Optima Health
OptimaFit Direct
Individual and Family Plan
Off Exchange

Effective Date: mm/dd/yy

INFORMATION ONLY

Evidence Of Coverage

Underwritten by Optima Health Plan

4417 Corporation Lane
Virginia Beach, VA 23462

This policy does not provide the ACA-required minimum essential pediatric oral health benefits. Stand-alone dental coverage that includes such benefits must be available to you for purchase separately from a qualified stand-alone dental plan.

OptimaHealth

IMPORTANT INFORMATION ABOUT YOUR INSURANCE

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

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

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

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

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

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

Office of the Managed Care Ombudsman.

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

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

OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462

[Date]

[First Name] [Last Name]
[Address 1]
[Address 2]
[City], [State] [Zip]

Dear Member:

As a valued member of Optima Health, your healthcare is important to us. This letter is meant to provide you with important enrollment information for you and any covered dependents.

Enclosed is your OptimaFit® Policy. Your Policy provides information about your benefits and services, and includes all of the terms and conditions of your health plan. Your Policy also contains:

- what you will pay out of your pocket for healthcare services,
- what you will pay for prescription medications,
- and much more.

Please read it carefully to understand which services are covered and which are not covered under the OptimaFit® plan you have selected. This document is also available online at optimahealth.com/members and the Optima Health mobile app.

Policy Holder Name	**[subscriber name]**
Effective Date:	**[date]**
Monthly Premium:	**[premium]**

In addition to the monthly premium amount stated above, you will also pay any deductible, copayment, and coinsurance amounts listed on the Schedule of Benefits, which can be found in your Policy.

You can also sign-in to optimahealth.com/members and the Optima Health mobile app to access many useful tools such as:

- a provider search tool to help you locate doctors in your area that can provide services covered under your plan;
- a pharmacy tool to look up costs for your prescription drugs;
- a treatment cost calculator to determine the cost of over 500 procedures and services,
- your Explanations of Benefits (EOBs).

We look forward to partnering with you for your healthcare needs. If you have any questions regarding your coverage, please do not hesitate to contact member services at the number on the back of your member ID card.

Sincerely,

Dennis Matheis
President

Enclosure

A Service of Sentara

Introduction And Welcome

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

In this EOC, You will find important information on:

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

Optima Health

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

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

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

How to Get Language Assistance

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

OptimaFit Silver 3500 30% Direct
HIOS Product ID#: 20507VA1420010-00 Off HIX
Plan Effective Date: Beginning on or after 01/01/2022
Optima Health Plan
Individual and Family Plan Benefit Summary

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

This policy does not provide the ACA-required minimum essential pediatric oral health benefits. Stand-alone dental coverage that includes such benefits must be available to you for purchase separately from a qualified stand-alone dental plan.

This document is an overview of Your Covered Services and Your out-of-pocket cost-sharing amounts including any Deductibles, Copayment and Coinsurance. This Plan has tiered Copayment or Coinsurance amounts listed for In-Network benefits. For some services You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals, or other Facilities or providers. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

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

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

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

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

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

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

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

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

Deductible and Maximum Out-of-Pocket Amount (MOOP)			
	In-Network Tier 1	**In-Network Tier 2**	**Out-of-Network**
Deductible Calendar Year	$3,500/Individual; $7,000/Family		Not Covered

The Plan has one combined Deductible for Tier 1 and Tier 2 In-Network Covered Services. Most amounts You Pay for Tier 1 and Tier 2 In-Network Covered Services will count toward meeting the In-Network Deductible. The Deductible applies to all Covered Services except for:

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

If You are the Subscriber, and the only Member covered under Your Plan, the Individual Deductible amount applies. If You have other Family Members on Your Plan the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one Family Member meets the Individual Deductible, his or her benefits will begin. Once the total Family coverage Deductible is met, benefits are available for all Family Members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a Member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible.

	In-Network Tier 1	**In-Network Tier 2**	**Out-of-Network**
Maximum Out-of-Pocket Calendar Year	$7,500/Individual; $15,000/Family		Not Covered

The Plan has one combined Maximum Out-of-Pocket Amount for Tier 1 and Tier 2 In-Network Covered Services. Most amounts You pay, or that are paid on Your behalf, for Tier 1 and Tier 2 In-Network Covered Services will count toward meeting the In-Network Maximum.
The following will not count toward any Plan Maximum Amount:

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

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

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Optima Health approved providers. ***Pre-Authorization is required for in-office surgery.**			
Primary Care Visit	You Pay $30	You Pay $60	Not Covered
Virtual Consult	You Pay $10	You Pay $10	Not Covered
Specialist Visit	You Pay $60	You Pay $120	Not Covered
Preventive Care Recommended Preventive Care Services are covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits/.			
Recommended exams, screenings, tests, immunizations, and other services	No Charge	No Charge	Not Covered
Outpatient Therapies and Services You pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient facility, a Hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of the Hospice or Early Intervention benefit, or as part of a treatment plan for Autism Spectrum Disorder. When You get physical, occupational, speech therapy in the home, the Home Health Visit limit will apply instead of the Therapy Services limits listed below.			
Occupational and Physical Therapy* Rehabilitative Services limited to 30 combined visits per Calendar year. Habilitative Services limited to 30 combined visits per Calendar year.	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Speech Therapy* Rehabilitative Services limited to 30 combined visits per Plan year for Tier 1 and Tier 2 providers. Habilitative Services limited to 30 combined visits per Plan year for Tier 1 and Tier 2 providers.	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Cardiac Rehabilitation*	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Pulmonary Rehabilitation*	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Vascular Rehabilitation*	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Vestibular Rehabilitation*	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
IV Infusion Therapy	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Respiratory/Inhalation Therapy	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Chemotherapy and Chemotherapy Drugs*	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Radiation Therapy*	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Outpatient Dialysis You pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.			
Dialysis Services	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.			
Surgery Services*	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient facility or lab or a Hospital outpatient facility or lab.			
Diagnostic Procedures	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
X-Ray Ultrasound Doppler Studies	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Lab Work	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a free-standing outpatient facility, or a Hospital outpatient facility or lab.			
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.			
Maternity Care ***Pre-Authorization is required for prenatal services**	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Inpatient Services			
Inpatient Hospital Services*	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Transplants* Covered at contracted facilities only.	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 100 days per stay.	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Ambulance Services Includes Emergency transportation, or non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way.			
Air, Water, Ground Services ***Pre-Authorization is required for non-emergency transportation.**	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered except for Emergency Services

