

Attachment A – Plan Document

City of Chesapeake Employee/Retiree Health Plan

Preferred Provider Organization Plan (PPO)

**Summary Plan Description
January 1, 2021**

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Administrative Information

Name of Plan:

Plus 750/25/75%
Equity Plus

Original Plan Effective Date:

January 1, 2016 for Plus 750/25/75%
January 1, 2017 for Equity Plus

Restated Plan Effective Date:

January 1, 2021

Type of Plan:

Group Health Plan

Important:

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, the In-Network benefits under the Plan are available only when the services are provided by Plan providers.

It is the covered person's responsibility to be familiar with the plan's coverage and to understand based on the services being rendered and the provider used by the covered person whether in-network or out-of-network coverage is applicable.

Pre-authorization is required regardless of the network chosen. It is the covered person's responsibility to make sure that pre-authorization is completed according to the terms set forth herein.

This Summary Plan Description (SPD) is intended to help you understand the main features of the plan. 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.

Administrative Information

Name and Address of Company or “Plan Sponsor”:

City of Chesapeake
306 Cedar Road
Chesapeake, VA 23322

Name, Address and Business Telephone Number of Plan Administrator:

Plan Administrator, City of Chesapeake Employee/Retiree Health Plan
c/o Allison Myers
306 Cedar Road
Chesapeake, VA 23322

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

Employer Identification Number (EIN):

54-0721442

Plan Number:

60748-Plus
60772-Equity Plus

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:

The City contributes 80%, on average, towards the premium of the selected tier.

Plan Year:

The financial records of the Plan are kept on a Plan year basis, which is the twelve-month period beginning January 1 and ending December 31.

Plan Provider Coordinator and Claims Processing:

The Plan has contracted with Sentara Health Plan, Inc. (“Sentara” or “SHP”), a Virginia corporation doing business as Optima Health and located at 4417 Corporation Lane, Virginia Beach, Virginia 23462, (757) 552-7100, to provide certain claims processing, health care utilization review, and health care provider coordination services for the Plan Administrator.

Administrative Information

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.

The Plan has contracted with Sentara Health Plans, Inc. (“Sentara” or “SHP”), a Virginia corporation doing business as Optima Health and located at 4417 Corporation Lane, Virginia Beach, Virginia 23462, (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.

Patient Protection Disclosure

PATIENT PROTECTION DISCLOSURE

The 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 Covered Persons. Until you make this designation, the 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 Optima Health at (757) 552-7110.

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

You do not need prior authorization from Optima Health Plan 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 Optima Health at (757) 552-7110.

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

You do not need prior authorization from the Plan (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 Optima Health at (757) 552-7110.

OPTIMA HEALTH

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

Optima Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Optima Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Optima Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact:

Civil Rights Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462
1-855-687-6260, 757-552-7116 Fax
languagehelp@sentara.com

If you believe that Optima Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sharon Dajon, Section 1557 Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462
1-844-801-3779, 757-552-7116 Fax
languagehelp@sentara.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator (above) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Non-Discrimination Notice

Complaint forms are available at <https://hhs.gov/ocr/office/file/index.html>

If you are visually impaired and need large print or other assistance to view this document, please contact us at 1-855-687-6260.

Additional Notices

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 your Plan insurance identification card.

As a Covered Person of the Plan you have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis 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.

Additional Notices

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or **dial 1-877-KIDS NOW or www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, **and you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility.

<p>FLORIDA <i>Medicaid</i></p>	<p>NORTH CAROLINA <i>Medicaid</i></p>
<p>Website: https://www.flmedicaidtprecovery.com/ Phone: 1-877-357-3268</p>	<p>Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p>VIRGINIA <i>Medicaid & CHIP</i></p>	
<p>Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</p>	

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 12/31/2019)

Patient Protection and Affordable Care

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 Department of Human Resources.

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.

The City’s Notice of Privacy Practices may be viewed at the following link: http://www.cityofchesapeake.net/Assets/documents/departments/human_resources/Notice+of+Privacy+Practices.pdf. In addition, copies of the Notice may be requested by contacting Human Resources at HIPAAPrivacyOfficer@CityofChesapeake.net or 757-382-6492.

If you have questions about the privacy of your health information please contact the City’s Privacy Officer at HIPAAPrivacyOfficer@CityofChesapeake.net or 757-382-6492.

If you wish to file a complaint under HIPAA, please contact Jason McNair, Privacy Officer, at HIPAAPrivacyOfficer@CityofChesapeake.net or 757-382-6236.

In-Network And Out-Of-Network Covered Services

Optima Health contracts with certain doctors and Hospitals to provide Your benefits. These doctors and Hospitals make up the Plan's Provider Network. We also call them Plan Providers or In-Network Providers. Plan Providers also include skilled nursing facilities, urgent care centers, outpatient care centers, laboratories, and other facilities and professionals. Access to a list of the In-Network Plan Providers is provided to Subscribers at the time of enrollment. You can also call Member Services to ask if a provider is in Our network. A list of Plan Providers is also on the Plan's website at optimahealth.com. 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 Preferred Provider Organization (PPO) plan. A PPO plan gives Members the choice to receive Covered Services from an In-Network Provider or an Out of Network Provider for most Covered Services. Members that see an In-Network Provider will pay In-Network cost sharing. Members that see an Out-of-Network Provider will pay Out-of-Network cost sharing. Out of pocket copayments, coinsurance or deductible amounts will generally be lower when Covered Services are received from In-Network Providers.

Non-Plan Providers may not accept Our Allowable Charge as payment in full. If Members use a Non-Plan Provider who charges more than our Allowable Charge the Provider may balance bill the Member the difference. Members will have to pay the difference to the Provider in addition to Copayment or Coinsurance amounts. Charges from Non-Plan Providers will be higher than the Plan's Allowable Charge, so Members will usually pay more out of pocket when using Out-of-Network benefits.

Covered Services Members receive from Non-Plan Providers will be administered under the Plan's PPO Out-of-Network benefits with the following exceptions:

- If during treatment at an In-Network hospital or other In-Network facility Members receive Covered Services from a Non-Plan Provider those Covered Services will be covered under the Plan's In-Network benefits.
- Emergency Care received Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts Members pay out of pocket for Out-of-Network Emergency Care will accumulate toward the Plan's Out-of-Network and In-Network Deductible and Maximum Out-of-Pocket amounts.

However, Members may have to pay the difference between what the Non-Plan Provider charges and the Plan's maximum allowable amount or Allowable Charge in addition to the Plan's Emergency Care Copayment, Coinsurance and Deductible amounts. Amounts a Member pays as a result of balance billing will not accumulate toward Deductible and Maximum Out-of-Pocket amounts. The maximum allowable amount or Allowable Charge for Emergency Care from an Out-of-Network Non-Plan Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In-Network and Out-of-Network Covered Services

In all other situations if there is no In-Network Provider available to provide a Covered Service Members must contact Us before You have 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 Your service or treatment as an Authorized Out-of-Network Service. An Authorized Out-of-Network Service means a Covered Service provided by an Out-of-Network Provider, which has been specifically authorized in advance by Us to be Covered under the Plan's In-Network level of benefits and cost sharing. All other requirements for Pre-Authorization under the plan will also apply to Covered Services from Out-of-Network Providers. If Members see an Out-of-Network Provider for a Covered Service without advance approval from the Plan the claim will be processed under the Plan's Out-of-Network benefits. Advance approval is not required for Out-of-Network Emergency Services. Non-Plan Providers may not accept Our Allowable Charge as payment in full. For Members that see a Non-Plan Provider who charges more than our Allowable Charge the Provider may balance bill for the difference.

Optima Equity Plus 2800/0%
Preferred Provider Organization/Out of Area Plan Summary of Benefits

City of Chesapeake 2021

Effective 1-1-21

This Summary of Benefits lists Your benefits and cost sharing amounts under the Plan.^{1,2} There are two benefit columns. One column lists Your Copayment or the percent Coinsurance You will pay for In-Network benefits from Plan Providers. The other column lists Your Copayment or the percent Coinsurance You will pay for Out-of-Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-Authorization, Covered Services, and Non-Covered Services please read Your entire Summary Plan Description (SPD) document carefully.

Deductibles, Maximum Out-of-Pocket Limits,

	In-Network Benefits	Out-of-Network Benefits
Deductibles per Calendar Year³	\$2,800 per Person \$5,600 per Family	\$3,100 per Person \$6,200 per Family
Maximum Out-of-Pocket Limit per Calendar Year	\$3,500 per Person ⁴ \$7,000 per Family ⁴	\$6,000 per Person ⁵ \$12,000 per Family ⁵

Physician Services

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery⁶.**

Physician Office Visits	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Primary Care Physician (PCP) Office Visit	After Deductible Covered at 100%	After Deductible You Pay 30%
MDLIVE Services Contact MDLIVE at 1-866-648-3638 or mdlive.com/optimahealth	After Deductible Covered at 100%	Virtual Consults are not Covered Out-of-Network
Specialist Office Visit	After Deductible Covered at 100%	After Deductible You Pay 30%
Vaccines and Immunotherapeutic Agents This does not include routine immunizations covered under Preventive Care.	After Deductible Covered at 50%	After Deductible You Pay 50%
Preventive Care^{10,11}	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Routine Annual Physical Exams Well Baby Exams Annual GYN Exams and Pap Smears¹¹ PSA Tests Colorectal Cancer Tests Routine Adult and Childhood Immunizations Screening Colonoscopy Screening Mammograms Women's Preventive Services	Covered at 100%	After Deductible You Pay 30%

Outpatient Therapy and Rehabilitation Services

You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder.

Short Term Therapy Services⁷	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Physical Therapy Occupational Therapy Pre-Authorization is required.⁶ Physical and Occupational Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year. ⁷ Copayment or Coinsurance applies at any place of service.	After Deductible Covered at 100%	After Deductible You Pay 30%
Speech Therapy Pre-Authorization is required.⁶ Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year. ⁷ Copayment or Coinsurance applies at any place of service.	After Deductible Covered at 100%	After Deductible You Pay 30%
Short Term Rehabilitation Services⁷	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Cardiac Rehabilitation Pulmonary Rehabilitation Vascular Rehabilitation Vestibular Rehabilitation Pre-Authorization is required.⁶ Services are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year. ⁷ Copayment or Coinsurance applies at any place of service.	After Deductible Covered at 100%	After Deductible You Pay 30%
Other Outpatient Treatments	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Chemotherapy Radiation Therapy IV Therapy Inhalation Therapy	After Deductible Covered at 100%	After Deductible You Pay 30%
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.	After Deductible Covered at 100%	After Deductible You Pay 30%

Outpatient Dialysis Services		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Dialysis Services Copayment or Coinsurance applies at any place of service.	After Deductible Covered at 100%	After Deductible You Pay 30%
Outpatient Surgery		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Outpatient Surgery Pre-Authorization is required.⁶ Coinsurance or Copayment applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible Covered at 100%	After Deductible You Pay 30%
Outpatient Diagnostic Procedures		
Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Diagnostic Procedures	After Deductible Covered at 100%	After Deductible You Pay 30%
X-Ray Ultrasound Doppler Studies	After Deductible Covered at 100%	After Deductible You Pay 30%
Lab Work	After Deductible Covered at 100%	After Deductible You Pay 30%
Outpatient Advanced Imaging and Testing Procedures		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
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 Magnetic Resonance Spectroscopy (MRS) Single Photon Emission Computed Tomography (SPECT) Nuclear Cardiology Pre-Authorization is required for all procedures except Sleep Studies, MRS, SPECT and Nuclear Cardiology.⁶ Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	After Deductible Covered at 100%	After Deductible You Pay 30%
Maternity Care		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Maternity Care^{8, 10, 11} Pre-Authorization is required for prenatal services.⁶ Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	After Deductible Covered at 100%	After Deductible You Pay 30%

