage, and/or submitted false proof of eligibility for Coverage, then the Subscriber's/Dependent's Coverage may be canceled. Disenrollment of a Subscriber or Dependent due to ineligibility for Coverage may result in the reversal and/or denial of claims during the period of ineligibility. The Subscriber/Dependent may be held responsible for any charges for claims for services during the period of ineligibility.

Changes in Eligibility. It is the Subscriber's responsibility to notify the Plan and/or SHP of any change in the eligibility status of himself/herself or a Dependent. Coverage for Dependent Children ends when a Dependent Child reaches the limiting age as specified in this document. If the Employee fails to notify the Plan of such changes, upon learning of the change in eligibility the Plan will retroactively terminate Coverage on the last day of the month in which eligible status ceased. The Plan may also seek to recover the usual and customary charge for services provided following such date. The Subscriber must notify the Plan of a divorce in order to be eligible for an continuation of coverage options under the Plan. Disenrollment of a Subscriber or Dependent due to ineligibility for Coverage may result in the reversal and/or denial of claims during the period of ineligibility. The Subscriber/Dependent may be held responsible for any charges for claims for services during the period of ineligibility.

Permissible Family Status Changes. You may make a change in the Coverage of Dependents between Open Enrollment Periods under certain circumstances. You are permitted to change to another Plan or to drop any other benefit in force. You may change Coverage with respect to your Dependents if one of the following events occurs:

Change in legal marital status including marriage, death of spouse, divorce, legal separation, and annulment;

- Change in number of dependents including birth, death, adoption, placement for adoption or court appointed legal guardianship;
- Change in employment status, including a change in worksite; 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;
- Change in Dependents eligibility for Coverage;
- Change in residence of Employee, spouse, or Dependent that effects eligibility.

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 Your present Coverage. For example, marriage is a permissible reason to change from Employee Only Coverage to Family Coverage. On the other hand, the death of a Child has no effect on Your Coverage, if You had a spouse and/or another Child and Family Coverage is in effect. All modifications due to a permissible family status change must be submitted to the Plan Administrator within 31 days of the event.

Qualified Medical Child Support Order (QMCSO). Participants and beneficiaries can obtain, without charge a copy of QMCSO determination procedures from the Plan Administrator. Reference Group's QMCSO policy

ENROLLMENT

Initial Enrollment. During the initial Plan Open Enrollment Period, each eligible Employee shall be entitled to apply for Coverage for himself or herself and for eligible Dependents who must be listed on the enrollment form provided by the Plan.

Newly Eligible Employee. Each new Employee entering employment after the Plan's initial effective date shall be permitted to apply for Coverage for himself or herself and eligible Dependents, within thirty one (31) days of becoming eligible.

Newly Eligible Dependents. Any person attaining eligibility to become a Dependent may be enrolled by the Employee by completing and submitting to the Plan a signed change of enrollment request form within thirty one (31) days of the Dependent's attaining eligibility.

Plan Open Enrollment. A Plan Open Enrollment Period shall be held at least once annually at which time eligible Employees and their eligible Dependents may enroll under the Plan.

HIPAA Special Enrollment Provisions.

The Plan shall provide special late enrollment periods during which eligible, but non-enrolled Employees or Dependents may enroll under the Plan. To be eligible to enroll during a special enrollment period Employees and Dependents must fall into the following categories:

- **Late enrollees with other coverage.** Employees or Dependents who initially decline coverage because they have other health insurance will be allowed to enroll late without evidence of insurability if the following conditions are met:
  - The Employee and/or Dependent must be eligible under the Plan's terms; and
  - The Employee or Dependent was covered under a group plan or had insurance when Coverage was previously offered to that person; and
  - The Employee stated in writing at the time Coverage was previously offered that another source of coverage was the reason for declining Coverage. This paragraph shall apply only if the Plan required such a statement at the time Coverage was previously offered to the Employee and Dependent and provided the Employee with notice of such requirement (and the consequences of such requirement) at that time;
  - The Employee's or Dependent's other coverage described above:
    i. was under a COBRA continuation provision and the coverage under such provision was exhausted, or
    ii. was not under a COBRA provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and
  - The Employee requests enrollment within thirty-one (31) days after the date of exhaustion of coverage described in (d) (i) above or termination of coverage or employer contribution described in (d) (ii).

- **Late enrollees due to marriage, birth, adoption, or placement for adoption.** An eligible Employee who could have applied for coverage during a Plan Open Enrollment Period or when first satisfying the requirements to be a Covered Person, but did not do so, may enroll himself or herself and his or her eligible Dependents under the Plan when an individual becomes the Employee's Dependent through marriage, birth, adoption or placement for adoption. In the case of birth or adoption of a child, the spouse of the Employee may be enrolled as a Dependent if such spouse is otherwise eligible for Coverage. The Employee must request late enrollment for himself or herself and his or her Dependents within thirty-one (31) days from the date of the marriage, birth, adoption or placement for adoption.
- **Special enrollment for employees and dependents that lose eligibility under Medicaid or CHIP coverage**. Employees or Dependents who are eligible for group coverage will be permitted to enroll late if they lose eligibility for Medicaid or CHIP coverage or 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.

The Plan is not required to allow special enrollment if the Employee or Dependent lost eligibility for prior coverage because of failure to pay premiums on a timely basis or was terminated for cause (such as making a fraudulent claim or intentionally misrepresenting a material fact in connection with coverage).

EFFECTIVE DATE OF COVERAGE

Subject to the Plan's receipt of enrollment information, any required premium contribution, and the provisions of this SPD, Coverage shall become effective on the earliest of the following dates:

- **Employees Coverage.** When an Employee makes written application for Coverage on or prior to the date he/she satisfies the eligibility requirements, Coverage shall be effective as of the date the eligibility requirements are satisfied. When an Employee makes written application for Coverage after the date he/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.

- **Effective Date of Dependent Coverage.** Coverage under the Plan for eligible Dependents will become effective on the later of: the date the Employee's Coverage becomes effective provided that the eligible dependent was included on the enrollment form completed by the Employee; or on the date the Employee acquires eligible Dependents, provided notification to the Plan is within enrollment guidelines and any required Coverage contribution has been paid on their behalf.

- **Newborn Children.** A newborn Child of the Employee will be covered from the moment of birth if the newborn is added to the Employees Coverage within thirty-one (31) days of birth.

- **Adopted Children**. Coverage for a Child adopted by the Employee or placed for adoption with the Employee will become effective from the effective date of the adoption

or placement for adoption if the child is added to the Employees Coverage within thirty-one (31) days of adoption or placement for adoption.

- **HIPAA Special Enrollment Periods Effective Dates.**
  - Coverage is generally effective no later than the first day of the first calendar month after the date the Plan receives a completed request for enrollment.
  - For special enrollment due to birth, adoption or placement for adoption late Coverage is effective on the date of the birth, adoption or placement for adoption.
  - For special enrollment due to marriage late Coverage 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.

- **Qualified Medical Child Support Order (QMCSO).** Coverage mandated by court order issues, including Qualified Medical Child Support Orders (QMCSO) as defined by federal law, will begin on the effective date of the court order if the request is made and an enrollment application is submitted within thirty-one (31) days of the order.

HOW BENEFITS ARE PAYABLE

The Plan Administrator, or parties acting for it, shall have the authority to make all determinations that are required for administration of this Summary Plan Description, and to construe and interpret the Summary Plan Description whenever necessary to carry out its intent and purpose and to facilitate its administration. All such determinations, constructions and interpretations made by the Plan shall be binding upon the Covered Person.

All benefits for Covered Services are subject to the Pre-authorization procedures, exclusions, limitations, and conditions including applicable Copayments, Coinsurance and/or Deductibles set forth herein.

Composition of Provider Network

Plan Providers include Physicians, Hospitals, Skilled Nursing Facilities, urgent care centers, laboratories, or any other duly licensed institution or health professional under contract to provide professional and hospital services to Covered Persons.

A list of Plan Providers and their locations is available to each Covered Person free of charge upon enrollment or upon request. Such list shall be revised from time to time as necessary. A Plan Provider's contract may terminate, and a Covered Person may be required to utilize another Plan Provider for Covered Services.

Primary Care Providers

Each Covered Person must designate a Primary Care Physician from the Plan's list of participating providers to provide and/or coordinate Covered Services. Primary Care Physicians include Internists, Pediatricians, Family Practitioners, and other physician specialties as the Plan may designate. Such list shall be revised from time to time as necessary. A Primary Care Physician's contract may terminate, and a Covered Person may be required to designate and utilize another Primary Care Physician.

Specialty Care Providers

A referral from the Covered Person's Primary Care Physician is not required for specialty care from a Plan Specialist.

PRE EXISTING CONDITIONS WAITING PERIODS

There are no preexisting condition waiting periods.

DEDUCTIBLES

A Deductible is the dollar amount which a Covered Person is responsible to pay before Covered Services are payable under this Plan. This amount will not be reimbursed under this Plan. The deductible applies to all covered medical expenses unless otherwise noted on the Plan Schedule of Benefits.

The Deductible under this Plan is found in the Schedule of Benefits.

MAXIMUM BENEFIT

Maximum Benefit means the total amount of benefits payable for a Covered Service. Maximum benefit amounts are listed on the Schedule of Benefits.

MAXIMUM OUT OF POCKET AMOUNT

Maximum Out of Pocket Amount means the total amount a Covered Person pays during a calendar year. The Plan maintains a record of payments made by the Covered Person. Once a Covered Person's payments reach the maximum allowable amount for a calendar year, no further payments will be required for that year except for those excluded Copayments or Coinsurance amounts listed on the Plan Schedule of Benefits. The Plan will notify the Covered Person within 31 days after the maximum limit has been reached. The Maximum Out of Pocket Amount for the Plan is listed on the Schedule of Benefits.

Wellness and Disease Management Programs

The Plan offers disease management programs designed to help improve health for Plan Members with specific health conditions. All of our programs are designed to give Members opportunities to improve health. If the Plan includes Wellness or Disease Management Programs Members may be eligible to earn rewards for completing certain activities, or by participating in programs that are available under the Plan.

In most cases The Plan will contact Members with details about programs that they are eligible to participate in. Members should always check with their regular doctor first; and should continue to see a doctor while enrolled in the wellness program.

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

If a program includes an incentive or reward and a Member completes all of the requirements incentives may include:

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

All of Sentara's wellness programs are voluntary. Rewards will not be based on a health outcome. If a Member decide to participate in a program, or not to participate, it will not affect eligibility to enroll or remain enrolled in the Plan or to receive Covered Services.

This section explains the internal Claim decision processes and how the Plan will determine Medical Necessity for payment of a Claim. The Plan uses 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. The Plan has instructions and procedures in place for providers to obtain Pre-Authorization.

Pre-Authorization is an evaluation process the Plan uses 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 Covered Person being eligible for Covered Services on the date the Covered Service is received.