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Emergency Services Includes Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services, and medical supplies provided in an Emergency Department, including an independent freestanding Emergency Department, In-Network or Out-of-Network.			
Emergency Services	After Deductible You Pay 50%	After Deductible You Pay 50%	After Deductible You Pay 50%
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance.			
Urgent Care Services	You Pay $75	You Pay $75	Not Covered
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Optima Health providers. ***Pre-Authorization is required for Inpatient Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**			
Inpatient Services*	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Outpatient Office Visits	You Pay $30	You Pay $30	Not Covered
Virtual Consults	You Pay $10	You Pay $10	Not Covered
Other Outpatient Visits(Facility/Freestanding Centers)	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is covered from an In-Network Plan Provider or a participating EyeMed Vision Services provider at the office visit Copayment or Coinsurance amount.			
Insulin Pumps*	No Charge	No Charge	Not Covered
Pump Infusion Sets and Supplies*	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution; and continuous glucose monitors, sensors and supplies. ***Pre-Authorization is required for talking blood glucose monitors**	No Charge	No Charge	Not Covered
Insulin, and Needles, and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	No Charge	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Prosthetic Limb Replacement			
Prosthetic Devices and Components, repair, fitting, replacement, adjustment*	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Durable Medical Equipment (DME) and Supplies			
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement, and rental items.**	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Wigs* Limited to one wig per Calendar year following cancer treatment.	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Early Intervention Services For Dependent children from birth to age three.			
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home.			
Home Health Care* Limited to a maximum of 100 visits per Member per Calendar year. This limit does not apply to home dialysis or home infusion therapy. Occupational, physical, and speech therapy, and cardiac rehabilitation under this benefit will count toward the home health maximum visit limit.	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Private-Duty Nursing			
Private-Duty Nursing* Includes services provided by an RN or LPN in the home. Limited to 16 hours per Calendar year.	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Hospice Care			
Hospice Care* Therapy visit limits do not apply to occupational, physical or speech therapy under this benefit.	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Vision Care Optima Health contracts with EyeMed Vision Services to administer this benefit. Services must be received from EyeMed providers.			
Pediatric Vision Care (Children up to the end of the month the child turns 19) Limited to one exam each Calendar year for glasses or contact lenses, and one pair of glasses, lenses and frames per Calendar year from a limited frame collection, or contact lenses from a limited selection instead of glasses. Low vision exams are limited to one every 5 years.	**Vision Exam:** No Charge **Vision Materials:** No Charge	**Vision Exam:** No Charge **Vision Materials:** No Charge	Not Covered
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.			
Surgery and Reconstruction* Prostheses* Physical Complications Lymphedema*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Infertility Services Includes limited services, for Members only, to diagnose and treat underlying medical conditions resulting in Infertility.			
Endometrial biopsies (Limited to 2 per lifetime) **Semen analysis** (Limited to 2 per lifetime) **Hysterosalpingography** (Limited to 2 per lifetime) **Sims-Huhner test (smear)** (Limited to 4 per lifetime) **Diagnostic laparoscopy** (Limited to 1 per lifetime)	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Clinical Trials Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.			
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Allergy Care			
Allergy Care, Testing, and Serum	After Deductible You Pay 30%	After Deductible You Pay 50%	Not Covered
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.			
Telemedicine Services *Pre-Authorization is required except for emergency services.	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Chiropractic Services Optima Health Contracts with American Specialty Health Group (ASH) to administer this benefit. Services include therapy to treat problems of the bones, joints, and back.			
Chiropractic Services *Pre-Authorization is required by ASH for all Chiropractic services. Limited to 30 visits per Calendar year for Rehabilitative services and 30 visits per Calendar year for Habilitative services.	After Deductible You Pay 30%	After Deductible You Pay 30%	Not Covered
Autism Spectrum Disorder Includes diagnosis and treatment of Autism Spectrum Disorder.			
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered

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

Prescription Drugs

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

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

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

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

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

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

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

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

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

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

Specialty Drugs are only available through an Optima Health specialty mail-order pharmacy, including Proprium Pharmacy at 1-855-553-3568 and are limited to a 30-day supply. Specialty Drugs can be delivered to Your home address. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Pharmacy Member Services at the number on Your Optima Health ID Card. You can also log onto optimahealth.com for a list of Specialty Drugs and specialty pharmacies.

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

Refills

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

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

Deductibles, Maximum Out-of-Pocket Amount (MOOP), and Benefits	
Deductibles	You must meet the medical Deductible listed on Your Plan documents before coverage for Tier 2, Tier 3 and Tier 4 drugs begin.
Maximum Out-of-Pocket Amount	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance or amounts You pay, or that are paid on Your behalf, apply to the Plan's Maximum Medical Out-of-Pocket Limit unless otherwise noted.
Insulin, and Needles and Syringes for Injection	Covered at the cost-sharing listed below for the applicable Tier. A Member's cost-sharing payment for a covered insulin drug will not exceed $50 per 30-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. Deductible does not apply.
Diabetic Testing Supplies including blood glucose monitors, test strips, lancets, lancet devices, and control solution	No Charge Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. *Pre-Authorization is required for talking blood glucose meters.
Continuous Glucose Monitors, Sensors, and Supplies	You pay the cost sharing for the applicable Tier.
Formulary	This Plan has a closed formulary and covers a specific list of drugs and medications. If Your drug is not on Our formulary, We have a process in place to request coverage. Please use the following link to see a list of drugs on the Plan's formulary:optimahealth.com/exchangesbc/hix4tierclosedigformulary2022.pdf

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

Retail Pharmacy Cost Sharing When You pick up Your drug at a retail pharmacy You will pay the Copayment (one Copayment for each 30-day supply) or the Coinsurance amount listed under the applicable Tier for Your drug: • You pay one Copayment or the Coinsurance for up to a 30-day supply • You pay two Copayments or the Coinsurance for a 31 to 60-day supply • You pay three Copayments or the Coinsurance for a 61 to 90-day supply **Tier 4 Specialty Drugs are only available from an Optima Health Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.**	
ACA Preventive Drugs ACA preventive prescription drugs and over-the-counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs (Tier 1)	You Pay $30
Preferred Brand & Other Generic Drugs (Tier 2)	After Deductible You Pay $55
Non-Preferred Brand Drugs (Tier 3)	After Deductible You Pay 40%
Specialty Drugs (Tier 4)	After Deductible You Pay 40%

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

Copayment and Coinsurance Mail Order (If Your Drug is available) for up to a 90-day supply Some Outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available from the Plan's Mail Order Pharmacy OptumRx Home Delivery. You may call OptumRx Home Delivery at 1-866-244-9113 to find out if Your drug is available. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy, including Proprium Pharmacy and are limited to a 30-day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over-the-counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs (Tier 1)	You Pay $90
Preferred Brand & Other Generic Drugs (Tier 2)	After Deductible You Pay $165
Non-Preferred Brand Drugs (Tier 3)	After Deductible You Pay 40%
Specialty Drugs (Tier 4)	Tier 4 Specialty Drugs are only available from an Optima Health Specialty pharmacy including Proprium Pharmacy and are limited to a 30-day supply.