Inpatient Services		
Inpatient Services	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Inpatient Hospital Services Pre-Authorization is required.⁶	After Deductible Covered at 100%	After Deductible You Pay 30%
Transplants Pre-Authorization is required.⁶	After Deductible Covered at 100%	After Deductible You Pay 30%
Skilled Nursing Facilities/Services⁷ Pre-Authorization is required.⁶ Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 90 days combined In- and Out-of-Network per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services. ⁷	After Deductible Covered at 100%	After Deductible You Pay 30%
Ambulance Services		
	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Ambulance Services⁹ Pre-Authorization is required for non-emergent transportation only.⁶ Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	After Deductible Covered at 100%	After Deductible You Pay 30%
Emergency Services		
	In-Network Benefits Copayments/ Coinsurances²	Out-of-Network Benefits Copayments/ Coinsurances²
Emergency Services⁹ Pre-Authorization is <u>not</u> required. Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.	After Deductible Covered at 100%	After Deductible Covered at 100%
Urgent Care Center Services		
	In-Network Benefits Copayments/ Coinsurances²	Out-of-Network Benefits Copayments/ Coinsurances²
Urgent Care Services⁹ Pre-Authorization is <u>not</u> required. 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 an Emergency Services Copayment or Coinsurance.	After Deductible Covered at 100%	After Deductible You Pay 30%
Mental/Behavioral Health & Substance Use Disorder Services		
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Pre-Authorization is required for partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.		
Mental/Behavioral Health/Substance Use Disorder	In-Network Benefits Copayments/ Coinsurances²	Out-of-Network Benefits Copayments/ Coinsurances²
Inpatient Services Pre-Authorization is required for all Inpatient Services.⁶	After Deductible Covered at 100%	After Deductible You Pay 30%
Outpatient Office Visits	After Deductible Covered at 100%	After Deductible You Pay 30%

Diabetes Treatment

Coverage includes benefits for equipment, 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 noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating Eye Med Provider at the applicable office visit Copayment or Coinsurance amount.

	In-Network Benefits Copayments/ Coinsurances ²	Out-of-Network Benefits Copayments/ Coinsurances ²
Insulin Pumps Pre-Authorization is required.⁶	After Deductible Covered at 100%	After Deductible You Pay 30%
Pump Infusion Sets and Supplies Pre-Authorization is required.⁶	After Deductible Covered at 100%	After Deductible You Pay 30%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution.	After Deductible Covered at 100%	After Deductible You Pay 30%
Insulin, Needles, and Syringes	Covered under the Prescription Drug Benefit.	Covered under the Prescription Drug Benefit.
Outpatient Self-Management Training and Education and Nutritional Therapy	After Deductible Covered at 100%	After Deductible You Pay 30%

Other Covered Services

	In-Network Benefits Copayments/ Coinsurances ²	Out-of-Network Benefits Copayments/ Coinsurances ²
Prosthetics and Components Pre-Authorization is required.⁶ Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components. Definitions: "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. "Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.	After Deductible Covered at 100%	After Deductible You Pay 30%

Other Covered Services		
	In-Network Benefits Copayments/ Coinsurances ²	Out-of-Network Benefits Copayments/ Coinsurances ²
<p>Autism Spectrum Disorder Pre-Authorization is required.⁶ Covered Services include “diagnosis” and “treatment” of Autism Spectrum Disorder.</p> <p>“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.</p> <p>“Diagnosis of autism spectrum disorder” means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.</p> <p>“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) psychiatric care, (iii) psychological care, (iv) therapeutic care, and (v) <u>applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.</u></p> <p>“Applied behavioral 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.</p>	<p>Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor 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.</p> <p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>	<p>Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor 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.</p> <p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>
<p>Clinical Trials Pre-Authorization is required.⁶ Coverage of Routine patient costs for Phase I, II and 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.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>

Other Covered Services		
	In-Network Benefits Copayments/ Coinsurances ²	Out-of-Network Benefits Copayments/ Coinsurances ²
<p>Chiropractic Care ^{6, 7} Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit.⁶ Pre-Authorization is required by ASH for all chiropractic care services. To receive services, contact ASH's Member Services at 1-800-678-9133. Representatives are available from 8 AM to 9 PM Monday-Friday. Coverage is limited to a combined maximum benefit with In- and Out-of-Network benefits of 20 visits per calendar year⁷. This benefit also includes coverage of Chiropractic appliances up to a combined maximum benefit with In-and Out-of-Network benefits of 1 appliance per Person per calendar year when medically necessary.⁷ For providers not in the ASH network the Member will be responsible for payment of all charges in excess of ASH's allowable charge in addition to any Coinsurance amount. Allowable charge is the lesser of the provider's actual charge or ASH's In-Network fee schedule for the same services.</p>	After Deductible Covered at 100%	After Deductible You Pay 30% of ASH's fee schedule
<p>Durable Medical Equipment (DME) and Supplies Orthopedic Devices and Prosthetic Appliances Pre-Authorization is required for single items over \$750.⁶ Pre-Authorization is required for all rental items.⁶ Pre-Authorization is required for repair and replacement.⁶ Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.</p>	After Deductible Covered at 100%	After Deductible You Pay 30%
<p>Early Intervention Services Pre-Authorization is required.⁶ Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.</p>	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.

Other Covered Services		
	In-Network Benefits Copayments/ Coinsurances²	Out-of-Network Benefits Copayments/ Coinsurances²
<p>Home Health Care Skilled Services⁷ Pre-Authorization is required.⁶ Services are covered up to a maximum combined benefit with In-Network and Out-of-Network benefits of 100 visits per calendar year for Members who are home bound, and in the Plan's judgment require Home Health Skilled Services.⁷ You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.</p>	After Deductible Covered at 100%	After Deductible You Pay 30%
<p>Hospice Care Pre-Authorization is required.⁶</p>	After Deductible Covered at 100%	After Deductible You Pay 30%
<p>Preventive Vision Services⁷ Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 12 months when done by a participating EyeMed Provider. To contact EyeMed about participating Providers call 1-888-610-2268.</p>	Covered at 100% Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.	For eye examinations from Out-of-Network Non-Plan Providers, Members will be reimbursed up to \$30 for an eye examination only. Cost sharing amounts You pay for benefits will not count toward Your Deductible or Maximum Out of Pocket Limit.
<p>Telemedicine Services Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.</p>	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. 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.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. 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.

Other Covered Services		
	In-Network Benefits Copayments/ Coinsurances ²	Out-of-Network Benefits Copayments/ Coinsurances ²
Hearing Aid Rider⁷ Pre-Authorization is required.⁶ The following services are covered up to the annual maximum benefit of \$2,500 per ear: <ul style="list-style-type: none"> the hearing aid(s); audiometric specialist office visits for fitting, including molds and dispensing; repair, replacement or refurbishment of the hearing aid(s) Batteries are not covered. Supplies are not covered.	After Deductible Covered at 100% Replacement is covered only every 36 months from date of acquisition.	After Deductible You Pay 30% Replacement is covered only every 36 months from date of acquisition.
Wigs⁷ Reimbursement for wigs in conjunction with chemotherapy.	After Deductible Coverage is limited to a maximum benefit of \$250 once every 12 months.	

Notes

All benefits are subject to the terms and conditions in the Summary Plan Description (SPD). Words that are capitalized are defined terms listed in the Definitions section of the SPD.

Children are covered up to the end of the month in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your 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.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your SPD for details about how to file a complaint or an appeal.

Under certain circumstances Your coverage can be terminated. However, Your Coverage can only be rescinded for fraud or intentional misrepresentation of material fact. Please look in Your SPD in the section on When Your Coverage will end.

For Optima Health plans that require that You choose a Primary Care Provider (PCP) You have the right to choose any PCP who participates in our network and who is available to accept You or Your family members. For children, You may choose a pediatrician as the PCP.

- You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.
- Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

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

Covered Services You receive from Non-Plan Providers will be administered under Your Out-of-Network benefits with the following exceptions:

- If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits.
- Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network

Emergency Care will accumulate toward Your Plan's Out-of-Network Deductible and Maximum Out-of-Pocket amounts.

When You use Out-of-Network benefits from Non-Plan Providers Allowable Charge may be a negotiated rate; or if there is no negotiated rate Allowable Charge is Optima Health's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full. If You use a Non-Plan Provider who charges more than our allowable amount the Provider may balance bill You for the difference. You will have to pay the difference to the Provider in addition to Your Copayment or Coinsurance amount. Charges from Non-Plan Providers will be higher than the Plan's Allowable Charge, so You will usually pay more out of pocket when You use Out-of-Network benefits.

Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at Your In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's Out-of-Network Deductible and Maximum Out-of-Pocket amounts. However, You may have to pay the difference between what the Non-Plan Provider charges and the Plan's maximum allowable amount or Allowable Charge in addition to Your Emergency Care Copayment, Coinsurance and Deductible amounts. Amounts You pay as a result of balance billing will not accumulate toward Deductible and Maximum Out-of-Pocket amounts.

The maximum allowable amount or Allowable Charge for Emergency Care from an Out-of-Network Non-Plan Provider will be the greatest of the following:

- i. The amount negotiated with In-Network Providers for the Emergency service;
 - ii. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost sharing for the Out-of-Network cost-sharing; or
 - iii. The amount that would be paid under Medicare for the Emergency service.
3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. If You have individual coverage You must satisfy the individual Member Deductible before Coverage begins. If You have family coverage You must satisfy the family coverage Deductible. Your Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual Member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. A Plan may have separate individual and family Deductibles for In-Network Covered Services and for Out-of-Network Services. Deductibles will not be reimbursed under the Plan. The Deductible does not apply to Preventive Care Visits and Screenings from In-Network Plan Providers. Amounts applied to Your In-Network Deductible will apply toward Your Plan's In-Network Maximum Out of Pocket Limit. Amounts applied to Your Out-of-Network Deductible will apply toward Your Out-of-Network Maximum Out of Pocket Limit. Should the Federal Government adjust the Deductible for high Deductible health plans as defined by the Internal Revenue Service, the Deductible amount in the Policy will be adjusted accordingly.
4. **Maximum Out of Pocket Limit for In-Network Benefits** means the total dollar amount You and Your family pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's Out-of-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out of Pocket Amount Optima Health will cover most In-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Plan In-Network benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out of Pocket Amount Optima Health will cover most In-Network benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayments or Coinsurances or any other charges for the following will not count toward Your In-Network Maximum Out of Pocket Limit:**

1. Amounts You pay for services or charges not covered under Your Plan;

2. Amounts You pay for any services after a benefit limit has been reached;
 3. Balance billing amounts from Non-Plan Providers;
 4. Premium amounts;
 5. Amounts You pay for Out-of-Network Services;
- 5. Maximum Out of Pocket Limit for Out-of-Network Benefits** means the total dollar amount You and Your family will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's In-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out-of-Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **If a service does not count toward Your Maximum Out-of-Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Deductibles, Copayments, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out of Pocket Limit:**
1. Amounts You pay for services or charges not covered under Your Plan;
 2. Amounts You pay for services after a benefit limit has been reached;
 3. Amounts You pay for In- Network Benefits;
 4. Amounts You pay for Vision care;
 5. Amounts You pay for any benefits covered under a plan rider including riders for Infertility Treatment, Vision Care and Materials, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction;
 6. Amounts applied to Your In-Network Deductible;
 7. Balance billing amounts that exceed the Plan's Allowable Charge for a Covered Service from a Non-Plan Provider;
 8. Premium amounts;
 9. Amounts You pay for transplant services from Non-Plan Providers
6. This benefit requires Pre Authorization before You receive services. We have instructions and procedures in place for providers to obtain Pre-Authorization through Case Management/Clinical Care Services. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.
 7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your Maximum Out of Pocket Maximum Limit.
 8. 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. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.
 9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the Member received care from a Plan Provider.
 10. Preventive Care includes the services listed below. You may be responsible for an office visit Copayment or Coinsurance when You receive preventive care. Some services may be administered under Your prescription drug benefit. Where no frequency or limits are indicated the Plan will use its normal medical care management

processes to determine frequency and appropriate level of covered services under this benefit. Please use the following link for a complete list of covered preventive care services: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>

1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;
2. Immunizations for routine use in children, adolescents, and adults 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. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:
 - **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 sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
 - **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
 - **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
 - **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
 - **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
 - **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
 - **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.
11. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your SPD in the Utilization Management Section for more information on Pre-Authorization.