On Your Schedule of Benefits We tell You what services require Pre-Authorization before You receive them. Generally the following types of services require Pre-Authorization:

- Inpatient hospitalization services;
- Partial hospitalization services;
- Residential treatment 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;
- 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;
- Transplant services;
- Injectable and infused medications, biologics, and IV therapy medications defined by our Pharmacy Committee;
- Intensive outpatient programs (IOP);
- Electro-convulsive therapy;
- Transcranial magnetic stimulation;
- Chemotherapy and Chemotherapy Drugs;
- Radiation Therapy
- Insulin pumps and pump supplies.
- Genetic Testing;
- Other services listed on the Plan Schedule of Benefits.

Organ Transplant

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

Newborn Mother Transfer

Sentara Health Plans 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.

Pre-Service Claims Decisions

A Pre-Service Claim means a Claim for a benefit that requires Pre-Authorization before the Covered Person has the service done.

The Plan makes decisions on Pre-Service Claims within 15 days from receipt of request for the service. The Plan may extend this period for another 15 days if The Plan determines more time is needed because of matters beyond the Plan's control. If the Plan does extend the period the Plan will notify the Covered Person/Provider before the end of the initial 15 day period. If the Plan makes an extension because the Plan does not have enough information to make a decision the Plan will notify the Covered Person/Provider of the specific information missing and the timeframe within which the information must be provided.

When the Plan has made a decision The Plan will send the Covered Person/treating Physician written notice.

Expedited Decisions For Urgent Care Claims

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

The Plan will notify the Covered Person/Provider of our decision not later than 72 hours from receipt of the request for service. If additional information is required to make a decision the

Plan will notify the Covered Person/Physician within 24 hours of receipt of the request. The

Plan will include the specific information that is missing and the applicable timeframes within which to respond.

Concurrent Claims Review and Approval of Care Involving an Ongoing Course of Treatment

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

Post Service Claims

Retrospective Review means our review of the Covered Person's medical records and other supporting documentation after services have been received to determine if the services were Medically Necessary, and if the Plan will pay for them.

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

The Plan will provide the Covered Person and Physician written notice of its decision.

Adverse Benefit Determinations

You have certain rights if the Plan denies a request for Pre-Authorization or make other Adverse Benefit Determinations. The Plan 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.

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 Adverse Benefit Determination Internal and External Appeal Process.

This section explains what services and benefits are Covered under the Plan. All Covered Services must be prescribed or performed by an appropriately licensed Plan Provider or facility, and must be Medically Necessary. All services and supplies are subject to the exclusions, limitations, and conditions of the Plan.

Some services may require Pre-Authorization by the Plan before You receive them. You can read about Pre-Authorization in Section 4 Internal Claims Procedures and Utilization Management.

You will be responsible for a Copayment or Coinsurance depending on the type and place of service. You will usually have to pay Your Copayment or Coinsurance when services are received. If Your plan has a Deductible You will pay that amount before the Plan will pay for Covered Services. Your Copayments, Coinsurance and Deductibles are listed on the Schedule of Benefits in this SPD.

ACCIDENTAL DENTAL SERVICES

Pre-Authorization is required.

The Plan will cover Medically Necessary dental services as a result of Accident/Injury to sound natural teeth, regardless of the date of the Accident/Injury. For Accidents/Injuries that happen on or after Your effective date of Coverage, treatment must be sought within 60 days of the Accident/Injury.

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 Your for amounts in excess of the Plan's fee schedule or allowable charge. The Plan will not cover amounts over Allowable Charges.

The Plan will Cover dental services performed during an Emergency Department visit immediately after an Accident/Injury in conjunction with the initial stabilization of the Injury. The Plan may retrospectively review all Emergency services. You will pay Your Emergency Copayment or Coinsurance.

ALLERGY CARE

The Plan will cover the following allergy care services:

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

AMBULANCE, STRETCHER, & WHEELCHAIR SERVICES

Pre-Authorization is required for non-emergency transportation.

In an Emergency the Plan will cover ambulance services from the place of Accident/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 or loss of limb.

Non-emergent transportation must be pre-authorized by the plan. The Plan 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 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.

Air Ambulance Services

Covered Services 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. The Plan may authorize Coverage of transportation between Hospitals or other facilities if Medically Necessary.

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

- For Covered emergency or non-emergency air ambulance services from Out-of-Network Providers Members are responsible for In-Network Copayments, Coinsurance and Deductibles listed on the Plan's Schedule of Benefits. Member cost sharing will be applied to In-Network Maximum Out-of-Pocket Amounts listed on the Plan's Schedule of Benefits. Members are protected from balance billing for air ambulance services received from Out- of-Network Providers.
- Benefits are available for air emergency transportation to the closes Hospital that can treat You 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.
- 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.
- Air ambulance is not Covered for transportation to other facilities such as a Skilled Nursing Facility, a doctor's office or Your home.

ANESTHESIA SERVICES

The Plan will cover general and regional anesthesia in an inpatient Hospital or outpatient facility. The Plan will cover 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. The Plan will cover the usual 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

Coverage includes 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 licensed in the state in which the psychiatrist 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, the Plan will have the right to request a review of that Treatment, including an independent review, not more than once every 12 months unless the Plan 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.

The Plan 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 they 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 Mental Health and Substance Use Disorder Covered Services.

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

Pre-Authorization is required.

The Plan will 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. Covered Persons 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. Covered Persons 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.

CHEMOTHERAPY, RADIATION THERAPY, IV THERAPY, AND INHALATION THERAPY

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

The Plan will cover Medically Necessary chemotherapy, radiation therapy, IV therapy and inhalation therapy. Therapy services must be prescribed by a physician and performed by a provider properly licensed or certified to provide the therapy service.

CLINICAL TRIALS

Pre-Authorization is required.

Coverage includes Routine patient costs for items and services furnished in connection with participation in an Approved clinical trial if all of the following are true:

- The treatment is being conducted in an Approved clinical trial.
- The Member is a Qualified individual.
- The treatment must be provided by a clinical trial approved by:
  - The National Cancer Institute;
  - An NCI cooperative group or an NCI center;
  - The FDA in the form of an investigational new drug application;
  - The Federal Department of Veterans Affairs; or
  - An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.
- The facility and personnel providing the treatment must be capable of doing so by virtue of their experience, training and expertise.
- All of the following must also be true:
  - There is no clearly superior, non-investigational treatment alternative; and
  - The available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and
  - The Member and the Physician or health care provider who provides services to the Member conclude that the Member's participation in the clinical trial would be appropriate, pursuant to procedures established by the Plan.

Reimbursement for Routine patient costs incurred during participation in clinical trials is determined like other medical and surgical procedures. The Plan does not impose durational limits, dollar limits, Deductibles, Copayments and Coinsurance factors that are less favorable than for physical Illness generally.

The Plan may require that a Qualified individual participate in an Approved clinical trial through a Plan Provider if such provider will accept the individual as a participant in the trial. However, The Plan will not preclude a Qualified individual from participating in an Approved clinical trial conducted outside the state in which the individual resides.

Definitions for this section:

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.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. “Cooperative group” includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

FDA means the United States Food and Drug Administration.

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.

Multiple project assurance contract means a contract between an institution and the Federal Department of Health and Human Services that defines the relationship of the institution to the Federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NCI means the National Cancer Institute.

NIH means the National Institutes of Health.

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 health benefit 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.

DIABETIC EQUIPMENT AND SUPPLIES

The Plan covers equipment and supplies prescribed by a provider for the treatment of these types of conditions:

- Insulin dependent diabetes;
- Gestational diabetes;
- Insulin using diabetes; and

- Non-insulin using diabetes.

The Plan will 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 exam is covered from a Plan Provider at the applicable office visit Copayment or Coinsurance amount.

The Plan does not consider services under this section to be Durable Medical Equipment. These benefits are not subject to any Plan maximum benefit limitations.

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.

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, and Genetic Testing.

The Plan will cover Medically Necessary diagnostic x-ray, 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.

The Plan Covers DME prescribed by an appropriate Physician for the care and treatment of disease and Accident/Injury. The Plan also covers colostomy, iliostomy, and tracheostomy supplies, and suction and urinary Catheters .The Plan will only Cover DME that is Medically Necessary. The Plan does not Cover DME used primarily for the comfort and well-being of a

Member. The Plan does not Cover DME if deemed useful, but not absolutely necessary for Your care. The Plan 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. The Plan 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 The Plan will cover replacement of prosthetic devices for growth if Medically Necessary. This also applies if the Child's condition is from an Accident/Injury or Illness which happened before the Child became a Covered Person under this Plan.

EARLY INTERVENTION SERVICES

Pre-Authorization is required.

The Plan covers 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. The Plan will 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.

The Plan may ask You to provide a copy of the certification. Deductible, Copayment, or Coinsurance amounts apply depending on what type of service is provided.

EMERGENCY SERVICES

If You are experiencing an Emergency, please call 911 or visit the nearest Hospital or independent freestanding Emergency Department for treatment. Emergency Services do not require Pre-Authorization. Emergency Services are Covered as In-Network Services regardless of whether You get care from an In-Network Plan Provider or an Out-of-Network Non-Plan Provider.

Coverage for Emergency Services related to Mental Health Services or Substance Use Disorder Services will be provided in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343.

Emergency Medical Condition means 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 a condition described in clause (i), (ii), or (iii) of

section 1867(e) (1) (A) of the Social Security Act (42 U.S.C. 1395dd (e) (1) (A)). That provision of the Social Security Act, refers to the following conditions: clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her

unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

Emergency Services means, with respect to an emergency medical condition – 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.

Emergency Services do not require Pre-Authorization. The Plan Covers In-Network and Out-of-Network Emergency Services. The Copayment or Coinsurance amount will be determined by the type and place of service associated with the Emergency. The Schedule of Benefits lists the the out-of-pocket Copayment or Coinsurance rate for Emergency Services, Inpatient Hospital Admissions, Ambulance Services and Urgent Care Visits. Emergency Services received Out-of-Network from Non-Plan Providers have the same Copayment or Coinsurance rate as would apply if the Emergency Services were provided In-network from Plan Providers. Cost-sharing amounts paid Out-of-Pocket for Out-of-Network Emergency Care will accumulate toward the Plan's In-Network Deductible and Maximum Out-of-Pocket amounts. Please also see the information notice in this SPD on Balance Billing and consumer protections from surprise bills from Out-of-Network Providers.

You must notify the Plan 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 the Plan because of Your medical condition, have a friend or relative call Us. You can use the number on the back of Your Plan 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.

The Plan 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.

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 After Hours Nurse Triage Program lets Covered Person's 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 Covered Persons where to get medical care on evenings and weekends when the doctor's office is closed. If Medically Necessary, the nurse will send Covered Persons 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. <u>This program is not a substitute for contacting your doctor.</u>

Mobile Crisis Services

Coverage under the Plan includes Mobile Crisis Response Services and Crisis Stabilization Services provided in a Residential Crisis Stabilization Unit or Crisis Receiving Center to the extent that such services are Covered in other settings or modalities, regardless of any difference in billing codes.