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

Notice/Notes/Terms & Conditions:

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

This Plan does not have pre-existing condition exclusions.

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

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

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

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

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

1-855-687-6260

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

Optima Health Amendments/Riders

Your Plan's Evidence of Coverage has no amended sections, changes, or additional Coverage riders that have been filed with the State of Virginia. Your benefits are as stated in this document.

Table of Contents

Section 1
How Your Plan Works

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

Patient Protections Disclosure Notice

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

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

Your Evidence Of Coverage or EOC

This booklet, any endorsements, the schedule of benefits, riders and Your Application make up Your Optima Health Plan. Please read every part of this booklet carefully so You will understand how Your Coverage works. Call Member Services if You have any questions.

Words or Terms We Use in this EOC

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

Your Optima Health ID Card

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

Your Schedule of Benefits and Your out-of-pocket expenses

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

Section 1
How Your Plan Works

Benefit Limits

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

Pre-Authorization

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

Optima Health Provider Network

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

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

Optima Health Direct Plan Tiered Plans

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

> **Tier 1 Physician, Facility or other provider** means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 1 cost sharing amounts listed on the Plan Schedule of Benefits. Tier 1 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 1 Physicians, Facilities, and other providers and their locations is available to each enrollee during enrollment and anytime upon request.
>
> **Tier 2 Physician, Facility, or other provider** means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 2 cost sharing amounts listed on the Plan Schedule of Benefits. Tier 2 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 2 Physicians and Facilities and other providers and their locations is available to each enrollee during enrollment and anytime upon request.]

Primary Care Providers

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

Section 1
How Your Plan Works

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

Specialty Care Providers

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

Choosing a Provider for Your Covered Services

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

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

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

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

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

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

Service Area

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

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How Your Plan Works

Optima Health contracts with providers outside of Our Service Area so that Members are able to receive care from Participating Providers and use In-Network benefits when they are away from home. If You are outside the Service Area and have questions about finding a Participating Provider, call the member Services number on the back of Your ID card.

Pre-existing Conditions

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

Special Enrollment Opportunity for Children under Age 26.

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

Lifetime Limits and Opportunity to Enroll

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

After Hours Nurse Triage Program

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

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

The After Hours Nurse Triage Program is available twenty-four (24) hours a day, seven (7) 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.

Wellness and Disease Management Programs

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

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

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

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

- Modifications to Your health plan Copayment, Coinsurance, or Deductible amounts;
- Gift or debit cards;
- Other rewards.

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

Stop Health Care Fraud!

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

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

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

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

Section 2
Definitions

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

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

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

ADVERSE BENEFIT DETERMINATION in the context of the internal appeals process means: (i) a determination by a health carrier or its designee utilization review entity that, based on the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the requested benefit; (ii) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review entity of a Covered Person's eligibility to participate in the health carrier's health benefit plan; (iii) any review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit; (iv) a rescission of Coverage determination as defined in § 38.2-3438 of the Code of Virginia (see Rescission of Coverage in Section 3); or (v) any decision to deny individual Coverage in an initial eligibility determination.

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

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

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

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.

Section 2
Definitions

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

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.

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.

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

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

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

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

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

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

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

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

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

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

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

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

"Custodial Care" includes: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, per the attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him or her to live outside an institution; and (3) rest cures, respite care and home care provided by family members. The Plan will determine if a service or treatment is Custodial Care. Nothing in this statement shall prevent a Member from appealing Optima Health's decision.

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

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

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 parts, or (d) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

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

Preventive and wellness services and chronic disease management; (10) Pediatric services, including oral and vision care.

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

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

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

1. The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
2. The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies; or
3. The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
4. The drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
5. The drug, device, or medical treatment is approved as Category B Non-Experimental/ Investigational by the FDA; or

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

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

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

HABILITATIVE SERVICES include Coverage for health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.

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

HOSPICE SERVICES means a coordinated program of home and inpatient care provided directly or under the direction of a licensed hospice. We Cover palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal Illness, whose medical prognosis is death within six months, provided by a medically directed interdisciplinary team.

HOSPITAL means an institution which:

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

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

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

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

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

MAXIMUM OUT-OF-POCKET LIMIT, MAXIMUM OUT-OF-POCKET AMOUNT, MAXIMUM, INDIVIDUAL MAXIMUM, or FAMILY MAXIMUM means the total amount a Member and/or eligible Dependents pay, or that are paid on their behalf to the extent allowed by Federal law and regulation, during a year as specified on the Schedule of Benefits. Member cost sharing including Copayments, Coinsurance, and Deductibles for Essential Health Benefits will count toward the Maximum Out-of-Pocket Amount listed on the Schedule of Benefits for this Plan.

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

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

1. Required to **identify, evaluate or treat** the Member's condition, disease, ailment or Injury, **including pregnancy related conditions;**
2. In accordance with recognized standards of care for the Member's condition, disease, ailment or Injury;
3. Appropriate with regard to standards of good medical practice;
4. Not solely for the convenience of the Member or participating Physician, Hospital, or other health care provider; and

5. The most appropriate supply or level of service which can be safely provided to the Member as substantiated by the records and documentation maintained by the provider of the services or supplies.

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

NON-ESSENTIAL HEALTH BENEFIT means a Covered Service that is not considered to be an ESSENTIAL HEALTH BENEFIT or part of the ESSENTIAL HEALTH BENEFITS PACKAGE.

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

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

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

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

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

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

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

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

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

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

PREMIUM means the amount of money prepaid to the Plan by the Individual Subscriber on behalf of himself/herself and eligible enrolled Dependents.

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

PRIMARY CARE PROVIDER (PCP) means the participating provider selected by a Member to provide first contact medical care and/or coordinate medical care, which includes pediatricians, family practitioners,

nurse practitioners, internists, obstetricians-gynecologists for females, and such other Physicians as designated by the Plan. At the time of enrollment each Member shall have the right to select a Primary Care Provider from among the Plan's affiliated Primary Care Providers, subject to availability. Any Member who is dissatisfied with his Primary Care Provider shall have the right to select another Primary Care Provider from among the Plan's affiliated Primary Care Providers, subject to availability. The Plan may impose a reasonable waiting period for this transfer.

REHABILITATIVE SERVICES include Coverage for therapies to restore and in some cases, maintain capabilities lost due to disease, Illness, Injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment.

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

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

RETROSPECTIVE REVIEW means the review of the Member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment.