Optima Plus 750/25/25%
Preferred Provider Organization/Out of Area Plan Summary of Benefits

City of Chesapeake 2021

Effective 1-1-21

(This Plan is closed to new enrollments effective 1-1-17)

This Summary of Benefits lists Your benefits and cost sharing amounts under the Plan.^{1,2} There are two benefit columns. One column lists Your Copayment or the percent Coinsurance You will pay for In-Network benefits from Plan Providers. The other column lists Your Copayment or the percent Coinsurance You will pay for Out-of-Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-Authorization, Covered Services, and Non-Covered Services please read Your entire Certificate of Insurance (COI) document carefully.

Deductibles, Maximum Out-of-Pocket Limits,

	In-Network Benefits	Out-of-Network Benefits
Deductibles per Calendar Year³	\$750 per Person \$1,500 per Family	\$1,000 per Person \$2,000 per Family
Maximum Out-of-Pocket Limit per Calendar Year	\$4,000 per Person ⁴ \$8,000 per Family ⁴	\$5,000 per Person ⁵ \$10,000 per Family ⁵

Physician Services

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery⁶.**

Physician Office Visits	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Primary Care Physician (PCP) Office Visit	You Pay \$25 Copayment	After Deductible You Pay 40%
MDLIVE Services Contact MDLIVE at 1-866-648-3638 or mdlive.com/optimahealth	Covered at 100%	Virtual Consults are not Covered Out-of-Network
Specialist Office Visit	You Pay \$70 Copayment	After Deductible You Pay 40%
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of \$250 per dose. This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 50%	After Deductible You Pay 50%
Preventive Care^{10,11}	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Routine Annual Physical Exams Well Baby Exams Annual GYN Exams and Pap Smears¹¹ PSA Tests Colorectal Cancer Tests Routine Adult and Childhood Immunizations Screening Colonoscopy Screening Mammograms Women's Preventive Services	Covered at 100%	After Deductible You Pay 40%

Outpatient Therapy and Rehabilitation Services

You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder.

Short Term Therapy Services⁷	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Physical Therapy Occupational Therapy Pre-Authorization is required.⁶ Physical and Occupational Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year. ⁷ Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 40%
Speech Therapy Pre-Authorization is required.⁶ Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year. ⁷ Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 40%
Short Term Rehabilitation Services⁷	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Cardiac Rehabilitation Pulmonary Rehabilitation Vascular Rehabilitation Vestibular Rehabilitation Pre-Authorization is required.⁶ Services are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year. ⁷ Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 40%
Other Outpatient Treatments	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Chemotherapy Radiation Therapy IV Therapy Inhalation Therapy	You Pay \$25 Copayment per PCP office visit You Pay \$70 Copayment per Specialist office visit After Deductible You Pay 25% per outpatient facility visit	After Deductible You Pay 40%
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.	After Deductible You Pay 25%	After Deductible You Pay 40%

Outpatient Dialysis Services		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Dialysis Services Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 25%	After Deductible You Pay 40%
Outpatient Surgery		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Outpatient Surgery Pre-Authorization is required.⁶ Coinsurance or Copayment applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible You Pay 25%	After Deductible You Pay 40%
Outpatient Diagnostic Procedures		
Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Diagnostic Procedures	After Deductible You Pay 25%	After Deductible You Pay 40%
X-Ray	After Deductible You Pay 25%	After Deductible You Pay 40%
Ultrasound	After Deductible You Pay 25%	After Deductible You Pay 40%
Doppler Studies	After Deductible You Pay 25%	After Deductible You Pay 40%
Lab Work	After Deductible You Pay 25%	After Deductible You Pay 40%
Outpatient Advanced Imaging and Testing Procedures		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
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 Magnetic Resonance Spectroscopy (MRS) Single Photon Emmission Computed Tomography (SPECT) Nuclear Cardiology Pre-Authorization is required for all procedures except Sleep Studies, MRS, SPECT and Nuclear Cardiology.⁶ Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	After Deductible You Pay 25%	After Deductible You Pay 40%
Maternity Care		
	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Maternity Care^{8, 10, 11} Pre-Authorization is required for prenatal services.⁶ Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	After Deductible You Pay 25%	After Deductible You Pay 40%

Inpatient Services		
Inpatient Services	In-Network Benefits Copayments/ Coinsurance²	Out-of-Network Benefits Copayments/ Coinsurance²
Inpatient Hospital Services Pre-Authorization is required.⁶	After Deductible You Pay 25%	After Deductible You Pay 40%
Transplants Pre-Authorization is required.⁶	After Deductible You Pay 25%	After Deductible You Pay 40%
Skilled Nursing Facilities/Services⁷ Pre-Authorization is required.⁶ Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 90 days combined In- and Out-of-Network per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services. ⁷	After Deductible You Pay 25%	After Deductible You Pay 40%
Ambulance Services		
	In-Network Benefits Copayments/Coinsurance²	Out-of-Network Benefits Copayments/Coinsurances²
Ambulance Services⁹ Pre-Authorization is required for non-emergent transportation only.⁶ Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	After Deductible You Pay \$25 Copayment and You Pay 25%	After Deductible You Pay 40%
Emergency Services		
	In-Network Benefits Copayments/ Coinsurances²	Out-of-Network Benefits Copayments/ Coinsurances²
Emergency Services⁹ Pre-Authorization is <u>not</u> required. Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.	After Deductible You Pay 25%	After Deductible You Pay 25%
Urgent Care Center Services		
	In-Network Benefits Copayments/ Coinsurances²	Out-of-Network Benefits Copayments/ Coinsurances²
Urgent Care Services⁹ Pre-Authorization is <u>not</u> required. 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 an Emergency Services Copayment or Coinsurance.	You Pay \$70 Copayment	After Deductible You Pay 40%
Mental/Behavioral Health & Substance Use Disorder Services		
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Pre-Authorization is required for partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.		
Mental/Behavioral Health/Substance Use Disorder	In-Network Benefits Copayments/ Coinsurances²	Out-of-Network Benefits Copayments/ Coinsurances²
Inpatient Services Pre-Authorization is required for all Inpatient Services.⁶	After Deductible You Pay 25%	After Deductible You Pay 40%
Outpatient Office Visits	You Pay \$25 Copayment	After Deductible You Pay 40%

Diabetes Treatment

Coverage includes benefits for equipment, 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 noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating Eye Med Provider at the applicable office visit Copayment or Coinsurance amount.

	In-Network Benefits Copayments/ Coinsurances ²	Out-of-Network Benefits Copayments/ Coinsurances ²
Insulin Pumps Pre-Authorization is required.⁶	Covered at 100%	After Deductible You Pay 40%
Pump Infusion Sets and Supplies Pre-Authorization is required.⁶	Covered at 100%	After Deductible You Pay 40%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution.	Covered at 100%	After Deductible You Pay 40%
Insulin, Needles, and Syringes	Covered under the Prescription Drug Benefit.	Covered under the Prescription Drug Benefit.
Outpatient Self-Management Training and Education and Nutritional Therapy	Covered at 100%	After Deductible You Pay 40%

Other Covered Services

	In-Network Benefits Copayments/ Coinsurances ²	Out-of-Network Benefits Copayments/ Coinsurances ²
Prosthetics and Components Pre-Authorization is required.⁶ Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components. Definitions: "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. "Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.	After Deductible You Pay 30%	After Deductible You Pay 40%

Other Covered Services		
	In-Network Benefits Copayments/ Coinsurances²	Out-of-Network Benefits Copayments/ Coinsurances²
<p>Autism Spectrum Disorder Pre-Authorization is required.⁶ Covered Services include “diagnosis” and “treatment” of Autism Spectrum Disorder.</p> <p>“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.</p> <p>“Diagnosis of autism spectrum disorder” means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.</p> <p>“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) psychiatric care, (iii) psychological care, (iv) therapeutic care, and (v) <u>applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.</u></p> <p>“Applied behavioral 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.</p>	<p>Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor 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.</p> <p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>	<p>Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor 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.</p> <p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>
<p>Clinical Trials Pre-Authorization is required.⁶ Coverage of Routine patient costs for Phase I, II and 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.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>

Other Covered Services		
	In-Network Benefits Copayments/ Coinsurances ²	Out-of-Network Benefits Copayments/ Coinsurances ²
<p>Chiropractic Care ^{6, 7} Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit.⁶ Pre-Authorization is required by ASH for all chiropractic care services. To receive services, contact ASH's Member Services at 1-800-678-9133. Representatives are available from 8 AM to 9 PM Monday-Friday. Coverage is limited to a combined maximum benefit with In- and Out-of-Network benefits of 25 visits per calendar year⁷. This benefit also includes coverage of Chiropractic appliances up to a combined maximum benefit with In-and Out-of-Network benefits of 1 appliance per Person per calendar year when medically necessary. ⁷ For providers not in the ASH network the Member will be responsible for payment of all charges in excess of ASH's allowable charge in addition to any Coinsurance amount. Allowable charge is the lesser of the provider's actual charge or ASH's In-Network fee schedule for the same services.</p>	After Deductible You Pay 25% of ASH's fee schedule	After Deductible You Pay 40% of ASH's fee schedule
<p>Durable Medical Equipment (DME) and Supplies Orthopedic Devices and Prosthetic Appliances Pre-Authorization is required for single items over \$750⁶ Pre-Authorization is required for all rental items.⁶ Pre-Authorization is required for repair and replacement.⁶ Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.</p>	After Deductible You Pay 30%	After Deductible You Pay 40%
<p>Early Intervention Services Pre-Authorization is required.⁶ Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.</p>	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.

Other Covered Services		
	In-Network Benefits Copayments/ Coinsurances²	Out-of-Network Benefits Copayments/ Coinsurances²
<p>Home Health Care Skilled Services⁷ Pre-Authorization is required.⁶ Services are covered up to a maximum combined benefit with In-Network and Out-of-Network benefits of 100 visits per calendar year for Members who are home bound, and in the Plan's judgment require Home Health Skilled Services.⁷ You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.</p>	After Deductible You Pay 25%	After Deductible You Pay 40%
<p>Hospice Care Pre-Authorization is required.⁶</p>	After Deductible You Pay 25%	After Deductible You Pay 40%
<p>Preventive Vision Services⁷ Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 12 months when done by a participating EyeMed Provider. To contact EyeMed about participating Providers call 1-888-610-2268.</p>	<p>Covered at 100% Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.</p> <p>Cost sharing amounts You pay for benefits will not count toward Your Deductible or Maximum Out of Pocket Limit unless services are considered an Essential Health Benefit (EHB) for children.</p>	<p>For eye examinations from Out-of-Network Non-Plan Providers, Members will be reimbursed up to \$30 for an eye examination only.</p> <p>Cost sharing amounts You pay for benefits will not count toward Your Deductible or Maximum Out of Pocket Limit.</p>
<p>Telemedicine Services Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. 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.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. 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.</p>

Other Covered Services		
	In-Network Benefits Copayments/ Coinsurances ²	Out-of-Network Benefits Copayments/ Coinsurances ²
Hearing Aid Rider⁷ Pre-Authorization is required.⁶ The following services are covered up to the annual maximum benefit of \$2,500 per ear: <ul style="list-style-type: none"> the hearing aid(s); audiometric specialist office visits for fitting, including molds and dispensing; repair, replacement or refurbishment of the hearing aid(s) Batteries are not covered. Supplies are not covered.	After Deductible You Pay \$70 Copayment Replacement is covered only every 36 months from date of acquisition.	After Deductible You Pay 40% Replacement is covered only every 36 months from date of acquisition.
Wigs⁷ Reimbursement for wigs in conjunction with chemotherapy.	After Deductible Coverage is limited to a maximum benefit of \$250 once every 12 months.	