Covered Services include:

- Services rendered at a Behavioral Health Crisis Service Provider;
- A Behavioral Health Assessment that is within the capability of a Behavioral Health Crisis Service Provider, including Ancillary Services routinely available to evaluate such Emergency Medical Condition, and
- Such further examination and treatment, to the extent that they are within the capabilities of the staff and facilities available at the Behavioral Health Crisis Service Provider, as required so that the patient's condition does not deteriorate.

Behavioral Health Crisis Service Provider means a provider licensed by the Virginia Department of Behavioral Health and Developmental Services to provide Mental Health or Substance Use Disorder Services as a provider of Mobile Crisis Response, Residential Crisis Stabilization, or a Crisis Receiving Center.

Crisis Receiving Center means a community-based facility licensed by the Virginia Department of Behavioral Health and Developmental Services to provide short-term assessment, observation, and Crisis Stabilization Services.

Mobile Crisis Response Services means services licensed by the Virginia Department of Behavioral Health and Developmental Services to provide rapid response, assessment, and early intervention for individuals experiencing an Acute Mental Health Crisis, deployed to the individual's location.

Residential Crisis Stabilization Unit means a community-based short-term residential program licensed by the Virginia Department of Behavioral Health and Developmental Services to provide short-term assessment, observation, support and crisis stabilization for individuals who are experiencing an Acute Mental Health Crisis.

FAMILY PLANNING SERVICES

The Plan covers 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 (FDA) approved contraceptive methods as required by Women's Preventive Services under ACA recommended preventive care guidelines.
- 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 an 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.

FORMULA AND ENTERAL NUTRITION PRODUCTS

Pre-Authorization is Required.

"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.
- Includes Medically Necessary special food products or supplements when prescribed by a doctor.

The Plan will apply the same cost sharing as other medicines Covered under the Plan.

HEMOPHILIA AND CONGENITAL BLEEDING DISORDERS

Pre-Authorization is required for home treatment.

The Plan covers the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Covered Services include the purchase of Blood Products and Blood Infusion Equipment required for home treatment of routine bleeding episodes associated with Hemophilia and other congenital bleeding disorders when the Home Treatment Program is under the supervision of the State-Approved Hemophilia Treatment Center.

The following definitions apply to services under this section:

Blood Infusion Equipment includes, but is not limited to, syringes and needles.

Blood Product includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.

Hemophilia means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into joints and muscles.

Home Treatment Program means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.

State-Approved Hemophilia Treatment Center means a hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with Hemophilia and other congenital bleeding disorders.

HOME HEALTH CARE SKILLED SERVICES

Pre-Authorization is required.

The Plan Covers Medically Necessary Home Health Care Skilled Services for Covered Persons. See Your Schedule of Benefits for visit limits.

The Plan will only Cover services when they are provided by a certified Home Health Care Agency.

The Plan 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:

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

Home Health Care Plan" means a program:

- For the care and treatment of the Covered Person in his or her home; and
- Established and approved in writing by the attending Physician; and
- 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:

- Part-time or intermittent nursing care by a nurse; or
- Part-time or intermittent home health aide services which consist primarily of medical or therapeutic caring for the patient; or
- Physical, speech, and occupational therapy, if provided by the home health care agency; or
- 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 Covered Person had been confined in a Hospital or Skilled Nursing Facility.

Home Health Skilled Care Visit means:

- Each visit by an R.N. or by an L.P.N. to provide nursing care; or
- Each visit by a therapist to provide physical, occupational, or speech therapy.

Part-time or Intermittent Care means 1 - 4 hours of Medically Necessary care administered in a 24-hour period.

HOSPICE CARE

Pre-Authorization is required.

The Plan will Cover Hospice Services for Covered Persons 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. The Plan will cover palliative and supportive physical, psychological, psychosocial and other health services provided by a medically directed interdisciplinary team.

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

The Plan will cover room and board in a semi-private room including general nursing care, and meals and special diets. The Plan does not cover private duty nursing while in the Hospital.

Other Hospital Services

The Plan will cover other hospital services You received 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.
- 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.

The Plan will 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.

The Plan will 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.

INTERRUPTION OF PREGNANCY SERVICES

Covered Services include services, supplies, and prescription drugs for a therapeutic abortion recommended by a Provider and performed to save the life of the mother, or as a result of incest or rape. The Plan will also Cover elective abortion services, supplies, and prescription drugs.

LYMPHEDEMA

Pre-Authorization is required.

The Plan will 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;

The Plan 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

The Plan will 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 plan's 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. Pre-authorization is not required for delivery.

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.

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

MEDICAL SUPPLIES AND MEDICATIONS

The Plan will cover medical supplies and prescription medications prescribed by Your Plan 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;
- Cancer chemotherapy drugs administered orally and intravenously or by injection.

MENTAL HEALTH/BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Pre-Authorization is required for all inpatient services, partial hospitalization services, intensive outpatient Program (IOP) and electro-convulsive therapy and Transcranial Magnetic Stimulation (TMS).

The Plan may be reached by calling 757-552-7174 or 1-800-648-8420.

Emergency Mental Health and Substance use disorder Services are subject to the same requirements as Emergency Medical Conditions and do not require Pre-authorization. Emergency Services received Out-of-Network from a Non-Plan Provider will not have a Copayment or Coinsurance amount that exceeds the cost-sharing that would apply if the Emergency Services were provided In-Network from Plan Providers.

Inpatient Mental Health and Substance Use Disorder Services

The Plan will cover Medically Necessary inpatient treatment. Covered services include treatment at a general hospital, an inpatient unit of a mental health treatment center or an intermediate care facility.

Outpatient Mental Health and Substance Use Disorder Services

The Plan will cover Medically Necessary outpatient care.

Residential Treatment Facilities/Centers (RTFs or RTCs)

Coverage includes inpatient services for mental health and/or Substance Use Disorder Treatment provided in a Facility licensed to provide a continuous, structured program of

treatment and rehabilitation, including 24 hour-a-day nursing care by, or under the supervision of a registered nurse (RN). Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly. Residential Treatment Services will not be covered if the services are merely custodial, residential, or domiciliary in nature.

Definitions

The following definitions will apply to this section:

Adult means any person who is nineteen years of age or older.

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 or by The Department of Behavioral Health and Developmental Services or (ii) a state agency or institution.

Child or adolescent means any person under the age of nineteen years.

Inpatient Treatment means Mental Health or Substance Use Disorder Services delivered on a twenty-four 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 public or private licensed Residential Facility, outside of a Hospital, that operates with the primary purpose of providing continuous structured twenty-four hour per day Inpatient Substance Use Disorder Services through a state-approved program.

Medication Management Visit means a visit no more than twenty 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 Use Disorder Treatment.

Mental Health Services means treatment for mental, emotional or nervous disorders.

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 Use Disorder Treatment Services rendered to a person individually, or as part of a group, while not confined as an inpatient. Services include diagnosis and treatment of psychiatric conditions including psychotherapy, group psychotherapy, psychological testing, and visits for medication management checks. Treatment also includes services delivered through a Partial Hospitalization or Intensive Outpatient Program, as defined herein.

Partial Hospitalization means a licensed or approved Outpatient 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 that 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 Use Disorder Services means treatment for alcohol or other drug dependence.

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 use disorder treatment practitioner, marriage and family therapist or clinical nurse specialist who renders mental health services. 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 use disorder counselor or substance use disorder 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 Program (EAP)

EAP provides short-term counseling by licensed mental health providers and referral services 24 hours a day, seven days a week. EAP is 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.

At no additional charge to employees, EAP offers access to services not traditionally covered under Mental Health or Substance Use Disorder benefits. These include parent-child conflict, marital counseling, career problems/work place conflicts, stress, and grief. Using EAP will not reduce covered mental health benefits. The EAP will provide referral services for more serious mental health conditions when necessary.

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 Employee Assistance Program at (800) 899-8174 or (757) 363-6777.

In addition to the services described above, EAP offers seminars and workshops designed to help employees increase personal adjustment, mental health, and work productivity. Topics include Parenting, Stress Management, Financial Planning, Elder Care, and others.

ORAL SURGERY

Pre-Authorization is required.

The Plan will cover the following:

- Surgical procedures required to repair Accident/Injury 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;
- 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.

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

OUTPATIENT PRESCRIPTION DRUG COVERAGE

Plan Formulary

This Plan has a closed formulary. That means there is a specific list of Medically Necessary drugs and medications that are Covered. Please use the following link to see a list of drugs on the open formulary: Prescription Drug Lists - Employer Plans | Members | Sentara Health Plans | Sentara Health Plans. You can also call Member Services at the number on Your Plan ID Card to find out if a drug is on the Plan formulary.
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Choosing a Pharmacy to Fill Your Prescription

All drugs must be U.S. FDA Approved and require a prescription. Copayments or Coinsurance must be paid at the time the prescription is filled at the pharmacy. If there is a Plan Deductible, that amount must be met before Coverage begins. Prescription Drug Coverage has specific Exclusions and Limitations listed in Section 6.

Retail Pharmacy

Prescriptions may be filled at a Plan retail pharmacy. The network of participating retail pharmacies includes 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. Call [Express Scripts] at 1-877-728-0179 to find out whether a drug is available.

Specialty Pharmacy

Specialty Drugs are available through a Plan Specialty mail order pharmacy including [Propium Pharmacy at 1-855-553-3568]. Specialty Drugs can be delivered to the Covered Person's home address from a Specialty mail order pharmacy. For questions or to find out whether a drug is considered a Specialty Drug, please call Member Services at the number on the Plan ID Card. A list of Specialty Drugs and Plan Specialty Pharmacy providers can be found by at by logging onto also log onto Manage My Plan | Members | Sentara Health Plans

Pharmacy and Therapeutics Committee

Our formulary is a list of U.S. FDA-Approved medications that are Covered. At its sole discretion, the Sentara 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. The Copayment or Coinsurance amount depends on the Tier of the Drug.

- **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 a local pharmacy.

Medications Requiring Pre-Authorization

The Plan uses a number of tools to determine whether a drug should be Covered. The Plan may limit the amount of some drugs. Some drugs require Pre-Authorization to make sure proper use and guidelines are followed. Physicians are responsible for Pre-Authorization. The Plan will notify You and the Physician of the decision. If Pre-Authorization is denied You have the right to file an appeal. Please see Section 4 on Pre-Authorization and Section 13 on filing an internal or external appeal.

Step Therapy Protocols and Exception Requests

For some prescription drugs, the Plan 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.

The Plan 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.

The Plan will respond to a step therapy exception request within 72 hours of receipt, including hours on weekends. The Plan will confirm that the request is approved, denied, or requires supplementation or additional information. In cases where exigent circumstances exist, The Plan will respond with a decision within 24 hours of receipt, including hours on weekends. An Enrollee 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 U.S. FDA guidelines, clinical literature, and manufacturer's instructions. Physicians may request an exception to the quantity limit.

Refills

There are 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.

Flu Shots and Other Covered Vaccines

The Plan covers flu shots and other vaccines listed on the formulary, including administration at authorized pharmacies.

Special Food Products or Supplements

The Plan covers 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

The Plan Covers self-administered injectable drugs and related supplies and equipment that are available at a retail pharmacies or received 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 a 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.