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

Albemarle Co., Amelia Co., Caroline Co., Charles City Co., Charlottesville City, Chesapeake City, Chesterfield Co., Colonial Heights Co., Cumberland Co., Dinwiddie Co., Fluvanna Co., Franklin City, Gloucester Co., Goochland Co., Greene Co., Halifax Co., Hampton City, Hanover Co., Harrisonburg City, Henrico Co., Hopewell City, Isle of Wight Co., James City Co., King and Queen Co., King William Co., Louisa Co., Madison Co., Mathews Co., Mecklenburg Co., Nelson Co., New Kent Co., Newport News City, Norfolk City, Page Co., Petersburg City, Poquoson City, Portsmouth City, Powhatan Co., Prince George Co., Richmond City, Rockingham Co., Southampton Co., Suffolk City, Surry Co., Sussex Co., Virginia Beach City, Williamsburg City, York Co.

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

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

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.

Section 2
Definitions

SUBSCRIBER or CONTRACT HOLDER means the individual or Member who meets the eligibility requirements, who has made an Application as the Subscriber and/or on behalf of his or her eligible Dependents, whose Coverage remains in force, and whose premiums have been paid.

SURGICAL OR ANCILLARY SERVICES are any professional services, including:

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

TIER 1 PHYSICIAN OR FACILITY means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 1 cost sharing amounts listed on the Plan Schedule of Benefits. Tier 1 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities. A list of Tier 1 and Tier 2 Physicians and Facilities and their locations is available to each enrollee during enrollment and anytime upon request.

TIER 2 PHYSICIAN OR FACILITY means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 2 cost sharing amounts listed on the Plan Schedule of Benefits. Tier 2 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities. A list of Tier 1 and Tier 2 Physicians and Facilities and their locations is available to each enrollee during enrollment and anytime upon request.]

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

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

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

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

Section 3
Eligibility, Renewal, and Termination of Coverage

CATASTROPHIC PLAN COVERAGE

If Your Plan is an OptimaFit Catastrophic Plan only the following people are eligible for Coverage:

- Qualified individuals under age 30;
- Qualified individuals of any age with a hardship exemption.

PERSONS WHO ARE ELIGIBLE FOR COVERAGE UNDER THIS PLAN

You and Your Dependents may be eligible to enroll and continue enrollment if:

- You live in Optima Health's Service Area; **and**
- You provide Us a complete Application; **and**
- You did not knowingly give Us any incorrect, incomplete or deceptive information about Yourself or Your Dependents; **and**
- All required premium payments are paid and up to date; **and**
- You meet all other requirements listed in this document.

ELIGIBLE DEPENDENTS

If You are a Subscriber, the following persons are eligible to enroll and to continue enrollment as Your Dependents:

- Your legal spouse;
- Your Children up to age 26 including:
  - Natural or step Children;
  - Legally adopted Children;
  - Children placed in foster care;
  - Children placed with You for adoption;
  - Other Children the subscriber has legal custody of.

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

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

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

PERSONS NOT ELIGIBLE FOR COVERAGE

The following persons are not eligible for Coverage:

- A person age 65 years or older; **or**
- A person eligible for Coverage in any social welfare programs. (NOTE: Eligibility for Medicaid does not make a person ineligible for Coverage under the Plan ;)
- 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 the Subscriber or spouse has legal custody of the grandchild.

Section 3
Eligibility, Renewal, and Termination of Coverage

INITIAL ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

When You first apply for Coverage You may also include any eligible Dependents on Your Application. The Application must be complete and accurate. The Subscriber must provide all documentation requested by the Plan.

Everyone named on the Application must be accepted before Coverage begins. When we have accepted Your Application and You have paid all required premiums Coverage will begin on the date shown on the Evidence of Coverage.

MAKING CHANGES TO YOUR PLAN

Some changes can only be made on Your yearly anniversary date, or when a qualifying event happens. Effective dates are generally the first of the month.

If You want to make a change call Member Services or go online at www.optimahealth.com.

Any changes You make to Your Plan may change the amount of premium You will have to pay for Coverage.

ADDING NEWBORNS OR ADOPTED CHILDREN TO YOUR PLAN

Newborn Children will be covered from the date of birth for 31 days. In order for Coverage to continue past the first 31 days the Child must be added to the Plan within 60 days of the birth. This also includes adopted newborns.

Coverage for Children adopted after the 31st day of birth is effective from and after the moment that the Child is placed in the custody of the adoptive parents. Evidence of placement and any applicable premium must be received by the Plan within 31 days of the date of placement

If You do not add the Child within the first 60 days after birth or placement for adoption You may not be able to add the Child until Your next anniversary date.

ADDING OTHER DEPENDENTS TO YOUR PLAN

You may apply to add an eligible Dependent within 60 days of a qualifying event. If We accept Your Dependent Coverage will begin on the first of the month following Our acceptance as long as all required premiums are paid. If You don't add Dependents within 60 days of the qualifying event You will have to wait until Your next policy anniversary date to add the Dependent. Qualifying events may include:

- Marriage;
- Divorce, legal separation, or annulment;
- Births, adoptions, or placement for adoption or placement for foster care;
- A loss of insurance Coverage under other Coverage;
- Reaching age 65 or becoming eligible for Medicare;
- Death of a Covered Person;
- Change in legal residence.

SPECIAL LATE ENROLLMENT PROVISIONS

The Plan provides special enrollment periods of 60 days from the date of a triggering event for qualified individuals or Dependents of qualified individuals. Those triggering events are:

1. A qualified individual or Dependent loses minimum essential coverage;

2. A qualified individual gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, or placement of a Child in foster care;

3. A qualified individual becomes a United States Citizen, a national or lawfully present individual.

4. A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange;

5. An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

6. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;

7. A qualified individual or enrollee received a child support order or other court order mandating Coverage under the Plan;

8. A qualified individual receives a delayed eligibility determination under Medicaid or FAMIS;

9. An Indian, as defined by the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month;

10. A qualified individual who is or becomes a Dependent of an Indian is enrolled or is enrolling in a QHP through an Exchange on the same Application as the Indian, may change from one QHP to another one time per month at the same time as an Indian;

11. A qualified individual or enrollee is a victim of domestic abuse or spousal abandonment and their Dependents who seek to apply for Coverage apart from the perpetrator of the abuse or abandonment;

12. A qualified individual or enrollee, or his or her Dependent adequately demonstrates to the Exchange that a material plan or benefit display error on the Exchange website related to Plan benefits, Service Areas, Covered Services or Premium influenced the decision to purchase a QHP through the Exchange;

13. A qualified individual provides satisfactory documentary evidence to verify his or her eligibility resolves a data matching issue following the expiration of an inconsistency period or has an annual household income under 100 percent of the Federal poverty level and did not enroll in Coverage while waiting for HHS to verify that he or she meets the citizenship, status as a national or lawful presence; and

14. A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

In the case of marriage, Special Late Enrollment only applies if at least one spouse was enrolled in a qualifying health plan for one or more days in the 60 days prior to marriage. This does not apply if the spouse was living in a foreign country or a U.S. territory for one or more days in the 60 days prior to marriage, or is a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation.