Notes

All benefits are subject to the terms and conditions in the Summary Plan Description (SPD). Words that are capitalized are defined terms listed in the Definitions section of the SPD.

Children are covered up to the end of the month in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your 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.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your SPD for details about how to file a complaint or an appeal.

Under certain circumstances Your coverage can be terminated. However, Your Coverage can only be rescinded for fraud or intentional misrepresentation of material fact. Please look in Your SPD in the section on When Your Coverage will end.

For Optima Health plans that require that You choose a Primary Care Provider (PCP) You have the right to choose any PCP who participates in our network and who is available to accept You or Your family members. For children, You may choose a pediatrician as the PCP.

- You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.
- Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

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

Covered Services You receive from Non-Plan Providers will be administered under Your Out-of-Network benefits with the following exceptions:

- If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits.
- Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's Out-of-Network Deductible and Maximum Out-of-Pocket amounts.

When You use Out-of-Network benefits from Non-Plan Providers Allowable Charge may be a negotiated rate; or if there is no negotiated rate Allowable Charge is Optima Health's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full. If You use a Non-Plan Provider who charges more than our allowable amount the Provider may balance bill You for the difference. You will have to pay the difference to the Provider in addition to Your Copayment or Coinsurance amount. Charges from Non-Plan Providers will be higher than the Plan's Allowable Charge, so You will usually pay more out of pocket when You use Out-of-Network benefits.

Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at Your In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's Out-of-Network Deductible and Maximum Out-of-Pocket amounts. However, You may have to pay the difference between what the Non-Plan Provider charges and the Plan's maximum allowable amount or Allowable Charge in addition to Your Emergency Care Copayment, Coinsurance and Deductible amounts. Amounts You pay as a result of balance billing will not accumulate toward Deductible and Maximum Out-of-Pocket amounts.

The maximum allowable amount or Allowable Charge for Emergency Care from an Out-of-Network Non-Plan Provider will be the greatest of the following:

- i. The amount negotiated with In-Network Providers for the Emergency service;
 - ii. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost sharing for the Out-of-Network cost-sharing; or
 - iii. The amount that would be paid under Medicare for the Emergency service.
3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. Your Plan may have separate Deductible amounts You have to meet for In-Network Covered Services and for Out-of-Network Covered Services. Amounts applied to an In-Network Deductible will apply toward the Plan's In-Network Maximum Out of Pocket Limit. Amounts applied to an Out-of-Network Deductible will apply toward the Plan's Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage You must satisfy the individual Member coverage Deductible before coverage begins. If You have family coverage You and Your family must satisfy the family coverage Deductible. This Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual Member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. Amounts You are required to pay for preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Preventive Care Visits and Screenings You receive from In-Network Plan Providers. Cost sharing amounts You pay for some Covered Services will not count toward any Deductible. Deductibles will not be reimbursed under the Plan. Any part of the calendar year Deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year.
4. **Maximum Out of Pocket Limit for In-Network Benefits** means the total dollar amount You and Your family pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's Out-of-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out of Pocket Amount Optima Health will cover most In-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Plan In-Network benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out of Pocket Amount Optima Health will cover most In-Network benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayments or Coinsurances or any other charges for the following will not count toward Your In-Network Maximum Out of Pocket Limit:**

1. Amounts You pay for services or charges not covered under Your Plan;

2. Amounts You pay for services after a benefit limit has been reached;
 3. Balance billing amounts from Non-Plan Providers;
 4. Premium amounts;
 5. Amounts You pay for Out-of-Network Services;
 6. Cost Sharing amounts including Copayments, Coinsurance, and Deductibles for the following:
 - i. Amounts You pay for Vision care unless services are considered an Essential Health Benefit (EHB) for children
 - ii. Amounts You pay for any benefits covered under a plan rider including riders for Vision Care and Materials unless services are considered an Essential Health Benefit (EHB) for children, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction unless services are considered Essential Health Benefit (EHB) for children
5. **Maximum Out of Pocket Limit for Out-of-Network Benefits** means the total dollar amount You and Your family will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's In- Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Deductibles, Copayments, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out of Pocket Limit:**
1. Amounts You pay for services or charges not covered under Your Plan;
 2. Amounts You pay for services after a benefit limit has been reached;
 3. Amounts You pay for In- Network Benefits;
 4. Amounts You pay for Vision care;
 5. Amounts You pay for any benefits covered under a plan rider including riders for Infertility Treatment, Vision Care and Materials, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction;
 6. Amounts applied to Your In-Network Deductible;
 7. Balance billing amounts that exceed the Plan's Allowable Charge for a Covered Service from a Non-Plan Provider;
 8. Premium amounts;
 9. Amounts You pay for transplant services from Non-Plan Providers;
6. This benefit requires Pre Authorization before You receive services. We have instructions and procedures in place for providers to obtain Pre-Authorization through Case Management/Clinical Care Services. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.
7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your Maximum Out of Pocket Maximum Limit.
8. 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. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.
9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical

screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the Member received care from a Plan Provider.

10. Preventive Care includes the services listed below. You may be responsible for an office visit Copayment or Coinsurance when You receive preventive care. Some services may be administered under Your prescription drug benefit. Where no frequency or limits are indicated the Plan will use its normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Please use the following link for a complete list of covered preventive care services: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>
1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;
 2. Immunizations for routine use in children, adolescents, and adults 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. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
 3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
 4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:
 - **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 sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
 - **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
 - **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
 - **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
 - **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
 - **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
 - **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.
11. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your SPD in the Utilization Management Section for more information on Pre-Authorization.

Section 1 - Definition

- 1.1 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, subject to Section 5.18, 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 accident or injury under such law, then such accident or injury shall be considered "non-occupational," regardless of its cause.
- 1.2 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.
- 1.3 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.)
- 1.4 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.
- 1.5 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.

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Section 1 - Definition

When a Covered Person uses Out-of-Network benefits from Non-Plan Providers the Allowable Charge may be a negotiated rate; or if there is no negotiated rate the Allowable Charge is the Plan's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full. Except during an Emergency or otherwise noted in this SPD, if Covered Persons use a Non-Plan Provider who charges more than our allowable amount the Provider may balance bill the Covered Person for the difference. Covered Persons will have to pay the difference to the Provider in addition to their Copayment or Coinsurance amount. Charges from Non-Plan Providers will be higher than the Plan's Allowable Charge so Covered Persons will usually pay more out of pocket when using Out of Network benefits.

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.

- 1.6 CASE MANAGEMENT/CLINICAL CARE SERVICES** mean Individual review and follow-up for ongoing services.
- 1.7 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.
- 1.8 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.
- 1.9 CLAIMANT** means a Covered Person or person authorized to act on their behalf in filing a request for Plan benefits.
- 1.10 COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law No. 99-272, and any subsequent amendments thereto.
- 1.11 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.
- 1.12 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.
- 1.13 CONCURRENT REVIEW** means ongoing medical review of the Covered Person's care while hospitalized.

Section 1 - Definition

- 1.14 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.
- 1.15 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.
- 1.16 COVERAGE** 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.
- 1.17 COVERED PERSON** means the Employee, and his/her Dependent(s) as defined in Section 2, who meet the eligibility requirements of the Plan Sponsor, and who are enrolled hereunder.
- 1.18 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.
- 1.19 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:
- A. help in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing;
 - B. preparing meals or special diets;
 - C. moving the patient;
 - D. acting as a companion or sitter;
 - E. 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.

Section 1 - Definition

- 1.20 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.
- 1.21 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 has been received by the Plan.
- 1.22 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.
- 1.23 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.
- 1.24 EMERGENCY** means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (a) serious jeopardy to the mental or physical health of the individual, or (b) danger of serious impairment of the individual's bodily functions, or (c) serious dysfunction of any of the individual's bodily organs, or (d) in the case of a pregnant woman, serious jeopardy to the health of the fetus.
- 1.25 EMERGENCY MEDICAL CONDITION** means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 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

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dysfunction of any bodily organ or part.)

- 1.26 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.
- 1.27 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.
- 1.28 EXPERIMENTAL/INVESTIGATIONAL** A drug, device, medical treatment or procedure may be considered experimental/investigational if:
- A. the majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
 - B. 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
 - C. 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
 - D. the drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
 - E. the drug, device, or medical treatment is approved as Category B Non- experimental/Investigational by the FDA; or
 - F. the drug, device, medical treatment or procedure is:
 - 1. currently under study in a Phase I or II clinical trial or
 - 2. an experimental study/investigational arm of a Phase III clinical study or
 - 3. otherwise under study to determine safety and efficacy/compare its safety and efficacy to current standards of care.

Section 1 - Definition

1.29 HOME HEALTH CARE AGENCY means an agency or organization, or subdivision thereof, which:

- A. is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home;
- B. is duly licensed, if required, by the appropriate licensing facility;
- C. 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;
- D. provides full-time supervision of such services by a Physician or by a R.N.;
- E. maintains a complete medical record on each patient; and
- F. has a full-time administrator.

1.30 HOME HEALTH CARE PLAN means a program:

- A. for the care and treatment of the Covered Person in his or her home;
- B. established and approved in writing by his or her attending Physician;
- C. certified, by the attending Physician, as required for the proper treatment of the injury or illness, and
- D. in place of inpatient treatment in a Hospital or in a Skilled Nursing Facility.

1.31 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.

1.32 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.

1.33 HOSPITAL means an institution which:

- A. is accredited under one of the programs of the Joint Commission on Accreditation of Health Care Organizations; or
- B. is licensed as a hospital under the laws of the jurisdiction where it is located;

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- C. 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;
- D. provides 24-hour nursing service rendered or supervised by an R.N.; and
- E. 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.

- 1.34 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.
- 1.35 INFERTILITY** means that the Covered Person is unable to conceive or produce conception after one year of unprotected intercourse; or if older than age 35 the Covered Person is unable to conceive or produce conception after six months of unprotected intercourse; and/or in either of the above situations the Covered Person is unable to carry the fetus to term (e.g. three or more consecutive spontaneous miscarriages prior to 20 weeks gestational age.)
- 1.36 IN-NETWORK SERVICES** means the level of benefits a Covered Person uses when he or she seeks Covered Services from a Plan Provider.
- 1.37 MAXIMUM OUT OF POCKET AMOUNT or MAXIMUM OUT OF POCKET LIMIT** means the total amount a Covered Person and/or eligible Dependent(s) pay during a calendar year as specified on the Plan Schedule of Benefits.
- 1.38 MEDICAL DIRECTOR** means a duly licensed Physician or his/her designee who has been appointed by Optima Health 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.