Women's Contraceptives

Covered Services under the Pharmacy Benefit include U.S. FDA approved Contraceptive Drugs and Devices, including those available over-the-counter. The Plan will not apply individual cost-sharing. However, cost-sharing may be applied to some drugs and devices when at least one Therapeutically Equivalent Version is available under the Plan without cost-sharing. If a health care provider recommends a particular Contraceptive Drug or Contraceptive Device for the

Covered Person, based on a determination of Medical Need, the Plan will provide Coverage for the recommended Contraceptive Drug or Contraceptive Device without cost-sharing. A twelve-month supply of hormonal contraceptives is available at one time if any applicable cost-sharing is paid.

Contraceptive Device means any device or non-drug product that has been approved as a contraceptive by the U.S. FDA.

Contraceptive Drug means any drug approved as a Contraceptive by the U.S. FDA.

FDA means the U.S. Food and Drug Administration.

Medical Need includes considerations such as severity of side effects, difference in permanence and reversibility of a Contraceptive Drug or Contraceptive Device, or an ability to adhere to the appropriate use of such drug or device, as determined by an attending health care provider.

Therapeutically Equivalent Version means a drug or device that has the same clinical effect and safety profile as another drug or device and that meets the criteria for therapeutic equivalence as determined by the U.S. FDA

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

The Plan considers 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 Coverage for a drug included on the formulary has been denied, there is the right to a full and fair appeal of the decision through the Plan's appeal process described later in this Summary Plan Description.

The Plan makes available to Members, Providers and pharmacists the complete, current drug formulary and any updates 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. If a modification to a formulary results in the movement of a prescription drug to a tier with a higher cost-share, the Plan will provide each affected individual Health Benefit Plan Policyholder or Contract Holder with no less than 30 days prior written notice. This notice does not apply to modifications that occur at the time of Coverage renewal.

The Plan has a process in place to allow a Covered Person, designated representative, prescribing physician, or other prescriber to ask the Plan to approve Coverage of a non-formulary drug:

- If, after reasonable investigation and consultation with the prescribing Physician, the Plan determined that the formulary drug is an inappropriate therapy for the Covered Person's Medical Condition.
- The Covered Person has been receiving the specific non-formulary prescription drug for at least six months prior 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 Covered Person; or
- Changing drug therapy presents a significant health risk to the specific Covered Person

The Plan will make a decision on a standard exception request and notify the Covered Person, 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 what would apply for formulary prescription drugs under the Covered benefits.

Any exception request for Coverage of non-formulary drugs can be made by the Enrollee, 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 the doctor send a Medical Necessity Form to Our Pharmacy Authorization Department at PO Box 66189 Virginia Beach, VA 23464 or call 757-552-7540 or 1-800-229-5522.

Expedited Exception Request Based on Exigent Circumstances

Exigent circumstances exist when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health, or ability to regain maximum function, or when a Covered Person is undergoing a current course of treatment using a non-formulary drug. The Plan will reach a decision on an Expedited Exception Request and notify the Enrollee, 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 under the Enrollee's Covered Benefits.

External Exception Request Review

If the Plan denies a standard or expedited request, there is 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 Enrollee, 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 under the Enrollee'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 under the Enrollee's Covered Benefits.

Synchronization of Medication

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 to be in the best interest of the Enrollee, and the Enrollee requests or agrees to a partial supply for the purpose of synchronizing the Enrollee's medications. For prescription drugs Covered under the Plan, a prorated daily cost sharing rate will be applied to prescriptions that are dispensed as a partial supply. Proration will not occur more frequently than annually.

Lost or Stolen Medication

Pre-Authorization is required.

Applicable Copayment, Coinsurance and/or Deductible amounts (if any) will apply. In the following circumstances, an additional 30-day supply of medication may be obtained from the pharmacy:

- The medication was lost; or
- The medication was stolen.

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

The Plan will cover preventive services according to PPACA federal health care reform laws and further defined under related federal regulations with no cost sharing if services are received from In-network Plan Providers according to the following:

- 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
- 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
- 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
- With respect to women, such additional preventive care and screenings 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 screening** 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
- Additional breast cancer screening, mammography, and prevention according to recommendations of the United States Preventive Service Task Force.

(HOME) PRIVATE DUTY NURSE SERVICES

Pre-Authorization is required.

Covered Services include Medically Necessary services of a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the home when the RN or LPN is not a relative or member of Your family. Services that are custodial in nature are not Covered Services.

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 U.S. 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 year when prescribed by a health care provider. Generic medications will be covered with member no out of pocket cost sharing.

PHYSICIAN SERVICES

All Pre-Authorization and referral requirements apply depending on the type and place of service.

The Plan will cover the following physician services:

- Surgical, home, Hospital, and office visits, for diagnosis and treatment of an Accident/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 Non-Plan Provider will be covered only if a Plan Provider is unavailable;
- Virtual Consults when provided by an Sentara Health Plans approved provider;
- Annual school and sports physicals;
- Maternity care and related checkups.

PREVENTIVE CARE SERVICES AND SCREENINGS

Annual Physicals

The Plan will cover one routine physical exam each year. Covered Services also include annual school and sports physicals.

Annual Gynecological (GYN) Exams

The Plan will cover one routine annual GYN exam every 12 months for females 13 years or older. Exams must be with a Plan provider. You do not need a referral from a PCP. The Plan will 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 obstetrical care are not considered routine.

Screening Mammograms

The Plan will one screening mammogram for Covered Persons between the ages of 35 to 39.

The Plan will cover a screening mammogram each year for Covered Persons age 40 and over.

Pap Smears

The Plan will cover annual pap smears including coverage for annual testing performed by any FDA approved gynecologic cytology screening technologies.

Prostate Screening Tests (PSA)

The Plan will cover one PSA test in a 12-month period and digital rectal examinations for Covered Persons over age 50 and Covered Persons over age 40 who are at high risk for prostate cancer.

Colorectal Cancer Screening

The Plan will Cover Colorectal Cancer Screening, examinations, and laboratory tests. Services will be Covered according to the most recently published recommendations established by the U.S. Preventive Services Task Force for colorectal cancer screening for which a rating of A or B is in effect with respect to the individual involved. Services are Covered without Member Copayments, Coinsurance or Deductibles when received from Plan Providers. Covered Services include

- An annual occult blood test;
- Flexible sigmoidoscopy or colonoscopy;
- Radiologic imaging in appropriate circumstances.
- Follow-up colonoscopy, following a positive non-invasive stool-based screening test or direct visualization;
- Polyp removal; and

- Anesthesia, provided in conjunction with preventive or diagnostic colonoscopies.

Routine Hearing Tests

The Plan will cover one annual routine hearing test.

Well Child Care

The Plan will 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;
- 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

The Plan will 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

The Plan will 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;
- Varicella

PREVENTIVE VISION CARE SERVICES
In-Network Coverage.

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

To receive Covered Services:

- Select a participating Vision Service Plan (VSP) network provider from the provider directory on the VSP website at directory@vsp.com, or by calling 1-800-877-7195 to speak with Member Services Monday thru Saturday 9 a.m. to 8 p.m. Eastern Standard Time.
- Visit or call the participating provider and identify yourself as a participant by providing Your Member ID information. The provider will verify eligibility, the Plan's Covered Services and any applicable Copayment or Coinsurance. Payment is due when You receive services.
- If the vision provider determines that additional medical care is needed, contact Your PCP or other physician for treatment options.

Out-of-Network Coverage

If You use a provider that is not in the VSP 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 Schedule of Benefits. For reimbursement call 1.800.877.7195 to speak with Member Services Monday thru Saturday 9 a.m. to 8 p.m. Eastern Standard Time.

PROSTHETIC COMPONENTS AND DEVICES

Pre-Authorization is required for all services.

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

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 Covered Persons who have had a mastectomy the Plan 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;
- Prostheses and physical complications of all stages of mastectomy, including lymphedema.

SKILLED NURSING SERVICES

Pre-Authorization is required.

The Plan will cover care given in a licensed Skilled Nursing Facility. The care must be ordered by a Physician. The Plan will cover semi-private room and board charges and other facility services and supply charges. See the Schedule of Benefits for the maximum number of days per year. Custodial Care is not Covered Service.

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.

The Plan does not cover technical fees or costs that result from the treating or consulting provider's provision of telemedicine services. The out of pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount that would be 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.

The Plan will Cover the following Therapy and Rehabilitation Services:

- Physical Therapy (PT);
- Occupational Therapy (OT);
- Speech Therapy;
- Cardiac Rehabilitation;
- Pulmonary Rehabilitation;
- Vascular Rehabilitation;
- Vestibular Rehabilitation.

See the Schedule of Benefits for benefit limits. All services must be Medically Necessary and done by a provider licensed to perform the services rendered.

The Plan will Cover Physical Therapy only to the extent of restoration to the level of the pre-trauma, pre-Illness, or pre-condition level.

The Plan will Cover Occupational Therapy services which assist the Covered Person to restore self-care and improve functionality in activities of daily living.

The Plan will Cover Speech Therapy that is Medically Necessary to correct an organic impairment of organic origin due to accident or Illness. The Plan will 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. The Plan does 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. The Plan will Cover Therapy and Rehabilitation Services furnished to a Covered Person on an outpatient or inpatient basis, according to a specific written treatment plan that:

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

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.

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]**

THERAPY AND REHABILITATION SERVICES (INCLUDING REHABILITATIVE AND HABILITATIVE PT, OT, ST THERAPY SERVICES)

Pre-Authorization is required.

The Plan will Cover the following therapy and rehabilitation services:

- Physical Therapy (PT);
- Occupational Therapy (OT);
- Speech Therapy;
- Cardiac Rehabilitation;
- Pulmonary Rehabilitation;
- Vascular Rehabilitation;
- Vestibular Rehabilitation.

See the Schedule of Benefits for benefit limits. All services must be Medically Necessary and done by a provider licensed to perform the services rendered.

Rehabilitative PT, OT, ST Services

Rehabilitative Services include therapies and devices to restore and, in some cases, maintain capabilities lost due to disease, Illness, Injury, or, in the case of Speech Therapy, loss due to a congenital anomaly or prior medical treatment. Rehabilitative Services may be provided in a variety of inpatient Facilities and outpatient settings. To be Covered, Rehabilitation Services must involve a Treatment Plan with a specific duration and attainable goals attainable the Covered Person can reach within a reasonable timeframe. Benefits will end when the treatment is no longer Medically Necessary and the Covered Person stops progressing toward those

goals. All services and treatments must be prescribed and supervised by a Physician and performed by a licensed therapist.

Covered Services include:

- Physical Therapy provided by a licensed therapist or other licensed Provider to ease pain, restore health, and avoid disability after an Illness, injury, or loss of an arm or leg including hydrotherapy, heat, physical agents, biomechanical and neuro-physical principles and devices;
- Treatment of Lymphedema;
- Occupational Therapy to restore activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing, and job-related activities;
- Speech Therapy and Speech Language Therapy, including services to identify, assess, and treat speech, language and swallowing disorders in Children and adults; Therapy will treat communication or swallowing difficulties to correct a speech impairment.
- Speech Therapy and Speech Language Therapy services to treat or correct a speech impairment.