The Plan provides special enrollment periods of 60 days from the date of a triggering event for qualified individuals or Dependents who:

1. Become eligible for assistance with respect to Coverage under a Medicaid or CHIP plan (including any waiver or demonstration project conducted under such plan).

2. Apply for Coverage under a Medicaid or CHIP plan and are later determined ineligible for Medicaid or CHIP.

3. Lose eligibility under Medicaid or CHIP coverage.

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

REMOVING A DEPENDENT FROM YOUR PLAN WHO IS NO LONGER ELIGIBLE

You must notify Us in writing when a Dependent no longer eligible for Coverage. Under the circumstances below a Dependent is no longer eligible to continue Coverage under Your Plan:

- **For Children at the end of the month they turn 26**. However, Children with intellectual disability or physical handicap may be eligible to continue Coverage beyond age 26. We will ask for certification of the Child's condition by a Physician. Certification will be requested no more frequently than annually.

- **For a Spouse when there is a divorce**. Coverage ends the day that the divorce decree is final. Your ex-spouse may be able to continue Coverage under an individual policy if We are notified within 31 days of the date the divorce is final. Please read the Continuation of Coverage provisions under When Coverage Will End.

COVERAGE MANDATED BY COURT ORDER.

Coverage mandated by court order issues, including Qualified Medical Child Support Orders (QMCSOs), will begin on the date of the court order if the request is made and an Application is submitted within 31 days of the order. Coverage mandated by the Child Support Act will begin on the first of the month following notification to the Plan.

RENEWAL OF COVERAGE

This Plan is guaranteed renewable and You may continue to stay covered under Your Plan at Your option as long as You are eligible. We will send You a renewal notice each year with information about changes in Your Plan. We will provide at least 75 days advance notice of any increase in Premium or Deductible amounts. However, under certain circumstances We may refuse to renew Your Plan.

Failure to Pay Your Premiums

We may refuse to renew Your Plan if You don't pay Your Premiums in a timely manner according to the Plan's Grace Period provisions.

Fraud or Material Misrepresentation on Your Application for Coverage

We may refuse to renew Your Plan for fraud or material misrepresentation with respect to Your Application for Coverage.

After two years from the date of this Plan, only fraudulent misstatements in the Application may be used to void the Plan or deny any Claim for loss incurred that starts after the two-year period.

Section 3
Eligibility, Renewal, and Termination of Coverage

Discontinuation of a product

We can refuse to renew Your Plan if We decide to discontinue a health care product that We offer in the individual market. If We discontinue a product We will provide You with written notice of discontinuation 90 days before Your Coverage will end. We will also offer You the option to purchase any other health plan that We currently offer in the individual market without regard to Claims status or medical history. If We stop offering all health insurance in the individual market in the Commonwealth of Virginia, We will send You written notice at least 180 days before Your Plan will end.

All notices will be mailed to Your last known address We have in our records.

You No longer live in Optima Health's Service Area

We may refuse to renew Your Plan or end Coverage if You have failed to maintain legal residence in the Service Area for six months.

You turn 65 and become eligible for Medicare.

We may refuse to renew Your Plan if You become eligible for Medicare, provided that Coverage may not end with respect to other individuals insured under the same Plan and who are not eligible for Medicare. Medicare eligibility or entitlement is not a basis for non-renewal or cancellation when renewing into the same policy.

TERMINATION OF THIS PLAN.

Your Plan Coverage cannot be terminated except for one or more of the following reasons:

1. Failure to pay the amounts due under the contract, including failure to pay a Premium required by the contract as shown in the contract or Evidence of Coverage;
2. The Policyholder or Contract Holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the Coverage.

The Plan will not terminate Coverage without giving the subscriber written notice of termination, effective at least 31 days from the date of mailing or, if not mailed, from the date of delivery, except that:

1. For termination due to nonpayment of premium, the Plan's grace period will apply;
2. For termination due to change of eligibility status, immediate notice of termination may be given.

All Coverage will stop if this Plan ends. This Plan will end at 12:01 am eastern standard time (EST) on the first of the following dates:

1. The date the Plan ends for nonpayment of premiums under the Grace Period;
2. The date We receive a written request from You to end the Plan, or any later date stated in Your request;
3. The date We decline to renew the Plan under the Renewal of Coverage provision; or
4. The date of Your death; or the termination date of Your Coverage if no Dependents are covered under this Plan.

For Dependents under the Plan all Coverage will end at 12:01 am eastern standard time on the first of the following dates:

1. Nonpayment of Premiums when due under the grace period provision;
2. The date We receive a written request from the Subscriber to end the Plan or remove a Dependent from the Plan or any later date stated in the Subscriber's request;

3. The date We decline to renew the Plan under the Renewal of Coverage provision; or
4. The date a Dependent does not meet the definition of an eligible Dependent.

We will refund any Premium paid and not earned due to Plan termination. The refund will be based on the number of full months that are prepaid.

WHEN YOU ASK US TO CANCEL YOUR PLAN

You may cancel this Plan at any time by written notice delivered or mailed to Us. Your Plan will end effective upon receipt, or on a later date that You specify in the notice. If Your Plan is cancelled We will promptly return the unearned portion of any Premium paid. The earned Premium will be computed pro rata. Cancellation will be without prejudice to any Claim originating prior to the effective date of cancellation.

ADDITIONAL TERMINATION PROVISIONS

Fraud or Material Misrepresentation on Your Application for Coverage

We may terminate Your Plan for fraud or material misrepresentation with respect to Your Application for Coverage.

After two years from the date of this Plan, only fraudulent misstatements in the Application may be used to void the Plan or deny any Claim for loss incurred that starts after the two-year period.

Misuse of Your Optima Health Identification Card

No one but the Member may use their Optima Health ID card. Use by anyone else is fraud. The Plan may prosecute the Member and the person using the card. Both the Member and the person using the Member's card are liable to the Plan for all costs resulting from the misuse of the identification card.

Loss of Eligibility

Under the terms of the renewal provision if We discover that anyone covered under this Policy is not eligible for Coverage We will cancel Coverage going forward. Coverage will end on the last day through which Premiums were paid.

Rescission of Coverage

In some limited circumstance We can cancel Coverage retroactively or going backward. This is called a Rescission of Coverage.

Coverage under the Plan can only be Rescinded for an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact as prohibited by the terms of Coverage. Optima Health will provide 30 days advance written or electronic notice if We Rescind a Policy. If Coverage is Rescinded, Members may appeal the Plan's decision.