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- 1.39 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:
- A. Required to identify, evaluate or treat the Covered Person's condition, disease, ailment or injury, including pregnancy related conditions;
 - B. In accordance with recognized standards of care for the Covered Person's condition, disease, ailment or injury;
 - C. Appropriate with regard to standards of good medical practice;
 - D. Not solely for the convenience of the Covered Person or participating Physician, Hospital, or other health care provider; and
 - E. The most appropriate supply or level of service which can be safely provided to the Covered Person as substantiated by the records and documentation maintained by the provider of the services or supplies.
- 1.40 MEDICARE** means Title XVII of the Act and all amendments thereto.
- 1.41 NON-PLAN PROVIDER** means any provider that is not a Plan Provider.
- 1.42 OPEN ENROLLMENT PERIOD** means a period of time occurring at least once annually during which time any eligible Employee may join or transfer from one type of health care plan to another.
- 1.43 OUT-OF-NETWORK OR OUT-OF-NETWORK SERVICES** means the level of benefits a Covered Person uses when he or she receives Covered Services from Non-Plan Providers.
- 1.44 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.
- 1.45 PLAN** means this self-insured group health plan which arranges to provide to Covered Persons the health insurance benefits that are set forth herein.
- 1.46 PLAN ADMINISTRATOR** means the individual or entity identified who is responsible for the operation of the Plan.
- 1.47 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.

Section 1 - Definition

- 1.48 PLAN PHARMACY** means a pharmacy which is licensed by the State and is under contract to provide covered prescription drugs to Covered Persons.
- 1.49 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.
- 1.50 PLAN SPONSOR/COMPANY** means the City of Chesapeake.
- 1.51 POST-SERVICE CLAIM** means any Claim for a benefit under the Plan that is not a Pre- Service Claim.
- 1.52 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.
- 1.53 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.
- 1.54 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.
- 1.55 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.
- 1.58 RESCISSION or RESEND** 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:
- A. The cancellation or discontinuance of coverage has only a prospective effect; or
 - B. 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.
- 1.59 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.

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1.60 SENTARA (SHP) means Sentara Health Plan, Inc., doing business as Optima 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.

Services from Plan Providers are available only in 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.

1.61 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.

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

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

Section 1 - Definition

- 1.64 URGENT MEDICAL 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 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 an urgent care claim is, except where a physician, with knowledge of the Covered Person's medical condition, determines that the claim is urgent.
- 1.65 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.
- 1.66 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.
- 1.67 YOU/YOUR** means the Covered Person.
- 1.68 WE/US** means Sentara Health Plan, doing business as Optima 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 this Summary Plan Description (SPD.)

Section 2 – Eligibility and Enrollment

2.1 ELIGIBILITY FOR COVERAGE

Eligibility for benefits under this Plan is to be determined by the Plan Sponsor in accordance with the terms herein.

A. Employees. Employees shall be eligible for benefits under this Plan if they are employed by the City on a regular full-time basis, which is at least thirty 30 hours per week, and reside or work in the Service Area.

If an eligible employee is no longer actively at work because of one of the following circumstances, coverage may continue if premiums are being paid on the employee's behalf:

1. For an approved short term leave of absence coverage will continue for not longer than 12 months.
2. For an employee who is totally disabled, coverage will continue for a period of no longer than 12 months. The Plan may require certification of disability from the employee.
3. The Family and Medical Leave Act (FMLA).
Employees on approved leave under the FMLA will remain on the City's health insurance as long as premiums are paid. Premiums will be deducted from the employee's pay while in a paid status; it is the employee's responsibility to pay the Department of Finance the premium which would have been deducted from the employee's paycheck when the employee is in a leave without pay status.
4. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

A covered employee performing military service of more than 30 days may elect to continue employer-sponsored health insurance for up to 24 months; however, he/she will be required to pay 102 percent of the full premium, which represents the City's share plus the employee's share plus two (2) percent for administrative costs. For military service of less than 31 days, health care coverage is provided as if the service Covered Person had remained employed.

Employees must be "actively at work" to receive covered benefits and services. An employee is considered actively at work on any day he or she is employed by the group, meets all the eligibility requirements of the group, 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 group's effective date of coverage must wait until they return to being actively at work to receive covered benefits. 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 group's eligibility requirements are met and premiums are being paid to the Plan.

Section 2 – Eligibility and Enrollment

If an employee's full time hire date is between the 1st and 15th of the month, coverage is effective on the first day of the month following; if an employee's full time hire date is between the 16th and the last day of the month, coverage is effective the first of the month following 30 days of employment provided that completed enrollment information has been received by the Plan from the Employee or on the Employee's behalf.

B. Retirees. In accordance with the City of Chesapeake's Administrative Regulation 2.20, full-time employees who retire from the City of Chesapeake, and are not eligible for Medicare, are eligible for the City's pre-Medicare medical plan if they meet one of the following criteria:

1. They retire after 15 or more years of continuous City service which is credited to the Virginia Retirement System (VRS); or
2. They retire due to line-of-duty injuries with less than 15 years of continuous City employment credited to the VRS.

Eligible retirees shall be entitled to the same benefits and shall have the same responsibilities as Employees under this Plan.

For all other circumstances coverage may continue for an individual who is not actively at work in accordance with City policy, state and federal laws.

C. Dependents. Dependents must be chiefly dependent upon the Employee for support. To be eligible for coverage as a Dependent, a person must be:

1. An Employee's lawful spouse;
2. Children up to the age 26. Eligible children include:
 - a. Natural or step children;
 - b. Legally adopted children;
 - c. Children placed with You for adoption;
 - d. Other children for whom the Employee is a court appointed legal guardian.
3. The Plan will not deny or restrict eligibility for a child who has not attained age 26 based on any of the following:
 - a. financial dependency on the Employee or any other person;
 - b. residency with the Employee or any other person;
 - c. student status;
 - d. employment status; or
 - e. marital status.

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

Section 2 – Eligibility and Enrollment

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.

4. 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 (4). Thus, 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.
5. 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, subject to Section 2.2(E) below.

D. Changes in Eligibility

1. **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 an Employee or Dependent is not eligible for coverage, never was eligible for coverage, and/or submitted false proof of eligibility for coverage, then the Employee's Dependent's coverage may be canceled. Disenrollment of an Employee/Dependent due to ineligibility for coverage may result in the reversal and/or denial of claims during the period of ineligibility. The Employee/Dependent may be held responsible for any charges for claims for

Section 2 – Eligibility and Enrollment

services during the period of ineligibility.

2. **Changes in Eligibility.** It is the Employee'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 Retiree 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 Employee must notify the Plan of a divorce so that the Employee's spouse may be added onto an individual policy or COBRA, if applicable. Disenrollment of an Employee or Dependent due to ineligibility for coverage may result in the reversal and/or denial of claims during the period of ineligibility. The Employee/Dependent maybe held responsible for any charges for claims for services during the period of ineligibility.

E. 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, coverage tier, or to drop coverage. You may change Coverage with respect to your Dependents if one of the following events occurs:

Individual

1. Change in legal marital status including marriage, death of spouse, divorce, legal separation, and annulment;
2. Change in number of dependents including birth, death, adoption, placement for adoption or court appointed legal guardianship;
3. Change in dependents eligibility for coverage;
4. Change in residence of employee, spouse, or dependent that affects eligibility.
5. Spouse or dependent loss of other coverage.

In order for one of these events to qualify as an occasion for changing your 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.

Section 2 – Eligibility and Enrollment

F. Qualified Medical Child Support Order (QMCSO)

Affected participants and beneficiaries can submit a written request to obtain, without charge, a copy of QMCSO from the Finance Department/Payroll Division. All questions, concerns or inquiries regarding “determination” would need to be addressed by the presiding jurisdiction of the particular order(s).

2.2 ENROLLMENT

A. 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.

B. 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.

C. Newly Eligible Dependents Any person attaining eligibility to become a Dependent may be enrolled by the Employee by submitting to the Plan a request for a life event change through the electronic platform, making the allowable enrollment changes and submitting acceptable documentation within thirty-one (31) days of the Dependent's attaining eligibility.

D. 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.

E. 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:

1. **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:
 - a. The Employee and/or Dependent must be eligible under the Plan's terms;
 - b. and the Employee or Dependent was covered under a group plan or had insurance when Coverage was previously offered to that person; and
 - c. 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 (c) 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;

Section 2 – Eligibility and Enrollment

- d. The Employee's or Dependent's coverage described in (b) 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
 - e. 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).
- 2. 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 enrollment under this paragraph 2 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.
- 3. 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 (1) lose eligibility for Medicaid or CHIP coverage or (2) they become eligible to participate in a premium assistance program under Medicaid or CHIP. In both cases the employee must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

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).

2.3 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:

Section 2 – Eligibility and Enrollment

- A. Employees Coverage.** When an Employee makes an application for Coverage through the City’s Employee Self Service portal, coverage will be effective as follows: If an Employee’s full time hire date is between the 1st and 15th of the month, coverage is effective on the first day of the month following; if an Employee’s full time hire date is between the 16th and the last day of the month, coverage is effective the first of the month following 30 days of employment provided that completed enrollment information has been received by the Plan from the Employee or on the Employee's behalf.
- B. 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.
- C. Newborn Children.** A newborn child of the Employee will be covered from the moment of birth if the newborn is added to the Employee’s Coverage within thirty-one (31) days of birth.
- D. 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 and adoption documentation is provided.
- E. HIPAA Special Enrollment Periods Effective Dates**
1. 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.
 2. For special enrollment due to birth, adoption or placement for adoption late enrollment is effective on the date of the birth, adoption or placement for adoption.
 3. For special enrollment due to marriage late enrollment is effective the first day of the calendar following the date of marriage, provided the request for enrollment and marriage certificate are received within thirty-one (31) days following the date of marriage.
- F. 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 is submitted within thirty-one (31) days of the order.

Section 3 – How the Plan Works

3.1. 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 Copayments and/or Coinsurance set forth herein.

Composition of Provider Network

Plan participating providers included Primary Care Physicians, specialist physicians, facilities, and ancillary providers who contract with the Plan to provide Covered Services.

A list of Plan Providers and their locations is available to each Covered Person without 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.

3.2. PRE EXISTING CONDITIONS AND WAITING PERIODS

There are no preexisting condition waiting periods.

3.3. 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 Plan may have separate Deductibles for in-network and out of network services.

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

3.4. MAXIMUM BENEFIT

Maximum Benefit means the total amount of benefits payable for a benefit or covered service. Maximum benefit amounts are listed on the Schedule of Benefits.

3.5. 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

Section 3 – How the Plan Works

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 benefit under the Plan is listed on the Schedule of Benefits. The Plan may have separate Maximum Out of Pocket Amounts for in-network and out-of-network services.

3.6 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 Optima'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.

Section 4 – Internal Claims Provisions and Utilization Management

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 by the Covered Person.

The Schedule of Benefits indicates what services require Pre-Authorization before You receive them. Generally the following types of services require pre-authorization:

- Inpatient hospitalization services;
- partial hospitalization services;
- non-emergency ambulance transport;
- inpatient and outpatient surgery;
- surgery in a physician's office;
- single items of durable medical equipment and orthopedic and prosthetic appliances over \$750;
- rental of durable medical equipment and orthopedic and prosthetic appliances;
- repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances;
- artificial prosthetic limbs;
- prenatal maternity services;
- home health care;
- skilled nursing facility care;
- physical, occupational, and speech therapy;
- cardiac, pulmonary, and vascular rehabilitation;

Section 4 – Internal Claims Provisions and Utilization Management

- 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;
- insulin pumps and pump supplies.

Organ Transplant

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

Newborn Mother Transfer

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

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

Penalty for failure to follow the Plan's Pre-Authorization Procedures

If a Covered Person does not properly follow the Plan's Pre-Authorization procedures and ensure that the provider/physician has obtained Pre-Authorization when it is required, and Optima Health determines through Retrospective Review that the Covered Service was

Medically Necessary, Optima Health will apply a \$500 fee which will be offset against any benefit owed by the Plan. The penalty fee will not count toward any Plan Deductible or maximum out of pocket amounts.