Habilitative PT, OT, ST Services

Habilitative Services include services and devices that help a Covered Person keep, learn or improve skills and functioning for daily living, and may be provided in a variety of inpatient and outpatient settings or facilities. Covered Services include:

- Physical and Occupation Therapy provided by a licensed therapist or other licensed provider to keep, learn or improve skills needed for daily living, such as therapy for a Child who is not walking at the expected age;
- Speech therapy and speech language therapy necessary to teach speech;
- Speech Therapy services to develop communication or swallowing skills to correct a speech impairment;
- Speech Therapy to keep, learn, or improve skills needed for daily living, such as therapy for a Child who is not talking at the expected age.

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.

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 care, durable medical equipment, and drug services that are delivered and administered 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.**

TRANSPLANT SERVICES

Pre-Authorization is required.

The Plan will cover Medically Necessary human organ and tissue transplants for Covered Persons who meet Medical Necessity criteria established by the Plan. The Plan does not cover transplants that are experimental. The Plan covers the following transplants:

- Kidney;
- Heart;
- Cornea;
- Liver;
- Lung;
- Heart-lung;
- Kidney-pancreas;
- Bone marrow transplants for leukemia, Hodgkin’s disease, non-Hodgkin’s lymphoma, severe combined immunodeficiency disease, aplastic anemia and Wiskott-Aldrich syndrome;
- Dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for the treatment of breast cancer.

Travel and Transportation

For organ or tissue transplants under this Plan, the Plan may Cover the cost of reasonable and necessary travel and lodging expenses if the facility where the authorized transplant procedure is to be performed is more than 50 miles from the Member’s home and the Plan has Pre-Authorized the costs. 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. Itemized receipts for all travel and lodging costs must be provided to the Plan and the Plan will determine whether expenses are Covered. Covered Services will not include childcare, rental

cars, buses, taxis or other transportation not approved by the Plan; or frequent flyer miles, and any other travel services not related to the transplant.

VIRTUAL CONSULTS

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

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

Vision Therapy

The following information is NOT found on the SOB. Vision Therapy effective is covered for convergence insufficiency. There is a 12 visit limit combined in and out of network. Services are separate from PT/OT/ST.

- Authorization is required
- Services are billed by an Ophthalmologist (Specialist)
- Allowed codes 92065 and 92499.

This chapter lists services that are not covered. Services mean both medical and behavioral health (mental health) services and supplies unless otherwise specifically stated. The Plan does not cover any services that are not listed in this section unless required to be covered under state or federal laws and regulations. The Plan does not cover services unless they are Medically Necessary. In this section examples may be given of specific services that are covered. However, that does not mean that other similar services are covered. Some services are covered only if they have been authorized by the Plan.

A

Abortion Services, supplies, and prescription drugs for elective abortion are not Covered. This exclusion does not include services Covered under the Plan's Preventive Care Benefits.

Acts of War, Disasters, or Nuclear Accidents. In the event of a major disaster, epidemic, war, or other event beyond our control, the Plan will make a good faith effort to provide Covered Services. However, benefits may not be able to be provided or may be delayed in the event of a major disaster. The Plan will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Acupuncture is not a Covered Service.

Adaptations to Your Home, Vehicle or Office are not Covered Services. Handrails, ramps, escalators, elevators, or any other changes because of a medical condition or disability are not Covered Services.

Ambulance Service for non-emergency transportation is not a Covered Service unless authorized by the Plan.

Non-medical **Ancillary Services,** to which an Enrollee may be referred, are not Covered Services. Vocational rehabilitation services, employment counseling, pastoral counseling, expressive therapies, health education, or other non-medical services are not Covered Services.

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

Aromatherapy is not a Covered Service.

Autopsies are not Covered Services.

B

Batteries are not covered except for use in:

- Motorized wheelchairs;
- Left Ventricular Assist Device (LVAD);
- Cochlear implants when authorized;

Blood Donors. The Plan does not Cover any costs for finding blood donors. The Plan does not Cover the cost of transportation and storage of blood in or outside the Plan's Service Area.
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Bone Densitometry Studies more frequently than once every two years are not Covered, unless Medically Necessary and approved by the Plan.

Bone or Joint treatment of the head, neck, face or jaw. The Plan does not exclude or impose limits on bone or joint treatments of the head, neck, face, or jaw that are more restrictive than limits on treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or Accident/Injury which prevents normal function of the joint or bone, and is deemed Medically Necessary to attain functional capacity of the affected part. The treatment must be Medically Necessary and be required because of a medical condition or Accident/Injury that prevents normal function of the joint or bone.

Botox injections are not Covered Services unless the Plan has approved them.

Breast Augmentation or Mastopexy is not a Covered Service unless the Plan has authorized them. Cosmetic procedures or surgery for breast enlargement or reduction are not Covered Services for correction of cosmetic physical imperfections. Breast implants are not a Covered Service. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Breast Ductal Lavage is not a Covered Service.

Breast Milk from a donor is not a Covered Service.

C

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

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

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

Cosmetic Surgery and Cosmetic Procedures are not Covered Services. Medical, Surgical, and Mental Health Services for, or related to, cosmetic surgery or cosmetic procedures are not Covered Services. Procedures meant to preserve, change**,** or improve how you look, for reasons other than for Medical Necessity, are deemed Cosmetic Services. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **The following are not Covered Services:**

- 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;
- Treatment or services resulting from complications due to cosmetic or 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;
- Cosmetic skin condition treatments by laser, light or other methods.

Costs of Services paid for by Another Payor are not Covered Services. Covered Services do not include 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 referral procedures. Covered Services will not include 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, unless they are determined to be Medically Necessary, include Covered Services, and are approved by the Plan

Custodial Care, Respite Care, Non-skilled Convalescent Care or Rest Cures are not a Covered Service. This exclusion applies even when services are recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home. This exclusion does not apply to Hospice Care.

D

Dentistry/Oral Surgery/Dental Care

Dentistry

- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are not Covered Services.
- Covered Services include Medically Necessary dental services from an Accident/Injury. It does not matter when the Accident/Injury occurred. For Accident/Injury occurring on or after Your effective date of Coverage treatment must be sought within 60 days of the Accident/Injury.
- Covered Services include Medically Necessary dental services performed during an Emergency department visit immediately after a traumatic injury and in conjunction with the initial stabilization of the traumatic injury subject to utilization review for Medical Necessity.
- Cosmetic services to restore appearance are not Covered Services.
- Dental implants or dentures and any preparation work for them are not Covered Services.
- Dental services performed in a hospital or any outpatient facility are not Covered Services. This does not include Covered Services listed under “Hospitalization and Anesthesia for Dental procedures.”

Oral Surgery

- Oral surgery which is part of an orthodontic treatment program is not a Covered Service.
- Orthodontic treatment prior to orthognathic surgery is not a Covered Service.

- Dental implants or dentures and any preparation work for them are not Covered Services.
- Extraction of wisdom teeth is not a Covered Service.

Dental Care

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are not Covered Services.
- Dental implants or dentures and any preparation work for them are not Covered Services.
- Treatment for biting or chewing injuries is not Covered.

Diagnostic tests, or Diagnostic Imaging, or Surgical Procedures are not Covered Services where there is insufficient scientific evidence of the safety or efficacy of the test or procedure in improving clinical outcomes.

Disposable Medical Supplies are not Covered Services unless ordered as part of wound care and authorized by the Plan. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide and other disposable supplies are not Covered Services.

Driver Training is not a Covered Service.

Durable Medical Equipment (DME) is a Covered Service only up to the limits stated on Your Plan's Schedule of Benefits. DME is limited to an amount, supply or type of DME that will safely and adequately treat Your condition. Covered Services will not include any of the following:

- More than one item of DME for the same or similar purpose;
- DME and appliances not uniquely relevant to the treatment of disease;
- Disposable medical supplies and medical equipment;
- Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide;
- DME for use in altering air quality or temperature;
- DME for exercise or training;
- DME mainly for comfort, convenience, well-being or education;
- Batteries for repair or replacement except for motorized wheelchairs or cochlear implants;
- Blood pressure monitors unless authorized by the Plan.

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 are not Covered Services where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.

Services, treatment, or testing required to complete **Educational Programs**, degree requirements, or residency requirements are not Covered Services.

Educational Testing, Evaluation, Screening, or tutorial services are not Covered Services. Any other service related to school or classroom performance is not a Covered Service. This does not include services that qualify as Early Intervention Services under the Plan's benefit or those services covered under Autism spectrum disorder benefits.

Enteral or Parenteral Feeding supplements are not Covered Services unless covered 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.

Exercise Equipment is not a Covered Service. Bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment are not Covered Services. Pool, gym, or health club membership fees are not Covered Services.

Experimental or Investigative drugs, devices, treatments, or services are not Covered. This also applies to services related to Experimental or Investigational services whether you get them before, during, or after you get the Experimental or Investigative service or treatment. The fact that a service is the only available treatment will not make it a Covered Service 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 and not an U.S. 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 or medical services is classified by the U.S. FDA as a Category B Non-experimental/investigational drug, device, or medical treatment.

Eye Examinations required for work are not Covered Services. Corrective or protective eyewear required for work is not a Covered Service.

Eye Glasses and contact lenses are not Covered Services. Fitting of lenses or eyeglasses is not a Covered Service. Covered Services are limited to the first pair of lenses following cataract surgery including contact lenses, or placement of intraocular lenses or eyeglass lenses only.

Eye Movement Desensitization and Reprocessing Therapy are is not a Covered Service.

F

The following **Foot Care Services** are not Covered Services unless authorized by the Plan.

- Operations which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions;
- Treatment and services related to plantar warts.

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 authorized by the Plan. Counseling is a Covered Service only when part of the approved genetic test unless considered preventive care.

GIFT programs (Gamete Intrafallopian Transfer) are not Covered Services.

H

Hearing Aids are not Covered Services. Fittings, molds, batteries or other supplies are not Covered Services.

Home Births are not Covered Services.

Home Health Care Skilled Services are not Covered unless Medically Necessary and the Plan has approved the services. Services and visits are limited, as stated on the Schedule of Benefits. The Plan does not Cover services after the Plan's benefit limit has been reached. The Plan does not Cover Custodial Care. The Plan does not Cover homemaker services, food and home delivered meals. Services provided by registered nurses and other health workers who are not employees of, or working under an approved arrangement with, a Home Health Care Provider are not Covered.

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not a Covered Service.

Implants for cosmetic breast enlargement are not a Covered Service. Cosmetic procedures or cosmetic surgery for breast enlargement or reduction are not Covered Services. Procedures for

correction of cosmetic physical imperfections are not Covered Services. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

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

Infertility Treatment or Services listed below are not Covered, unless listed as Covered Services under What is Covered in this Summary Plan Description (SPD):

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as a Covered Service in this SPD;
- Services, tests, medications, and treatments for the enhancement of conception;
- Services, tests, medications, and treatments that aid in or diagnose potential problems with conception not listed as a Covered Service in this SPD;
- 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 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;
- Surrogate pregnancy services;
- Drugs used to treat infertility.