The written or electronic advance notice will at a minimum include the following:

1. Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;
2. An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;
3. Notice that the Covered Person, or the Covered Person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;

4. A description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and
5. The date when the advance notice ends and the date back to which the Coverage will be rescinded.

If Coverage is Rescinded a person losing Coverage is entitled to a refund of any paid Premiums from the date Coverage is voided or Rescinded.

Non-Payment.

In accordance with the Plan's Grace Period non-payment of Premiums by the Subscriber on account of the Subscriber and Dependents will cause this Plan to terminate.

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

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

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

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

Section 4
Your Monthly Premium Payments and Your Out-of-Pocket Costs

MONTHLY PREMIUMS

You must pay Your Premiums in advance on or before the first day of the month to which they apply. Your Payment is considered made when We actually received it, or when payment is verified as received electronically or via credit or debit card by the Plan.

If any payment You make is dishonored or returned unpaid for any reason, You may have to pay a service charge of $25.00. We may also require that future premium payments be made in cash or by certified or cashier's check, or other cash-equivalent forms of payment.

Your Premiums must be paid in full on time in order for Your Coverage to remain in effect. In accordance with the Plan's Grace Period provisions Your Coverage will be cancelled for non-payment of Premiums. If You later decide to apply for enrollment in another Optima plan, before the new Coverage will start, We will require that You pay all past due Premium owed to Us for Coverage You were enrolled in during the twelve month period prior to the effective date of the new Coverage. This will include any period in which Your Coverage was effective, including any Grace Period. This will apply to annual open enrollment periods and special enrollment periods. You will also have to pay any applicable initial binder payments for Your new Coverage.

GRACE PERIOD

The Contract Holder is entitled to a grace period of 31 days for the payment of any premium due except the first premium. During the grace period Coverage shall continue in force unless the Contract Holder has given the Plan written notice of discontinuance in accordance with the terms of the contract and in advance of the date of discontinuance. If We don't receive all of the premium that is due Your Coverage will be cancelled. The Contract Holder shall be liable to the Plan for the payment of a pro rata premium for the time the contract was in force during the race period.

REINSTATEMENT FOLLOWING CANCELLATION FOR NONPAYMENT

At our discretion if Your Policy is cancelled due to nonpayment of premium We may allow reinstatement of Your Coverage. We must receive all premium due payment in order to have Your Coverage reinstated. Your payment must be in the form of cash, certified check, or money order. Once We receive payment Coverage will be reinstated without a break in Coverage.

COPAYMENTS AND COINSURANCE

Copayment and Coinsurance are out-of-pocket amounts You pay directly to a Provider for a Covered Service. You will usually have to pay Your out-of-pocket amount when You receive a service.

A Copayment is a flat dollar amount.

A Coinsurance is a percent of Optima Health's Allowable Charge for the Covered Service You receive.

ALLOWABLE CHARGE

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.

Section 4
Your Monthly Premium Payments and Your Out-of-Pocket Costs

Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be covered under Your In-Network benefits. All other services You receive from Non-Plan Providers will not be covered, and You will be responsible for payment of all charges to the Non-Plan Provider.

If You receive the following Covered Services Out-of-Network from a Non-Plan Provider You will be covered at the In-Network Copayment or Coinsurance level. Cost sharing amounts You pay out-of-pocket for these Covered Services will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket Amounts:

- Emergency Services, regardless of the final diagnosis;
- Covered Emergency air ambulance services;
- Non-emergency surgical or ancillary services done at an In-Network Facility by an Out-of-Network Non-Plan Provider.

BALANCE BILLING PROTECTION FOR OUT-OF-NETWORK SERVICES

Beginning January 1, 2021, Virginia state law protects You from "balance billing" if You receive Emergency Services from an Out-of-Network Non-Plan Provider or non-emergency surgical and ancillary services provide by an Out-of-Network Non-Plan Provider at an In-Network Facility.

Please also see the complete Member notice on Balance Billing Protection for Out-of-Network Services in the notices section of this Policy.

What is balance billing?

Providers and facilities that do not directly contract with Your health plan are referred to as Out-of-Network Non-Plan Providers. Your health plan is generally not required to Cover non-emergency care that you get from Out-of-Network Non-Plan Providers. Under Your health plan, You're responsible for certain cost sharing amounts such as Copayments, Coinsurance and Deductibles for Covered Services. Balance billing occurs when an Out-of-Network Non-Plan Provider bills You for covered charges above Your cost sharing amounts that Your plan did not pay.

When You cannot be balance billed:

An Out-of-Network Non-Plan Provider cannot balance bill or attempt to collect costs from You that exceed Your Plan's In-Network cost sharing requirements, such as Copayments, Coinsurance and Deductibles, for the following services:

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

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

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

Section 4
Your Monthly Premium Payments and Your Out-of-Pocket Costs

Your In-Network cost sharing requirement will be based on what Optima Health usually pays an In-Network Provider. Emergency Services will be covered at the highest tier (Tier 1). Non-emergency services provided at a Network Facility involving Surgical or Ancillary Services provided by an Out-of-Network Provider will be paid at the same Tier level as the network Facility. If You have a high Deductible or catastrophic health plan, Your Deductible will be based on any additional amounts Your Plan must pay to the Provider. Any amounts You are responsible for under this protection must count toward the Maximum amount You must pay for In-Network Services. If You pay an amount that exceeds this, the Provider must refund that amount with interest.

When You receive services, We will provide an Explanation of Benefits (EOB) that will show the out-of-pocket amount You are responsible for.

Your health plan contracts with certain health care professionals and facilities. These are called "In-Network" Providers. Insurers are required to advise You, via their websites or on request, which Providers and facilities are in their networks. Health care professionals and facilities must also tell You which provider networks the participate in either on their website or on request. Using In-Network Providers may help You avoid additional costs.

Other Out-of-Network Services

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

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

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

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

- We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

DEDUCTIBLE

A Deductible is a dollar amount that You must pay out-of-pocket for health Plan benefits before We begin to pay for benefits. If Your Plan has a Deductible it will be listed on the Schedule of Benefits. Your Plan may have separate Deductibles for individuals and for families. Your Plan may have a separate Deductible for In-Network Services and for Out-of-Network Services. Your Plan may have a separate Deductible for outpatient prescription drugs.

MAXIMUM OUT-OF-POCKET AMOUNT

Maximum Out-of-Pocket Amount means the total amount Your or Your Dependents pay during a year as specified on Your Plan's Schedule of Benefits. Deductible, Copayment and Coinsurance amounts for Essential Health Benefits will be accumulated and will apply toward the Maximum dollar amount listed on the Schedule of Benefits.