Section 4 – Internal Claims Provisions and Utilization Management

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 performed.

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

Expedited Decisions for Urgent Medical Care or Treatment

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 the Covered Person 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. 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 our decision.

Plan Providers must follow certain procedures to make sure that if a previously approved course of treatment or hospital stay needs to be extended, the extension is requested in time to minimize disruption of needed services. Optima Health 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

Section 4 – Internal Claims Provisions and Utilization Management

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, Covered Person will be notified prior to the end of the initial 30 day period.

If the extension is necessary due to Optima Health 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 Covered Person's medical circumstances. **Please also read Section 14 for complete information on Your rights to file an internal and external appeal of an Adverse Benefit Determination.**

Section 5 – What is Covered

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

Some services may require Pre-Authorization by the Plan before You receive them. You can read about Pre-Authorization in Section 4.

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 out of Your pocket before the Plan will pay for benefits. Your Copayments, Coinsurance and Deductibles are listed on the Schedule of Benefits in this book.

5.1 ACCIDENTAL DENTAL SERVICES

Pre-Authorization is required.

The Plan will cover Medically Necessary dental services as a result of accidental injury to sound natural teeth, regardless of the date of the injury. For injuries that happen on or after Your effective date of coverage, treatment must be sought within 60 days of the accident.

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

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

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

The Plan will cover dental services performed during an Emergency Department visit immediately after an Accidental Injury in conjunction with the initial stabilization of the injury. The Plan may retrospectively review all Emergency Department services. You will pay the Emergency Department Copayment or Coinsurances.

Section 5 – What is Covered

5.2 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.

5.3 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 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.

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.

5.4 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.

5.5 AUTISM SPECTRUM DISORDER

Coverage includes the "Diagnosis" and "Treatment" of "Autism spectrum disorder.

Section 5 – What is Covered

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

Section 5 – What is Covered

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 Biologically Based Mental Health Illness.

5.6 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

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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.

5.7 CHEMOTHERAPY, RADIATION THERAPY, IV THERAPY, AND INHALATION THERAPY

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.

5.8 CHIROPRACTIC SERVICES

The Plan subcontracts with American Specialty Health, through a contract with Sentara Health Plans, Inc. to provide Chiropractic Services in the Plan's Service Area. Pre- Authorization is required by American Specialty Health for all services. If You have questions about what is covered or how to find an American Specialty Health provider, please call American Specialty Health toll free at 1-800-678-9133 Monday through Friday 8 a.m. to 9 p.m.

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

- A. Covered Services include examination, re-examination, manipulation, conjunctive therapy, radiology, chiropractic appliances, and laboratory tests related to the delivery of chiropractic services subject to the following:
 - 1. An initial examination is performed by the participating provider to determine the nature of the Covered Person's problem and, if covered services appear warranted, a treatment plan of services to be furnished is prepared. One initial examination is provided for each new patient. A Copayment is required when services are rendered.
 - 2. A re-examination may be performed by the participating provider to assess the need to continue, extend, or change a treatment plan approved by American Specialty Health. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a co-payment is required.
 - 3. Subsequent office visits, as set forth in a treatment plan approved by

Section 5 – What is Covered

American Specialty Health, may involve an adjustment, a brief re-examination and other services, in various combinations. A co-payment is required for each visit to the office.

4. Adjunctive therapy, as set forth in a treatment plan approved by American Specialty Health, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.
5. X-rays and clinical laboratory tests are payable in full when referred by a participating chiropractor and authorized by American Specialty Health

Radiological consultations are a covered benefit when authorized by American Specialty Health as Medically Necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital which has contracted with American Specialty Health to provide those services.

6. Chiropractic appliances are covered up to the limit stated on the Schedule of Benefits.

B. Exclusions and Limitations

The following are excluded from Coverage:

1. Any services or treatments not authorized by American Specialty Health except for initial examination and Emergency Services.
2. Any services or treatments not delivered by participating chiropractors for the delivery of chiropractic care to Members, except for Emergency Services.
3. Services for examinations and/or treatments for conditions other than those related to neuromusculoskeletal disorders from participating chiropractors.
4. Hypnotherapy, behavior training, sleep therapy, and weight programs.
5. Thermograph.
6. Services, lab tests, X-rays and other treatments not documented as clinically necessary as appropriate or classified as experimental or investigational and/or as being in the research stage.
7. Services and/or treatments that are not documented as Medically Necessary services.
8. Magnetic resonance imaging, CAT scans, bone scans, and nuclear radiology and any diagnostic radiology other than covered plain film studies.
9. Transportation costs including local ambulance charges.
10. Education programs, non-medical self-care or self-help or any self-help physical exercise training or any related diagnostic testing.
11. Services or treatments for pre-employment physicals or vocational rehabilitation.
12. Any services or treatments for pre-employment physicals or

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vocational rehabilitation.

13. Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment, except as described as covered in this section.
14. Drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.
15. Services provided by a chiropractor practicing outside the Service Area, except for Emergency Services.
16. Hospitalization, anesthesia, manipulation under anesthesia and other related services.
17. All auxiliary aids and services, including but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
18. Adjunctive therapy not associated with spinal, muscle or joint manipulation.
19. Vitamins, minerals, or other similar products.

5.9 CLINICAL TRIALS FOR TREATMENT STUDIES ON CANCER AND LIFE THREATENING DISEASES OR CONDITIONS

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:

1. The treatment is being conducted in an approved clinical trial.
2. The Covered Person is a Qualified Individual.
3. The treatment must be provided by a clinical trial approved by:
 - a. The National Cancer Institute;
 - b. An NCI cooperative group or an NCI center;
 - c. The FDA in the form of an investigational new drug application;
 - d. The Federal Department of Veterans Affairs; or
 - e. 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.
4. The facility and personnel providing the treatment must be capable of doing so by virtue of their experience, training and expertise.
5. All of the following must also be true:
 - a. There is no clearly superior, non-investigational treatment alternative; and
 - b. 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

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- c. The Covered Person and the Physician or health care provider who provides services to the Covered Person conclude that the Covered Person'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 include:

“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 Federal 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.

“Covered Person” means a Covered Person.

“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.

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“**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.

5.10 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.

Covered Persons may call 1-800-SENTARA for information on educational classes.

An annual diabetic exam is covered from an Optima Health 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.

Equity Plus Plans - Members may call Liberty Medical Supplies at 1-866-691-9277, Home Care Delivered at 1-800-867-4412; or EdgePark Medical Supplies at 1-888-394-5375 to arrange for prescribed testing supplies to be delivered to them at home. Insulin, syringes and needles are covered under the Plan's prescription drug benefit.

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

5.11 DIAGNOSTIC, X-RAY, AND LABORATORY

SERVICES Pre-authorization is required for diagnostic

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).

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

5.12 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 injury. The Plan also covers colostomy, ileostomy, 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 injury or illness which happened before the child became a Covered Person under this Plan.

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5.13 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.

5.14 EMERGENCY SERVICES

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

Emergency Medical Condition means 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.)

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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.

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

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 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.

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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. Air ambulance services are also covered when pre- authorized or in cases of threatened loss of life.

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

Retrospective Review means Our review of Your medical records and any other supporting documentation after You have received emergency treatment or non-authorized services.

Emergency, Urgent Care, Ambulance, and Emergency Mental Health Services may be subject to Retrospective Review to determine responsibility for payment.

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

The After Hours Nurse Triage Program lets Covered Persons 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.

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

5.15 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.

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.

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

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5.16 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. The benefits include the purchase of blood products and blood infusion equipment required for home treatment. The home treatment program must be under the supervision of the state-approved hemophilia treatment center.

5.17 HOME HEALTH CARE SKILLED

SERVICES Pre-Authorization is required.

The Plan covers Home Health Care Skilled Services for Covered Persons who are homebound for medical reasons, physically unable to seek care on an outpatient basis, or in place of inpatient hospitalization. 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:

- A. **“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 Covered Person’s home; and
 - 2. is duly licensed, if required, by the appropriate licensing facility; and
 - 3. has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered nurse (R.N.) to govern the services provided; and
 - 4. provides for full-time supervision of such services by a Physician or by a registered nurse (R.N.); and
 - 5. maintains a complete medical record on each patient; and
 - 6. has a full-time administrator.

- B. **“Home Health Care Plan”** means a program:

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

C. “Home Health Care Skilled Services” means:

1. Part-time or intermittent nursing care by a nurse or
2. Part-time or intermittent home health aide services which consist primarily of medical or therapeutic caring for the patient; or
3. Physical, speech, and occupational therapy, if provided by the home health care agency; or
4. Surgical dressings, medical appliances, oxygen and supplies which are Medically Necessary for treatment of the Covered Person 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.

D. “Home Health Skilled Care Visit” means:

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

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

5.18 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.

- A. **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.
- B. **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.

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5.19 HOSPITAL SERVICES

Pre-Authorization is required.

A. 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.

B. 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;
- administration of whole blood and blood products;
- 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.

C. 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.

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- 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.

5.20 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.

5.21 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.

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5.22 INTERRUPTION OF PREGNANCY SERVICES

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

5.23 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.

5.24 MATERNITY SERVICES

Pre-Authorization is required for prenatal 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.

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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.

5.25 MEDICAL SUPPLIES AND MEDICATIONS

The Plan will cover medical supplies and prescription medications administered by Express Script and prescribed by Your provider. Some medications and supplies may be covered under the Plan's outpatient prescription drug benefit administered by Express Script. 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

5.26 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).

Optima Health can be reached by calling 757-552-7174 or 1-800-648-8420.

Emergency Mental Health Services and Substance use disorder are subject to the same requirements as emergency medical care and do not require Pre-authorization. The Covered Person's medical benefit covers emergency medical care related to a psychiatric condition. If You receive Emergency Services Out-of-Network from a Non-Plan Provider Your Copayment or Coinsurance rate cannot exceed the cost-sharing requirement that would apply if services were provided In-Network from Plan Providers.

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

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care. 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 licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four hours per day, state-approved program of inpatient substance use disorder services.

“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 as an individual or part of a group while not confined as an inpatient. Such 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

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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.

5.27 ORAL SURGERY

Pre-Authorization is required.

The Plan will cover the following:

- surgical procedures required to repair accidental injuries to the jaws, mouth, lips, tongue or hard and soft palates;
- treatment of fractures of the facial bones;
- excision including diagnostic biopsy of malignant and/or symptomatic tumors and cysts of the jaws, gums, cheeks, lips, tongue, hard and soft palates, and salivary glands;
- orthognathic surgical procedures such as osteotomy or other reconstruction of the jaws and/or facial bones (when associated with severe malocclusion) that are necessary to restore and maintain function;
- 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.

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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.

5.28 PPACA RECOMMENDED PREVENTIVE CARE SERVICES

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

In addition to the Preventive Care Services described section, the Plan will cover preventive services according to PPACA federal health care reform laws and further defined under related federal regulations with no Covered Person cost sharing if services are received from In- network Plan Providers according to the following:

1. Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; and
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings not described in item (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph including:
 - **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
 - **Contraceptive Methods and Counseling including:** Food and Drug Administration- approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
 - **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
 - **Gestational diabetes including** screening for women between 24 and 28 weeks

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pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

- **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
- **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
- **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
- **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services

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

5.29 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 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 Optima Health approved provider.
- maternity care and related checkups.

5.30 PREVENTIVE CARE SERVICES AND SCREENINGS

A. Annual Physicals

The Plan will cover one routine physical exam each year.