J

K

L

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

M

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

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not Covered Services. **The following are not Covered Services:**

- Exercise equipment;
- Air conditioners, purifiers, humidifiers and dehumidifiers,

- Whirlpool baths,
- Hypoallergenic pillows or bed linens,
- Telephones,
- Handrails, ramps, elevators and stair glides;
- Orthotics not approved by Us;
- Changes made to vehicles, residences or places of business;
- Adaptive feeding devices, adaptive bed devices;
- Water filters or purification devices;
- Disposable Medical Supplies such as medical dressings, disposable diapers;
- Over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

Medical Nutritional Therapy and nutrition counseling are not Covered Services except when provided as part of preventive care, diabetes education or when received as part of preventive wellness services or screening visits. Nutritional formulas and dietary supplements that are available over the counter and/or without a written prescription are not Covered Services.

Membership Fees to pools, gyms, health clubs, or athletic clubs are not Covered Services. .

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.

Motorized or Power Operated Vehicles or chair lifts are not Covered Services unless authorized by the Plan.

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 upon by both the Plan and the Group.

O

Oral Surgery services listed below are not Covered Services:

- Oral surgery which is part of an orthodontic treatment program;
- Orthodontic treatment prior to orthognathic surgery;
- Dental implants or dentures and any preparation work for them;
- Extraction of wisdom teeth.

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 received from **Out-of-Network Non-Plan Providers** are not Covered, except in the following situation:

- 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.

OUTPATIENT PRESCRIPTION DRUG EXCUSIONS AND LIMITATIONS

Outpatient Prescription Drugs

The following limitations and exclusions apply to the Plan's Prescription Drug Benefits.

Limitations And Other Coverage Terms.

1. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.
2. Copayment and Coinsurance are out-of-pocket amounts paid directly to the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. Coinsurance is a percentage of Sentara's Allowable Charge.
3. Deductible means the dollar amount that must be paid out-of-pocket each year for Covered Services before the Plan begins to pay for benefits.
4. Prescriptions may be filled at a Plan pharmacy or at a non-participating pharmacy if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies.
5. All Covered outpatient prescription drugs must have been approved by the U.S. Food and Drug Administration and require a prescription either by state or federal law.
6. Amounts paid 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.
7. 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 from 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.
8. Some drugs require Pre-Authorization from the Plan, in order to be Covered. The Physician is responsible for obtaining Pre-Authorization. You can call Member Services at the number on the Plan ID card to verify that the prescription drug has been pre-authorized.
9. Unless required by law, certain Prescription Drugs may not be Covered under the Plan when a Clinically Equivalent Drug is available. Clinically Equivalent Drug means a drug that, for most individuals, gives similar results for a disease or condition. For questions about whether a certain drug is Covered by the Plan, please call the Member Services number on the back of the Plan ID 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, the Plan will Cover the other Prescription Drug instead of the Clinically Equivalent Drug."
10. At its' sole discretion, Sentara's Pharmacy and Therapeutics Committee determines which Tier a Covered drug is placed and whether a particular drug is included on the the

Plan's formulary. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee reviews medical literature and evaluates whether to add or remove a drug from the preferred/standard drug list of the Plan's formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.

11. Insulin, syringes, and needles are Covered under the Plan's Prescription Drug Benefit. Blood glucose monitors, test strips, lancets, lancet devices and control solution are Covered under the Plan's Prescription Drug Benefit. Insulin pumps, pump infusion sets and supplies, and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes, if prescribed by a health care professional legally authorized to prescribe such items under law, are Covered under the Plan's Medical Benefit. 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.
12. Intrauterine Devices (IUDs), and cervical caps and their insertion are Covered under the Plan's Medical Benefits.
13. Covered U.S. Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to 2 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 the Plan's Prescription Drug Benefits.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications without approved U.S. 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 Prescription Drug Benefits.
8. Medication taken or administered in a Physician's office is excluded from Prescription Drug Benefits, unless Covered under the Plan's "Medication Administered by a Medical Provider" section in this Summary Plan Description, Section 5 "What is Covered".
9. Medication taken or administered in whole or in part, while a Covered Person is a patient in a licensed Hospital is excluded from Prescription Drug Benefits.
10. Medications for Cosmetic Purposes only, including but not Limited to Retin-A for aging, are excluded from 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 from 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 from Coverage.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from 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 from 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. 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. This exclusion does not apply to Plan Covered Services under the “Medically Necessary Formula and Enteral Nutrition Products” benefits in Section [6] “What is Covered “of Summary Plan Description.
21. Dietary supplements, including but not limited to medical food, food or formula products, or other nutritional or electrolyte supplements are excluded from Coverage under the Pharmacy Benefit.
22. 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.
23. Minerals, topical and oral fluoride treatments, 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.
24. Pharmaceuticals approved by the U.S. FDA as a medical device are excluded from Coverage.
25. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription
26. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
27. Infertility drugs are excluded from Coverage.
28. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
29. Abortifacient drugs that cause abortions are not covered.
30. Digital Therapeutics, including digital devices, software and applications are excluded from Coverage.
31. Refills after one year from the original prescription date.
32. Administration charges for the administration of any drug, except Approved Covered Immunization.
33. Delivery charges for delivery of prescription drugs;

34. **This Plan uses a Closed Formulary. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are excluded from Coverage.**

Non-formulary requests. Enrollees have the right to request a non-formulary prescription drug if they believe they need a prescription drug that is not on the Plan's list of Covered drugs (formulary), or have been receiving a specific non-formulary prescription drug for at least six months prior to the development or revision of the formulary and the prescribing physician has determined that the formulary drug is inappropriate for the Enrollee's condition, or that changing drug therapy presents a significant health risk. The prescribing physician must complete a Medical Necessity form and deliver it to the Sentara Pharmacy Authorization Department. After reasonable investigation and consultation with the prescribing physician, the Plan will make a determination. The Plan will act on such requests within one business day of receipt of the request. The Enrollee will be responsible for all applicable Copayments, Coinsurance, or Deductibles, depending upon which Tier a drug is placed by the Plan.

P

PARS System (Physical Activity Reward System) is not a Covered Service unless approved by the Plan.

PASS Devices (Patient Activated Serial Stretch) are not Covered Services unless approved by the Plan.
Paternity Testing is not a Covered Service.

Penile implants are not a Covered Service.

Personal comfort items are not Covered Services. Telephones, televisions, extra meal trays, personal hygiene items, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs and any other similar items for personal comfort are not Covered Services.

Physician Examinations are limited as follows:
- 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 by the Plan.
- Services or supplies ordered or done by a provider not licensed to do so are not Covered Services.

Physician's Clerical Charges are not Covered Services. Charges for broken appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records or correspondence to other parties, and any other clerical services are not Covered Services.

Prescription Drugs
- Over-the-counter medications are not Covered Services

Pulsed Irrigation Evacuation System is not a Covered Service

Q

R

Reconstructive surgery - is not a Covered Service unless services follow trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. If the trauma occurred before the Member's effective date of Coverage, the reconstructive surgery is a Covered Service subject to the Plan's Medical Necessity determination. 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 or for mental are not Covered Services.

S

Services. The following are not Covered Services:

- 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;
- Virtual Consults except when provided by Sentara Health Plans approved providers;
- Charges for missed appointments;
- Charges for completing forms
- Charges for copying medical records.
- Cervices not listed as a covered service under this plan.
- Any service or supply that is a direct result of a non-covered service.

Spinal Manipulation is not a Covered Service.

Sterilization

- Reversal of voluntary sterilizations is not a Covered Service.
- Any infertility services required because of a reversal are not Covered Services.

T

Non-interactive **Telemedicine Services** such as Fax, telephone only conversations, or email are not Covered Services.

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. Covered Services do not include any of the following except for those services that are covered through Early Intervention Services or Autism Spectrum Disorder Benefits**:**

- Therapies for developmental delay or abnormal speech pathology;
- Therapies which are primarily educational in nature;
- Special education services;
- Treatment of learning disabilities;
- Lessons for sign language;
- Therapies to correct an impairment resulting from a functional 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;
- Gambling therapies;
- Remedial education and programs.

Total Body Photography is not a Covered Service.

Transplant Services. Covered Services do not include any of the following:

- Organ and tissue transplant services not listed as covered;
- Organ and tissue transplants not Medically Necessary;
- Organ and tissue transplants considered experimental or investigative;
- Travel and lodging services not approved by the Plan, including mileage, rental cars, airfare, standard hotel accommodations, companion accommodations;
- Travel and lodging services including childcare, meals, taxis, buses, tolls, lodging upgrades;
- Services from non-contracted providers unless pre-authorized by the plan;
- Services and supplies for organ donor screenings, searches and registries;
- 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 person.

Transportation by Ambulance or other transportation services that are not Emergency Services are Covered Services only when approved and authorized by the Plan.

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

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

U

V

Treatment of **Varicose Veins or telangiectatic dermal veins** (spider veins) for cosmetic purposed is not a Covered Service.

Video Recording or Video Taping of procedures or treatment is not a Covered Service.

Vision Correction Surgery such as Radial Keratotomy, PRK, LASIK, or any other eye corrective procedure that is not Medically Necessary is not a Covered Service. This exclusion does not apply to Medically Necessary Ophthalmology procedures to treat Medical Conditions of the eye, such as Diabetes, Glaucoma, Cataracts, Retinopathy, and Corneal Erosion.

Vision Exams and Materials not listed as a Covered Services are not covered.

W

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

Wisdom Teeth extraction is not a Covered Service.

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

TERMINATION OF EMPLOYEE COVERAGE

Except as provided below and under Section 12 Continuation Of Coverage an Employee's coverage under this Plan will terminate on the first of the following:

- The date this Plan terminates;
- The last day of the month in which the Employee ceases to be employed by the Plan Sponsor or otherwise ceases to be an Eligible Employee;
- The date the Employee contribution, if any, for Plan Coverage cease due to non-payment by the Employee;
- The date any Employee fails to pay, have paid on his or her account or for his or her benefit, or make satisfactory arrangements to pay any Copayment, Coinsurance, or any other required contributions for coverage under the Plan; or
- The date the Employee dies.

TERMINATION OF DEPENDENT COVERAGE

Except as provided below and under Section 12 Continuation Of Coverage a Dependent's coverage under this Plan will terminate on the first of the following:

- The date this Plan terminates;
- The date any Covered Person fails to pay, have paid on his or her account or for his or her benefit, or make satisfactory arrangements to pay any Copayment, coinsurance, or any other required contributions for Coverage under the Plan;
- The date the Employee's coverage under this Plan terminates;
- The date a spouse or Child ceases to satisfy the Plan's definition of an Eligible Dependent; or
- The date the spouse or Child becomes covered as an Employee under this Plan.