Section 4
Your Monthly Premium Payments and Your Out-of-Pocket Costs

Member cost sharing including Deductible, Copayments, and Coinsurance amounts for Non-Essential Health Benefits will not count toward the Maximum Out-of-Pocket Amount listed on the Schedule of Benefits for this Plan.

We maintain a record of Your payments. When You have reached the Maximum Out–of-Pocket Amount, no further payments will be required for that year, except for those services listed on Your Schedule of Benefits that do not apply toward the Maximum Out-of-Pocket Amount. We will notify You within 30 days after You have reached Your Maximum. We will promptly refund any payments charged after You reach Your Maximum.

EMERGENCY DEPARTMENT COPAYMENT

If Your Plan requires a Copayment for an Emergency Department visit, and You are admitted to the Hospital from the Emergency Department, the Plan waives the Emergency Department Copayment. The Member will be responsible for all applicable Deductibles and inpatient Hospital Copayments or Coinsurances as specified on the Schedule of Benefits.

INPATIENT HOSPITAL COPAYMENT

The Plan will waive the inpatient Hospital Copayment if the Member is readmitted for the same diagnosis within 30 days of the original Admission.

A newborn that remains in the Hospital after the mother is discharged will be admitted as an inpatient under the newborn's own name. The Plan may apply an Inpatient Hospital Copayment, Coinsurance, and Deductible as listed on the Schedule of Benefits for any services received by the newborn.

OFFICE VISIT COPAYMENTS FOR PREVENTIVE CARE

Recommended Preventive Care under PPACA will be covered with no Member cost sharing when received from Plan Providers. However You may still have to pay Your office visit cost sharing including Copayment, Coinsurance and Deductible listed on the Schedule of Benefits of Your Evidence of Coverage in certain circumstances.

1. You will pay office visit cost sharing if Your preventive care item or service is billed separately, or is tracked as individual encounter data separately from the office visit.

2. You should not pay office visit cost sharing if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit, and the primary purpose of the office visit is the delivery of the preventive item or service.

3. You will pay office visit cost sharing if an item or service is not billed separately, or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.

4. You will pay all charges for any preventive care and office visits You receive from an Out-of-Network Non-Plan Providers.

Section 4
Your Monthly Premium Payments and Your Out-of-Pocket Costs

PRESCRIPTION INSULIN DRUG COST SHARING

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

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

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

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

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

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

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

PRE-AUTHORIZATION

Some services require Pre-Authorization before You receive them. Your Physician or other provider is responsible for getting Pre-Authorization. When Pre-Authorization is the responsibility of an In-Network Plan Provider, any reduction or denial of benefits will not affect the Member. We have instructions and procedures in place for providers to obtain Pre-Authorization.

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

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

- Inpatient and partial hospitalization services
- Ambulance transport services that are not Emergency Services;
- 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;
- 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;
- Operations which involve the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia, or bunions;
- Treatment and services related to plantar warts;
- Transcranial Magnetic Stimulation (TMS);
- Insulin pumps and insulin pump infusion sets;
- Chemotherapy and Chemotherapy Drugs;
- Radiation Therapy.

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

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

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

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

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

Organ Transplant

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

Newborn Mother Transfer

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

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

PRE-AUTHORIZATION FOR DRUGS PRESCRIBED FOR THE TREATMENT OF A MENTAL DISORDER

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

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

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

PRE-SERVICE CLAIMS DECISIONS

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

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

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

EXPEDITED DECISIONS FOR URGENT CARE CLAIMS

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

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

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

EXPEDITED DECISIONS FOR CANCER PAIN MEDICATIONS

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

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

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

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

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

RETROSPECTIVE REVIEW OF POST-SERVICE CLAIMS

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

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

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

ADVERSE BENEFIT DETERMINATIONS

You have certain rights if We deny a request for Pre-Authorization or make other Adverse Benefit Determinations. We will provide written notice of Adverse Benefit Determinations. For Urgent Claims notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notification of an Adverse Benefit Determination will include the following:

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

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, Experimental treatment, or similar exclusion or limit, You are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances. **Please also read Section [10] How to File a Complaint or Appeal**.

Section 6
What is Covered

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

- Medically Necessary;
- Listed as a Covered Service;
- Ordered or provided by a licensed Provider;
- Not be excluded.

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

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

ALLERGY CARE, TESTING AND TREATMENT

We Cover Allergy Care, Testing and Treatment including:

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

AMBULANCE SERVICES

We Cover ambulance services that are:

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

Emergency Air, Ground, Water Services

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

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

- Benefits are available for air Emergency transportation when using ground ambulance would endanger Your health, and Your medical condition requires more urgent transportation to an acute care Hospital than a ground ambulance can provide.
- Your benefits include air transportation to the closest Hospital that can treat You.
- Transportation or transfer by air ambulance from one Hospital to another Hospital is only a

Covered Service when Your condition requires certain specialized medical services that are not available at the Hospital that first treats You and using a ground ambulance would endanger Your health.

- Transportation or transfer by air is not a Covered Service just because You, Your family, or Your provider prefers you receive treatment by a specific provider or at a specific Hospital.
- In the case of non-emergent air ambulance transportation, We reserve the right to select the air ambulance provider. If You do not use the air ambulance Provider We select ,You will be responsible for charges from the Out-of-Network Provider.
- Air ambulance is not covered for transportation to other facilities such as a Skilled Nursing Facility, a doctor's office or Your home.

Non-Emergency Stretcher & Wheelchair Transportation Services

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

ANESTHESIA SERVICES

When Medically Necessary the following are Covered Services:

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

AUTISM SPECTRUM DISORDER

Pre-Authorization is Required.

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

The following definitions apply:

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

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

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

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

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

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

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

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

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

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

Except for inpatient services, We may ask for a review of treatment. The review may be an independent review. We will not ask for a review more than once every 12 months unless We, and the individual's Physician or psychologist, agree that a more frequent review is needed. We will Cover the cost of any review.

We will apply cost sharing and Pre-Authorization procedures as We do for all other Covered Services under the Plan.

CLINICAL TRIALS

Pre-Authorization is required.

For a Qualified Individual Covered Services includes:

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

Approved Clinical Trial means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is (i) a federally funded or approved trial, (ii) conducted under an

Investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) a drug trial that is exempt from having an Investigational new drug application.

The Facility and personnel providing the treatment must be capable of doing so by virtue of their experience, training and expertise. Federally funded or approved trials include trials approved or funded by one of the following:

- The National Institutes of Health;
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare and Medicaid Services;
- The Department of Defense or the Department of Veterans Affairs;
- An NCI "Cooperative group" or an NCI center meaning 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;
- The FDA in the form of an Investigational new drug application; or
- An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

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

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

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

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

We determine reimbursement for patient costs incurred during participation in clinical trials like other medical and surgical procedures. We do not impose durational limits, dollar limits, Deductibles, Copayments and Coinsurance factors that are less favorable than for physical Illness generally.