B. Annual Gynecological (GYN) Exams

The Plan will cover one routine annual GYN exam every 12 months for females 13 years or older. You must see a Plan provider. You do not need a referral from a PCP. The

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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 OB are not considered routine.

C. Screening Mammograms

The Plan will cover 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.

D. Pap Smears

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

E. Prostate Screening Tests (PSA)

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

F. Colorectal Cancer Screening

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

1. an annual occult blood test;
2. flexible sigmoidoscopy or colonoscopy;
3. radiologic imaging in appropriate circumstances.

G. Routine Hearing Tests

The Plan will cover one annual routine hearing test.

H. Well Child Care

The Plan will cover routine care and periodic review of a child's physical and emotional status. Covered Services include:

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1. a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards;
2. 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;
3. 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.

I. 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.

J. 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;

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- Varicella

5.31 PREVENTIVE VISION CARE

A. In-Network Coverage

The Plan subcontracts with EyeMed Vision Services, through a contract with Sentara Health

Plans, Inc., to administer preventive vision benefits. The Plan covers a routine eye examination, refraction, and prescription for eyeglass lenses from an EyeMed provider.

To receive Covered Services:

1. Select a participating EyeMed network provider from the Plan's provider directory or by calling 1-888-610-2268. Automated location information is available 24 hours a day. Customer service representatives are available Monday through Friday 9 a.m. - 9 p.m., and Saturdays 9 a.m. - 5 p.m.
2. Visit or call the participating provider and identify yourself as a participant by providing Your Member ID information. The provider will verify eligibility, Your Plan's Covered Services and any applicable Copayment or Coinsurance. Payment is due when You receive services.
3. If the vision provider determines that You need additional medical care You should contact Your PCP or other physician for treatment options.

B. Out-of-Network Coverage

If You use a provider that is not in the EyeMed 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 EyeMed Customer Service at 1-888-610- 2268. EyeMed will verify eligibility and give You a claim form. Mail the completed form with a copy of Your bill to:

EyeMed Vision Services
P.O. Box 8504 Mason, OH 45040-7111
Attn: Vision Care Department

5.32 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.

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Definitions:

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

“**Limb**” means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

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

5.33 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 Covered Person. 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.

5.34 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 Your Schedule of Benefits for the maximum number of days per year. Custodial Care is not covered.

5.35 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

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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. Your out of pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount you would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment. Covered Services will include the use of telemedicine technologies as it pertains to Medically Necessary remote patient monitoring services to the full extent that these services are available.

5.36 THERAPY AND REHABILITATION

SERVICES Pre-Authorization is required.

The Plan will cover the following therapy and rehabilitation services:

- physical therapy;
- occupational therapy;
- speech therapy;
- cardiac rehabilitation;
- pulmonary rehabilitation;
- vascular rehabilitation;
- vestibular rehabilitation.

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

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

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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

5.37 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.

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

5.38 VIRTUAL CONSULTS

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

Virtual Consult means a medical consult using a secure platform (as determined by Optima

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Health in its sole discretion) with email, interactive video, and telephone to connect a provider and a patient.

Section 6 – What Is Not Covered (Exclusions and Limitations)

This chapter lists services that are not covered. Services mean both medical and behavioral health (mental health) services and supplies unless 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 is covered in the first 12 weeks of pregnancy. After 12 weeks abortion is covered if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

Acupuncture is not covered.

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

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

Non-medical **Ancillary Services** You are referred to are not covered. Vocational rehabilitation services, employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education, or other non-medical services are not covered.

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

Aromatherapy is not covered.

Artificial Hearts or mechanical heart devices, or their placement **is not covered**.

Autopsies are not covered.

B

Batteries are not covered except for motorized wheelchairs and cochlear implants when authorized

Bone Densitometry Studies more than once every two years are not covered unless authorize by the Plan.

Section 6 – What Is Not Covered (Exclusions and Limitations)

Bone or Joint treatment of the head, neck, face or jaw. The Plan does not exclude coverage 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 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 injury that prevents normal function of the joint or bone.

Botox injections are not covered unless the Plan has approved them.

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

Breast Ductal Lavage is not covered.

Breast Milk from a donor is not covered.

C

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

Chiropractic Care is covered. Chiropractic care includes diagnosis, correction, and management of vertebral subluxations or neuro-musculoskeletal conditions.

Contact Lenses are not covered. Fitting of lenses or eyeglasses is not covered. The Plan will cover 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. The Plan does not cover medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary.

The Plan will not cover any of the following:

- 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;

Section 6 – What Is Not Covered (Exclusions and Limitations)

- 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;
- vitiligo or other cosmetic skin condition treatments by laser, light or other methods.

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

Court ordered examinations or treatments are not covered unless they are determined to be Medically Necessary and are a Covered Service under the Plan.

Custodial Care is not covered. The Plan will not cover any of the following:

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

D

Dentistry/Oral Surgery/Dental Care

Dentistry

- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are not covered.
- The Plan will cover Medically Necessary dental services from an accidental injury. It does not matter when the injury occurred. For injuries occurring on or after Your effective date of coverage treatment must be sought within 60 days of the accident.
- The Plan will cover 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.
- Dental implants or dentures and any preparation work for them are not covered.

Section 6 – What Is Not Covered (Exclusions and Limitations)

- Dental services performed in a hospital or any outpatient facility are not covered. 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 covered.
- Orthodontic treatment prior to orthognathic surgery is not covered.
- Dental implants or dentures and any preparation work for them are not covered.

Dental Care

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are not covered.
- Dental implants or dentures and any preparation work for them are not covered.

Diagnostic tests or Surgical Procedures are not covered where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.

Disposable Medical Supplies are not covered. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide and other disposable supplies are not covered.

Driver Training is not covered.

Durable Medical Equipment (DME) is covered up to the limits stated on Your Plan’s Schedule of Benefits. The Plan will only cover an amount, supply or type of DME that will safely and adequately treat Your condition. The Plan will not cover 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. This includes drugs paid for directly by the clinical trial or another payor.

Section 6 – What Is Not Covered (Exclusions and Limitations)

E

Electron Beam Computer Tomography (EBCT) is not covered. The Plan does not cover any other diagnostic imaging test 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.

Educational Testing, Evaluation, Screening, or tutorial services are not covered. Any other service related to school or classroom performance is not covered. 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.

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

Exercise Equipment is not covered. The Plan does not cover bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment. The Plan does not cover pool, gym, or health club membership fees.

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

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

Eye Examinations required for work are not covered. Corrective or protective eyewear required for work is not covered.

Section 6 – What Is Not Covered (Exclusions and Limitations)

Eye Glasses and contact lenses are not covered. Fitting of lenses or eyeglasses is not covered. The Plan will cover 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 not covered.

Eye Corrective Surgery such as Radial Keratotomy, PRK, LASIK, or any other eye corrective surgery is not covered.

F

The following **Foot Care Services** are not covered 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 Plan does not cover any of the following **Foot Care Services** except for Covered Persons 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 is not covered unless authorized by the Plan. Counseling is covered only as part of the approved genetic test unless considered preventive care.

GIFT programs (Gamete Intrafallopian Transfer) are not covered.

Growth Hormones are only covered under the Plan's Outpatient Prescription Drug Benefits. Growth hormones for the treatment of idiopathic short stature are not covered.

H

Hearing Aids are not covered unless Your plan has a rider. Fittings, molds, batteries or other supplies are not covered unless Your plan has a rider.

Home Births are not covered.

Home Health Care Skilled Services are not covered unless You are homebound, physically unable to seek care on an outpatient basis or the service is provided in lieu of inpatient hospitalization Services are limited as stated on Your Plan's Schedule of Benefits. The Plan does not cover any services after You have reached Your Plan's limit. The Plan will only cover

Section 6 – What Is Not Covered (Exclusions and Limitations)

services or supplies listed in Your home health care plan. Custodial care is not covered. Transportation is not covered.

Hypnotherapy is not covered.

I

Immunizations required for foreign travel or for employment are not covered.

Implants for cosmetic breast enlargement are not covered. The Plan does not cover cosmetic procedures or cosmetic surgery for breast enlargement or reduction. The Plan does not cover procedures for correction of cosmetic physical imperfections. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Incarceration – The Plan does not cover services and treatments done during incarceration in a Local, State, Federal or Community Correctional Facility or prison.

Infertility Services are not covered. **The Plan will not cover any of the following:**

- services, tests, medications, and treatments for the diagnosis or treatment of Infertility;
- services, tests, medications, and treatments for the enhancement of conception;
- services, tests, medications, and treatments that aid in or diagnose potential problems with conception;
- in-vitro Fertilization programs;
- artificial insemination or any other types of artificial or surgical means of conception;
- drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- reproductive material storage;
- treatment 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;
- semen analysis;
- Sims-Huhner test (smear);
- drugs used to treat infertility.

J

K

Keloids from body piercing or pierced ears are not covered.

Section 6 – What Is Not Covered (Exclusions and Limitations)

L

Laboratory Services from Non-Plan providers or laboratories are covered under Out-of-Network benefits only. This 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

Massage Therapy is not covered unless provided as part of an approved therapy program.

Matristem Extracellular Wound Care System is not covered.

Maximum Benefit Amounts are stated on Your Plan's Schedule of Benefits. The Plan does not cover any additional benefits after a benefit limit has been reached.

Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not covered

Medically Necessary Treatments - Any services, supplies, treatments, or procedures not specifically listed as a Covered Service, and any other services, supplies, or treatments or procedures determined not to be Medically Necessary are not covered unless required to be covered under state or federal laws and regulations.

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not covered. **The Plan does not cover any of the following:**

- 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.

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

Mobile Cardiac Outpatient Telemetry - (MCOT) is not covered.

Section 6 – What Is Not Covered (Exclusions and Limitations)

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not covered.

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

N

Neuro-cognitive therapy is not covered.

Newborns or other children of a Covered Dependent Child are not covered.

O

Obstetrical Care Home births are not covered.

Oral Surgery services listed below are not covered:

- 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.

Out-of-Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers, whether referred or directed by a Plan Provider, are covered under Out-of-Network Benefits only. 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.

P

PARS System (Physical Activity Reward System) is not covered.

Pass Devices (Patient Activated Serial Stretch) are not covered.

Paternity Testing is not covered.

Penile implants are not covered.

Personal comfort items are not covered. 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

Section 6 – What Is Not Covered (Exclusions and Limitations)

personal comfort are not covered.

Physician Examinations are limited as follows:

- physicals for employment, insurance or recreational activities are not covered.
- executive physicals are not covered.
- school physicals are not covered.
- a second opinion from a Non-Plan Provider is covered 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.

Physician's Clerical Charges are not covered. 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.

Prescription Drugs -

- Outpatient prescription drugs are excluded from Coverage.
- Over-the-counter medications are excluded from Coverage.

Private Duty Nursing is not covered.

Pulsed Irrigation Evacuation System is not covered

Q

R

Reconstructive surgery - is not covered 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 Covered Person's effective date of Coverage, the reconstructive surgery is covered subject to the Plan's Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is covered.

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

Residential or Sub-Acute Level of Care or treatment is not covered.

S

Second Opinions from Plan providers do not require authorization. A second opinion from a Non-Plan provider is covered only when a Plan provider is not available.

Section 6 – What Is Not Covered (Exclusions and Limitations)

Services. The Plan does not cover any of the following:

- 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 Optima Health approved providers;
- charges for missed appointments;
- charges for completing forms
- charges for copying medical records.
- services not listed as a covered service under this plan.
- any service or supply that is a direct result of a non-covered service.