EXCEPTIONS TO TERMINATION PROVISIONS - EXTENSION OF ACTIVE SERVICE (DURING ABSENCE FROM EMPLOYMENT)

If cessation of active service is due to one of the following circumstances, Coverage may continue until the end of the stipulated period below, **provided the Plan is in force:**

- For an approved layoff, Coverage will continue for a period of not longer than three (3) months.
- For an Employee who is unable to work due to total disability, Coverage will continue for a period not longer than six (6) months.
- The Family and Medical Leave Act (FMLA). FMLA requires employers of 50 or more employees to give up to 12 weeks of unpaid, job-protected leave to eligible employees for the birth, or adoption of a child or for the serious illness of the employee or a spouse, child or parent.

Reference Group's FMLA policy

- The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). According to USERRA any employee called to Active Duty can continue the health care coverage they have for themselves and/or any family members covered under the Plan for up to 24 months.

Reference Group's USERRA policy

An Employee who returns to work within three (3) months of a layoff or an approved leave of absence will retain the same employment status for purposes of this Summary Plan Description as prior to the said date and no eligibility waiting period will apply. An Employee who returns after three months of an approved leave of absence or layoff will be considered a new Employee and will be subject to all eligibility requirements, including all requirements relating to the effective date of coverage.

ADDITIONAL TERMINATION PROVISIONS

Misuse of Plan Identification Card

If the Covered Person permits the use of his or her or any other Covered Person's Plan identification card by any other person, or uses another person's card, the card may be retained by the Plan and Coverage of the Covered Person may be terminated effective upon written notice. Both the Employee and the Dependent shall be liable to the Plan for all costs incurred as a result of the Dependent's misuse of the identification card.

Fraud or Misrepresentation.

If a Covered Person, on behalf of himself/herself or another Covered Person, knowingly causes or allows incorrect or incomplete information to be furnished to the Plan which constitutes a material misrepresentation, then the Coverage of the Covered Person who either furnished such information or on whose behalf such information was furnished, may be voided immediately upon written notice. In addition, such Covered Person shall be responsible for all costs incurred by the Plan for such Covered Person.

Failure to Pay Copayments, Premiums, etc.

If a Covered Person fails to pay, or arrange for payment of any Copayment or other required contribution for Coverage under the Plan, Coverage will terminate upon written notice by the Plan.

WORKERS' COMPENSATION

The benefits under this Summary Plan Description for Covered Persons eligible for Workers' Compensation are not designed to duplicate any benefit to which such Covered Persons are eligible under the Workers' Compensation Law. All sums payable pursuant to Workers' Compensation for services provided hereunder to Covered Persons are payable to and retained by the Plan. It is understood that Coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation.

MEDICARE

Except as otherwise provided by applicable federal law that would require the Plan to be the primary payor, the benefits under this Summary Plan Description for Covered Persons aged sixty five (65) and older, or Covered Persons otherwise eligible for Medicare, do not duplicate any benefit to which such Covered Persons are eligible under the Medicare Act, including Part B of such Act. In cases where the Plan has paid for services covered hereunder, but Medicare is the responsible payor, the Plan will pursue all sums payable pursuant to the Medicare program, and such sums shall be payable to and retained by the Plan. In all other cases, all sums payable pursuant to the Medicare program for services provided hereunder are payable up to the amount of the secondary payor's liability.

OTHER GOVERNMENT PROGRAMS

Except as otherwise provided by applicable law that would require the Plan to be the primary payor, the benefits under this Summary Plan Description shall not duplicate any benefits to which Covered Persons are entitled or for which they are eligible under any other governmental program. To the extent that the Plan has duplicated such benefits, the Plan will pursue all sums payable pursuant to the government program and sums shall be payable to and retained by the Plan. In all other cases, all sums payable pursuant to the government program for services provided hereunder are payable up to the amount of the secondary payor's liability.

COVERED PERSON'S COOPERATION

Each Covered Person shall complete and submit to the Plan such consents, releases, assignments and other documents as may be requested the Plan in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. Any Covered Person who fails to so cooperate may be responsible for the Usual and Customary Charge for services subject to this section.

COORDINATION OF BENEFITS

This Coordination of Benefits (“COB”) provision applies to This Plan when a Covered Person has health coverage under more than one Plan. “Plan” and “This Plan” are defined below. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

- Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
- May be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

Definitions

Plan is any of these which provide benefits or services for, or because of, medical care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment or group practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
- Medical benefits coverage of group and group-type contracts, except for mandated coverage under personal Injury protection insurance.

Each contract or other arrangement for coverage under any of the plans listed above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

This Plan is the part of this Document that provides benefits for health care expenses.

Primary Plan or **Secondary Plan** is determined by the order of benefit determination rules. 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 reduced and it may recover from the Primary Plan the reasonable cash value of benefits provided by this Plan. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

Allowable Expense means the Usual and Customary Charge for an item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition 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 covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those relating to services provided without required pre-authorizations by the Plan or referrals from the Primary Care Physician.

Claim Determination Period means a calendar 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.

ORDER OF BENEFIT DETERMINATION RULES

General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

- The other plan has rules coordinating its benefits with those of This Plan; and

- Both those rules and This Plan's rules, in subparagraph B below, require that This Plan's benefits be determined before those of the other plan; or
- The other plan is a governmental plan and federal law requires This Plan to be the Primary Plan.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the plan which covers the person as an Employee (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.

2. Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph 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 which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

   However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, 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. Dependent Child/Separated or Divorced. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the 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 expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefits of a plan which covers 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 that 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. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee longer are

determined before those of the Plan which covered that person for the shorter term. Two consecutive Plans shall be treated as one plan if the claimant was eligible under the second Plan within twenty-four (24) hours after the termination of the first Plan.

The start of a new plan does not include:

- A change in the amount or scope of a Plan's benefits;
- A change in the entity paying, providing or administering Plan Benefits; or
- A change from one type of Plan to another (e.g., single employer to multiple employer plan).

6. Continuation Coverage. If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also covered under another group health plan, the following shall be the order of benefit determination:
   a. First, the benefits of a plan covering the person as an employee (or as that employee's dependent);
   b. Second, the benefits of coverage purchased under the continuation plan.

   If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Applies. This Section applies when, in accordance with the Section titled, "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

Reduction in This Plan's Benefits. The benefits of this Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

2. The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. 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 any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, this Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services. Nothing in this section shall be interpreted to require the Plan to reimburse a Covered Person in cash for the value of services provided by a plan which provides benefits in the form of services.

COPAYMENTS

Copayments are specific dollar amounts the Covered Person must pay for Covered Services. Copayments are listed on the Schedule of Benefits. Members must pay Copayments to the provider of the service at the time they receive service.

COINSURANCE

Coinsurance amounts are charges required to be paid by the Covered Person for Covered Services. Coinsurance amounts are expressed as a percentage 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.

DEDUCTIBLE

A Deductible is a dollar amount that Covered Persons must pay out of pocket for health plan benefits before the Plan begins to pay for benefits. If the Plan has a Deductible it will be listed on the Schedule of Benefits.

MAXIMUM OUT-OF-POCKET AMOUNT

Out-of-pocket-maximum means the total amount an Employee and/or eligible Dependents pay during a calendar year. Copayment and/or Coinsurance amounts for certain services will be accumulated and will apply toward the maximum dollar amount listed on the Schedule of Benefits. Maximum Out of Pocket Amounts and excluded copayments are listed on the Schedule of Benefits.

EMERGENCY ROOM COPAYMENT

If the Plan requires a Copayment for an emergency room visit and the Covered Person is hospitalized as a result of an Emergency the Plan waives the Emergency room Copayment. The Covered Person will be responsible for all applicable inpatient hospital Copayments or Coinsurances as specified on the Schedule of Benefits.

PLAN PROVIDERS

Requests for benefits for services received from a Plan Provider shall be made to the Plan Provider by the Covered Person presenting his/her Plan identification card at the time such services are initiated. Plan Providers are responsible for submitting to the Plan all bills for services rendered to Covered Persons.

NON-PLAN PROVIDERS

Claims for Covered Services rendered by Non-Plan Providers should be sent to the Plan c/o Sentara Health Administration, Inc., 1300 Sentara Park, Virginia Beach, VA 23464 for payment consideration. If a charge is made to a Covered Person for any service that is reimbursable under this Summary Plan Description, written proof of such charge shall include an itemized statement plus diagnosis and must be submitted to the Plan within ninety (90) days after the delivery of the service. Failure to furnish such documentation within the specified period shall not invalidate nor reduce any such claim if for good reason it was not possible to submit the claim within the specified period, provided such proof is produced on a timely basis.

PAYMENT BY PLAN

The Plan may make payment to the person or institution providing the services. However, if the Covered Person furnishes evidence satisfactory to the Plan that payment has been made to such person or institution for the service covered, reimbursement will be made to the Covered Person after deducting any payment made by the Plan before receipt of such evidence.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
(For use by single-employer group health plans)

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay or COBRA continuation coverage.

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."

If the Plan provides retiree health coverage, add the following paragraph:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Portsmouth Public Schools, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- 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. You must provide this notice to: Sharon Plummer, Benefits Supervisor.

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, Medicaid, 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.

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.

Plan contact information

Sharon Plummer, Benefits Supervisor
Portsmouth Public Schools
801 Crawford Street, 3rd Floor
Portsmouth, VA 23704
757-398-8488 ext. 14148

Section 12 Adverse Benefit Determination Internal and External Appeal Process

This section explains how Covered Persons can file an appeal of an Adverse Benefit Determination. An Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for, a claim for a Covered Service based on:

- A Covered Person's eligibility to participate in the Plan;
- A Utilization Management decision; or
- Failure to cover an item or service because the Plan considers it to be Experimental, Investigational, or not Medically Necessary; or
- Rescission of Coverage.

The Plan's Appeals Process

When the Plan makes an Adverse Benefit Determination, the Covered Person has the right to a full and fair review of the Plan's determination in accordance with the Plan's appeal procedure.

The Covered Person has 180 calendar days from the date he/she receives notice of the Plan's Adverse Benefit Determination in which to request an appeal in writing. Appeal forms and written appeal procedures will be available at the Covered Person's request.
The Covered Person has the right to designate an authorized representative, such as a physician or family member, to act on his or her behalf in filing an appeal of an Adverse Benefit Determination.

The Covered Person must complete the appeal process before seeking any alternative remedies available.

The appeal review takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Covered Persons may submit new information to the Plan in writing or in person. The review will not take the initial Adverse Benefit Determination into consideration, and the individual reviewing the appeal will not have participated in the original decision.

If the Adverse Benefit Determination under appeal relates in whole or in part to a medical judgement, including determinations regarding whether a particular treatment, drug, or other service is experimental, investigational, or not Medically Necessary or appropriate, a peer of the treating health care provider who specializes in a discipline pertinent to the issue under review, and who has not participated in the Adverse Benefit Determination or any prior reconsideration, will review the decision.

When the Plan completes its review of an Adverse Benefit Determination it will give the Covered Person written notification of the outcome. If the Plan does not reverse its decision the written notice will include:

- The specific reason or reasons for the Plan's Adverse Benefit Determination;
- Reference to the specific plan provisions on which the Plan based its determination; and
- Any further appeal rights available to the Member.

Upon request, the Covered Person is entitled to the following free of charge:

- Reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- Copies of any internal rule, guideline, protocol, or other criteria relied upon in making the adverse decision;

- 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 the Member's medical circumstances.

Types of Claims

The type of claim under review will determine what process the Covered Person or his or her designated representative must follow to request an appeal.

Pre-service claim means any claim for a benefit under the Plan for which the Plan requires approval before the Covered Person obtains medical care. An example would be obtaining Pre-Authorization for a diagnostic test or medical procedure. To appeal the Plan's decision on a Pre-Service claim the Covered Person must follow the Appeal Procedure for Pre- and Post-Service Claims explained below.

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 Covered Person or the ability of the Covered Person to regain maximum function; or (2) in the opinion of a physician with knowledge of the Covered Person's medical condition, following the Plan's normal appeal procedure would subject the Covered Person 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 Covered Person's medical condition determines that the claim is urgent. To appeal any denial of an Urgent Care Claim the Covered Person must follow the Appeal Procedure for Expedited Appeals.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim; for example a claim for reimbursement for a diagnostic test already performed. To appeal a Post-Service Claim the Covered Person must follow the Appeals procedure for Pre- and Post-Service claims.

Concurrent care decision/claim 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. An example is where the Plan reviews an inpatient hospital stay approved for five days on the third day to determine if the full five days is appropriate. To appeal a Concurrent Care Decision/Claim the Covered Person must follow the procedure for expedited appeals.

Expedited Appeals Of Urgent Care Claims And Concurrent Care Decisions/Claims

The Covered Person or treating physician may request an expedited appeal by telephone, facsimile, or letter, and must explicitly state "expedited appeal" in the request to initiate this process. To Contact the Plan with a request for an expedited appeal:

By Phone: Call Member Services at the number on the Plan ID card
Or Call 833-702-0037

By Facsimile: 877-240-4214

By Mail: Send requests for an Appeal to:

Sentara Health Plan
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, VA 23466-2876

The Plan will consider an expedited appeal and notify the Covered Person of its decision as soon as possible, but not later than one business day after it receives all necessary information and not later than 72 hours from the receipt of the request.

Expedited appeals relating to a prescription to alleviate cancer pain shall be decided not more than twenty-four hours from receipt of the request.

Appeals of Pre-Service or Post-Service Claims Following an Adverse Benefit Determination by the Plan

Requesting an Appeal

To request forms to initiate a written appeal, please contact the Plan:

By Phone: Call Member Services at the number on the Plan ID card
Or Call 833-702-0037

By Facsimile: 877-240-4214

By Mail: Send requests for an appeal to:

Sentara Health Plan
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, VA 23466-2876

The Covered Person must complete the information in the packet provided by the Plan to him or her and return it to the Plan. The Covered Person should provide to the Plan any new information for the Plan to consider when deciding the appeal. When completing the appeals forms, the Covered Person should make sure to include the following:

- The Covered Person's name, address, telephone number, Covered Person's Plan Member number, and group number;
- The date of service, place of service, provider and charge related to the service;
- Any additional written comments, documents, records, or other information necessary to make a determination.

For Pre-Service Claims, the appeal decision will be completed and the Covered Person's notified of the Plan's decision within 30 calendar days of the Plan's receipt of written request for the appeal.

For Post-Service Claims, the appeal decision will be completed and the Covered Person notified of the Plan's decision within 60 calendar days of the Plan's receipt of written request for the appeal.

Sources for Additional Information

You may also contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory or visit their website at www.dol.gov.

External Review of Adverse Benefit Determinations

If you have exhausted your plan's internal appeal rights and your plan continues to deny the payment, coverage, or service requested, or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. There are two levels of external appeal a standard level and an expedited level.

Requesting a Standard External Review

You must file a request for an external appeal within four months after receiving notice of a final adverse benefit determination. To begin your external appeal please contact:

By Phone:	Call Member Services at the number on the Plan ID card Or Call 833-702-0037
By Facsimile:	877-240-4214
By Mail:	Send requests for an appeal to: Sentara Health Administration, Inc. APPEALS DEPARTMENT P.O. Box 66189 Virginia Beach, VA 23466-6189

Within five business days after receiving the external review request, a preliminary review of the request will be done to determine whether:

- You are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care service was provided.
- The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the eligibility requirements under the terms of the plan (e.g., worker classification or similar determination).
- You exhausted the plan's internal appeal process, if required to do so.
- You have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, you will receive written notice including the following:

- If the request is complete but not eligible for external review, the notification will include the reasons for ineligibility and contact information for the DOL's Employee Benefits Security Administration.
- If the request is not complete, the written notification will describe the information needed to complete the request, and you will have to complete the request within the four-month filing period or within 48 hours after receiving the notification, whichever is later.

If your request is eligible and complete your appeal will be referred to and independent review organization (IRO). The IRO will contact you with instructions on how you can submit additional information to the IRO to be considered in your appeal. The IRO will conduct an independent review and not be bound by any decisions or conclusions reached during your plan's internal review. The IRO will notify you and your plan of their decision within 45 days after the IRO receives the request for the external review.

Requesting an Expedited External Review

You can request and expedited external review of an adverse benefit determination that involves a medical condition for which the time frame for completion of an expedited internal appeal (or a standard external review in the case of a final internal adverse benefit determination) would seriously jeopardize your life or health or your ability to regain maximum function.

You can also request and expedited external review if you receive a final internal adverse benefit determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, and you have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, a preliminary review will be conducted and you will be provided written notification as described above under the Standard External Review.

If Your request is eligible and complete your appeal will be referred to an IRO. The IRO will conduct the external review and notify you of their decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after

the date of providing that notice, the IRO will provide written confirmation of the decision to you and your plan.

Other Resources to Help You

For questions about appeal rights, or for assistance, contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

MAJOR DISASTERS AND OTHER CIRCUMSTANCES BEYOND THE PLAN'S CONTROL

In the event that circumstances beyond the Plan's, or its designee's, control - including, but not limited to, a major disaster, epidemic, or civil insurrection - result in facilities, personnel or resources used by the Plan, or its designee, being unable to provide or arrange for the benefits and services it 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. However, in such circumstances, neither the Plan, its designee, nor Plan Providers shall incur any liability or obligation for the delay of, or failure to provide or arrange for, such benefits and services.

SEVERABILITY

In the event any provision of this Summary Plan Description is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Summary Plan Description, 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.

NAMED FIDUCIARY AUTHORITY

In addition to those powers, rights and duties delegated it elsewhere in the Plan, and the extent that the authority is not delegated to another person under this Plan, the Named Fiduciary shall have the authority to:

- Interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits;
- Adopt rules of procedures and regulations that it determines may be necessary for the proper and efficient administration of the Plan in a manner consistent with the provisions of the Plan;
- Appoint individuals to assist in the administration of the Plan and any other agents it deems advisable including legal, accounting, and actuarial services.

ASSIGNMENT

No person other than Covered Person is entitled to receive Covered Services under this Summary Plan Description. Such right to Covered Services is not transferable.

RELATIONSHIP OF PARTIES

Independent Contractors. Plan Providers are not agents or employees of the Plan, or Sentara, nor is the Employer, the Plan, or Sentara, or any employee of the Employer, the Plan, or Sentara, an employee or agent of Plan Providers. The Employer, the Plan, and Sentara shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Covered Person while receiving care from any Plan Provider or in any Plan Provider's facilities.

Patient/Provider Relationship. Plan Providers maintain the provider patient relationship with Covered Persons and are solely responsible to Covered Persons for all health services. Certain Covered Persons may, for personal reasons, refuse to accept procedures or treatment by Plan Physicians. Plan Physicians may regard such refusal to accept their recommendations as incompatible with continuance of the physician patient relationship and as obstructing the provision of proper medical care. Plan Physicians shall use their best efforts to render all Medically Necessary Services and Supplies in a manner compatible with a Covered Person's wishes, insofar as this can be done consistently with the Plan Physician's judgment as to the requirements of proper medical practice. If a Covered Person refuses to follow a recommended treatment or procedure, and the Plan Physician believes that no professionally acceptable alternative exists, such Covered Person shall be so advised. In such case, neither the Plan, nor any Plan Provider, shall have any further responsibility to provide care for the condition under treatment. The continued refusal by the Covered Person to follow the recommended treatment or procedure(s) may result in termination of the Covered Person's Coverage pursuant to provisions herein.

IDENTIFICATION CARD

Cards issued by the Plan to Covered Persons pursuant to this Summary Plan Description are for identification only. Possession of a Plan Identification Card confers no right to services or other benefits under this Summary Plan Description. To be entitled to such services or benefits, the holder of the Plan ID card must, in fact, be a Covered Person. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Summary Plan Description will be liable for the actual cost of such services or benefits.

AUTHORIZATION TO EXAMINE HEALTH RECORDS

Each Covered Person consents to and authorizes a Physician, Hospital, Skilled Nursing Facility or any other provider of care to permit the examination and copying of any portion of the Covered Person's Hospital or medical records or claims information, when requested by the Plan or its designee. Information from such records of Covered Persons and information received from Physicians or Hospitals incident to the Physician patient relationship or Hospital patient relationship or claims information shall be kept confidential and, except for use reasonably necessary in connection with government requirements established by law or the administration of this Summary Plan Description, may not be disclosed without the consent of the Covered Person. The Covered Person agrees that medical and Hospital records and claims information may be reviewed by the Plan Administrator and Sentara and may be shared between the Plan Administrator and Sentara for program audit and other purposes not inconsistent with applicable law.

MODIFICATIONS OF BENEFITS AND RIGHT TO TERMINATE

In accordance with this Summary Plan Description, the Plan Sponsor makes Coverage available to persons who are eligible under Section 2 Eligibility and Enrollment. The Plan Sponsor reserves the right to amend, modify or terminate the Plan at any time. No change may be made to the Plan unless made in writing by the Plan Administrator with notice to Covered Persons in accordance with applicable federal law. This Summary Plan Description shall be subject to amendment, modification, and termination by the Plan Sponsor without the consent or concurrence of any Covered Persons.

LIMITATION ON BENEFITS OF THIS PLAN

No person or entity other than the Plan Sponsor, Sentara and Covered Persons hereunder is or shall be entitled to bring any action to enforce any provision of the Plan against the Plan Sponsor, Sentara or Covered Persons hereunder, and the covenants, undertakings, and agreements set forth in the Plan shall be solely for the benefit of, and shall be enforceable only by, the Plan Sponsor, Sentara and the Covered Persons.

GOVERNING LAWS

The Plan shall be administered according to the laws of the Commonwealth of Virginia to the extent that such laws are not preempted by the laws of the United States of America.

PLAN NOT A CONTRACT OF EMPLOYMENT

The Plan does not constitute a contract of employment and participation in the Plan will not give any Employee the right to be retained in the employment of the Employer.

ENTIRE CONTRACT

The Purchaser Services Agreement and the Summary Plan Description together with all exhibits and amendments thereto, the individual Enrollment Applications of Members, Medical Care Management Policies, and any other questionnaire, form or other document provided in execution with the Purchaser Services Agreement 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.