Sex Orientation or Gender Identity Disorder Treatment of any kind is not covered. This includes surgery, therapy, and any other medical or behavioral health services related to gender identity.

Sex Change Operations or gender reassignment surgery is not covered.

Spinal Manipulation is not covered unless the Plan includes Covered Services for Chiropractic Care.

Sterilization

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

I

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

Physical, Speech, and Occupational **Therapies** are limited as stated on Your Schedule of Benefits. Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. **The Plan does not cover 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;

Section 6 – What Is Not Covered (Exclusions and Limitations)

- 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 covered.

Transplant Services. The Plan does not cover 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;
- services from non-contracted providers unless pre-authorized by the plan;

Travel and Transportation expenses are not covered. Medically Necessary transport is covered only when approved by the Plan. Elective or non-emergent ambulance services are only covered when approved and authorized by the Plan. Treatment and services, other than Emergency Services, received outside of the United States of America are not covered.

U

V

Video Recording or Video Taping of any covered service procedure is not covered.

Vision Exams and Materials not listed under Covered Services are not covered.

W

Wisdom Teeth extraction is not covered.

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

X

Section 6 – What Is Not Covered (Exclusions and Limitations)

Y

Z

Section 7 – When Your Coverage Will End

7.1 TERMINATION OF EMPLOYEE COVERAGE

Except as provided below and under “Continuation of Coverage,” an Employee's coverage under this Plan will terminate on the first of the following:

- A. the date this Plan terminates;
- B. the last day of the month for which the Employee has paid premiums or otherwise ceases to be an Eligible Employee;
- C. the date the Employee contribution, if any, for Plan Coverage ceases due to non-payment by the Employee;
- D. the date the Employee dies.

7.2 TERMINATION OF DEPENDENT COVERAGE

Except as provided below and under “Continuation of Coverage,” a Dependent's coverage under this Plan will terminate on the first of the following:

- A. the date this Plan terminates;
- B. the date the Employee's coverage under this Plan terminates;
- C. the date a spouse or child ceases to satisfy the Plan's definition of an Eligible Dependent; or
- D. the date the spouse or child becomes covered as an Employee under this Plan.

7.3 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 following time period stipulated below, **provided the Plan is in force**:

- A. For an approved layoff, Coverage will continue for a period of not longer than three (3) months.
- B. For an Employee who is unable to work due to total permanent disability, Coverage will continue for a period not longer than twelve (12) months.
- C. The Family and Medical Leave Act (FMLA).
Employees on approved leave under the FMLA will remain on the City's health insurance as long as premiums are paid. Premiums will be deducted from the employee's pay while in a paid status; it is the employee's responsibility to pay the Department of Finance the premium which would have been deducted from the employee's paycheck when the employee is in a leave without pay status.

Section 7 – When Your Coverage Will End

- D. 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.

A covered employee performing military service of more than 30 days may elect to continue employer-sponsored health insurance for up to 24 months; however, he/she will be required to pay 102 percent of the full premium, which represents the City's share plus the employee's share plus two (2) percent for administrative costs. For military service of less than 31 days, health care coverage is provided as if the service Covered Person had remained employed.

- E. 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.

7.4 ADDITIONAL TERMINATION PROVISIONS

In addition to the termination provisions above, a Covered Person's Coverage under the Plan will terminate as follows:

- A. **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 Covered Person's misuse of the identification card.
- B. **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.

Section 8 – Coordination of Benefits

8.1 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.

8.2 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.

8.3 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.

8.4 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.

Section 8 – Coordination of Benefits

8.5 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:

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

DEFINITIONS

“**Plan**” is any of these which provides benefits or services for, or because of, medical care or treatment:

- 1. 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.
- 2. 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).
- 3. 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 (1), (2) or (3) 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/Secondary Plan:**” The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

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.

Section 8 – Coordination of 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.

8.6 ORDER OF BENEFIT DETERMINATION RULES

- A. **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:
1. The other plan has rules coordinating its benefits with those of This Plan; and
 2. 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
 3. The other plan is a governmental plan and federal law requires This Plan to be the Primary Plan.
- B. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

Section 8 – Coordination of Benefits

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.

Section 8 – Coordination of Benefits

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

8.7 EFFECT ON THE BENEFITS OF THIS PLAN

- A. **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.
- B. **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.

Section 8 – Coordination of Benefits

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

8.8 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.

8.9 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.

8.10 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:

- A. The persons it has paid or for whom it has paid;
- B. Insurance companies; or
- C. 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.

Section 9 – Member Out of Pocket Amounts

9.1 COPAYMENTS

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

9.2 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.

9.3 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.

9.4 MAXIMUM OUT-OF-POCKET AMOUNT

Out-of-pocket-maximum means the total amount a Covered Person 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.

9.5 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.

Section 10 – Claims for Reimbursement

10.1 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.

10.2 NON-PLAN PROVIDERS

Claims for Covered Services rendered by Non Plan Providers should be sent to the Plan c/o Sentara Health Plan, 4417 Corporation Lane, Virginia Beach, VA 23462 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.

10.3 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.

Section 11 – Continuation of Coverage

CONTINUATION COVERAGE RIGHTS UNDER COBRA**

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving 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 Covered Persons 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 for 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:

Section 11 – Continuation of Coverage

- 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 retired 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-retired 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."

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 the City of Chesapeake, 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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or

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- The retired 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 30 days after the qualifying event occurs. You must request an enrollment change through the City's Employee Self Service portal, <https://ess.cityofchesapeake.net>. You will need to provide documentation to support the qualifying event.

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

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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

Jamie Crowder
Department of Human Resources
306 Cedar Road
Chesapeake, VA 23322
757-382-6052
jcrowder@cityofchesapeake.net

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COBRA contact:

Lilybeth Ebba

Department of Finance

306 Cedar Road

Chesapeake, VA 23322

757-382-6708

lebba@cityofchesapeake.net

Section 12 – Internal and External Appeal Process (How to Appeal an Adverse Benefit Determination)

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.
- 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;

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- Reference to the specific plan provisions on which the Plan based its determination; and
- Any further appeal rights available to the Covered Person.

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 Covered Person'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.

- A. 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.
- B. 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 an urgent care claim is, 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.
- C. 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

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appeal a Post-Service Claim the Covered Person must follow the Appeals procedure for Pre- and Post-Service claims.

- D. **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 ID card

By Facsimile: at 757-687-6232

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

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

By Phone: Call Member Services at the number on the ID card

By Facsimile: 757-687-6232

By Mail send requests 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 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 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.

Section 12 – Internal and External Appeal Process (How to Appeal an Adverse Benefit Determination)

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:

State Corporation Commission

Bureau of Insurance – External Review

P.O. Box 1157

Richmond, VA 23218

877-310-6560 (telephone)

804-371-9915 (fax)

externalreview@scc.virginia.gov

Independent External Appeal Process

When the Bureau receives your appeal, it is sent to the health carrier or self-funded plan contact involved to verify your request's completeness and eligibility. If any additional information is needed to complete your request or verify eligibility, the health carrier/self-funded plan contact will request from you the specific information needed. A timeframe will be given for you to submit this information. If you do not submit this information to the entity requesting it in a timely manner, your request may be terminated. If your request is determined to be ineligible, you may appeal this determination to the Bureau.

After you have been notified that your request is complete and eligible for this review process, the Bureau will randomly select an Independent Review Organization (IRO) that is not affiliated with your carrier or self-funded plan, and has no conflict of interest with your case to perform the review. For standard External Review requests, once you are notified of the name of the IRO, you will be given 5 business days from your receipt of this notification to submit any additional information you would like reviewed regarding your case. Your health carrier/self-funded plan must also submit all of its documents and information considered in making its determination to the IRO for review. The IRO will issue its determination to the parties involved. The decision is binding on the health carrier/self-funded plan, and on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

If a request for an expedited External Review is submitted when an expedited internal appeal request has been made, the IRO will make a determination as to whether the internal expedited appeal process must be completed prior to the expedited External Review process beginning.

Section 12 – Internal and External Appeal Process (How to Appeal an Adverse Benefit Determination)

Qualifications for an Independent External Review

To qualify for an Independent External Review:

1. The patient must be covered by a contract issued in Virginia by a licensed health carrier and the plan has elected to use Virginia's External Review process.
2. You must have exhausted the carrier's internal appeal process. The process is deemed to be exhausted in the following situations:
 - All available internal appeals have been exhausted.
 - The patient filed an appeal and has not received a response from the carrier on its determination (unless a delay was agreed to) by either 30 days from the date of filing a pre-service appeal, or 60 days from the date of filing a post-service appeal.
 - A request for an expedited internal appeal of an adverse determination has been filed with the health carrier. A simultaneous expedited External Review may be requested.
 - The health carrier has agreed to waive the exhaustion requirement.
3. The adverse determination for an admission, availability of care, continued stay, or other health care services that is a covered benefit has been reviewed by the health carrier or its designated review entity and has been determined to not meet its 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.

A complete External Review request must be received by the Bureau of Insurance within 120 days after the date you received notice of your right to an External Review.

Types of Coverage that are Ineligible for an Independent External Review

The following types of coverage are not eligible for Virginia's process of Independent External Review:

- Policies or certificates that provide coverage only for a specified disease, specified accident or accident-only coverage;
- Credit;
- Disability income;
- Hospital indemnity;
- Long-term care;
- Dental, vision, or any other limited supplemental benefit or a Medicare supplement policy of insurance;
- Plans through Medicare, Medicaid, or the federal employee's health benefits program;
- Any coverage issued under Chapter 55 of Title 10 of the U.S. Code (TRICARE), and any coverage issued supplemental to that coverage;

Section 12 – Internal and External Appeal Process (How to Appeal an Adverse Benefit Determination)

- Any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance; and

Automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group or Individual basis.

Other Resources to Help You

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

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.

Section 12 – Internal and External Appeal Process (How to Appeal an Adverse Benefit Determination)

Other resources to help you:

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

Section 13 – Miscellaneous Provisions

13.1 MAJOR DISASTERS AND OTHER CIRCUMSTANCES BEYOND THE PLAN'S CONTROL

In the event that circumstances not within the Plan's or its designee's control including, but not limited to, a major disaster, epidemic, or civil insurrection, results in the 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. In such circumstances, however, neither the Plan, its designee nor Plan Providers shall incur any liability or obligation for delay, or failure to provide or arrange for such benefits and services.

13.2 SEVERABILITY

In the event that 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.

13.3 POLICIES AND PROVISIONS

The Plan may develop and adopt policies, procedures, rules and interpretations to promote orderly, equitable, and efficient administration of coverage.

13.4 NAMED FIDUCIARY AUTHORITY

In addition to those powers, rights and duties delegated to 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:

1. Interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits;
2. 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;
3. Appoint individuals to assist in the administration of the Plan and any other agents it deems advisable including legal, accounting, and actuarial services.

13.5 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.

Section 13 – Miscellaneous Provisions

13.6 RELATIONSHIP OF PARTIES

- a. **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.
- b. **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.

13.7 IDENTIFICATION CARD

Cards issued by SHP 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 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.

Section 13 – Miscellaneous Provisions

13.8 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 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.

13.9 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 the Section titled, "Eligibility, Enrollment, and Effective Date." 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.

13.10 LIMITATION ON BENEFITS OF THIS PLAN

The covenants, undertakings, and agreements set forth herein shall be solely for the benefit of, and shall be enforceable only by, the Plan Sponsor, SHP and the Covered Persons.

13.11 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.

13.12 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.

Section 13 – Miscellaneous Provisions

13.13 ENTIRE CONTRACT

The Purchaser Services Agreement and the Summary Plan Description together with all exhibits and amendments thereto, the individual Enrollment Applications of Covered Persons, and any 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.