The Plan is not required to provide benefits for the following services:

- The Investigational item, device, or service, itself;
- Items and services that given only 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.

DENTAL SERVICES (All Members/All Ages)

Pre-Authorization is required.

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

Treatment of Accidental Injury

Covered Services include the following:

- Dental services needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an Accident except for injuries resulting from chewing or biting;
- Dental appliances needed to treat an accidental Injury to the teeth;
- Repair of dental appliances damaged in accidental Injury to the jaw, mouth or face.

Preparing the Mouth for Medical Treatments

Covered Services include the following services to prepare the mouth for medical treatments, such as radiation therapy to treat cancer and prepare for transplants:

- Examination and evaluation;
- X-rays;
- Extractions;
- Anesthesia.

Newborn Care

Covered Services include dental services and dental appliances for newborns to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

DIABETES CARE MANAGEMENT

Pre-Authorization is required for insulin pumps and insulin pump infusion sets. Some services may be provided under the Plan's Prescription Drug Benefit. Screenings for gestational diabetes are Covered under Preventive Care.

We Cover FDA approved equipment and medical supplies, and education as prescribed by a provider for the treatment of insulin dependent diabetes, gestational diabetes, insulin using diabetes; and non-insulin-using diabetes.

Covered Services include:

- Insulin pumps and insulin pump infusion sets and supplies;
- Home blood glucose monitors and control solution;
- Lancets, lancet devices and test strips;
- Insulin, and syringes and needles for injection;
- Outpatient self-management training and education performed in person, including medical nutrition therapy, when provided by a certified, registered or licensed health care professional;
- Routine diabetic foot care, treatment of corns, calluses, and care of toenails;
- An annual diabetic eye exam when received from a Plan Provider.

Members may call 1-800-SENTARA for information on educational classes. Diabetic education may be received from pharmacies that are certified to perform this service. Contact the pharmacy to determine if they are certified to perform this service.

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

For OptimaFit Plans other than OptimaFit Equity HSA eligible plans
Self-injected insulin and related supplies including syringes, needles, blood glucose monitors, test strips, lancets, lancet devices and control solution are covered under the Plan's Prescription Drug Benefit.

DIAGNOSTIC AND LABORATORY SERVICES AND TESTING

Pre-Authorization is required for Outpatient Advanced Imaging Procedures including Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET Scans), Computerized Axial Tomography (CT Scans), Computerized Axial Tomography Angiogram (CTA Scans), Sleep Studies and Genetic testing and counseling. Pre-Authorization is not required for Magnetic Resonance Spectroscopy (MRS), Single Photon Emission Computed Tomography (SPECT Scans), and Nuclear Cardiology.

Your Plan includes Coverage for diagnostic and advance imaging procedures when ordered by Your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms. Covered Services include:

- Diagnostic Radiology including X-rays, mammograms, ultrasound or nuclear medicine;
- Diagnostic Lab and pathology services or tests;
- Diagnostic Hearing and Vision tests;
- Diagnostic EKGs, EEGs, and Echocardiograms;
- Advanced Diagnostic Imaging procedures including Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), Positron Emission Tomography (PET Scans), Computerized Axial Tomography (CT Scans), Computerized Axial Tomography Angiogram (CTA Scans), Single Photon Emission Computed Tomography (SPECT Scans), QCT Bone Densitometry, PET/CF Fusion scans, Diagnostic CT Colonography, and nuclear cardiology;
- Professional services for test interpretation, X-ray reading, lab interpretation, and scan reading;
- Diagnostic Sleep Testing;
- Tests ordered before a surgery or Admission;
- BRCA and fetal screening;
- Genetic testing and counseling is covered when Medically Necessary.

DIALYSIS TREATMENTS

The Plan Covers treatment for acute and chronic (end stage) renal disease. Covered Services include:

- Hemodialysis;
- Home intermittent peritoneal dialysis (IPD);
- Home continuous cycling peritoneal dialysis (CCPD);
- Home continuous ambulatory peritoneal dialysis (CAPD);
- Dialysis treatments in the home, an outpatient dialysis facility or doctor's office;
- Home dialysis equipment and supplies;
- Training for the Member and the person who will help the Member with home self-dialysis.

DURABLE MEDICAL EQUIPMENT (DME) AND MEDICAL DEVICES, ORTHOTICS, AND PROSTHETICS, AND MEDICAL AND SURGICAL SUPPLIES

Pre-Authorization is required for items over $750.

Pre-Authorization is required for all rental items.

Section 6
What is Covered

Pre-Authorization is required for all repair and replacement.

Durable Medical Equipment (DME) and Medical Devices

We Cover the rental or purchase, whichever is less expensive, of medical equipment and devices meeting the following criteria:

- The equipment is Medically Necessary and not just for the convenience of the Member; and
- The equipment or devices is ordered by a health care provider for use outside a medical Facility; and
- The equipment or device is non-disposable and meant for multi-use; and
- The equipment or device is meant only for medical use by the patient or Member.

Covered DME and Devices and Services include:

- Oxygen concentrator;
- Ventilator;
- Oxygen and equipment for administration;
- Nebulizers;
- Hospital type beds;
- Wheel chairs;
- Traction equipment;
- Walkers;
- Crutches;
- Cochlear implants;
- Negative pressure wound therapy devices;
- Maintenance and supplies needed for use of covered equipment;
- Batteries for powered wheel chairs;
- Repair and replacement costs unless damage is due to neglect.

Orthotics

Covered Services include:

- Certain types of orthotics such as braces, boots and splints, other than foot orthotics;
- The initial purchase, fitting, adjustment and repair of Covered orthotics.

Prosthetics

For Coverage of Artificial Limbs please refer to **PROSTHETIC COMPONENTS AND DEVICES**.

Coverage for Prosthetics includes, but is not limited to, the following when Medically Necessary:

- Medically Necessary surgically implanted prosthetic devices;
- Internal or external breast prosthesis after a mastectomy (See also benefits for Reconstructive Breast Surgery);
- Colostomy and other ostomy supplies directly related to ostomy care;
- Composite facial prosthesis;
- A wig needed following cancer treatment;
- Repair, fitting, adjustments and replacements of a Covered prosthetic device.

Medical and Surgical Supplies

Covered Services include medical and surgical supplies to treat your condition that are purchased and used once and not rented. Covered supplies include syringes, needles, dressings, splints and other items that service only a medical purpose. Covered Services do not include common items for the home available over the counter such as Band-Aids, thermometers, and heating pads.

Devices and Supplies for Sleep Treatment

Covered Services includes Medically Necessary devices and supplies such as APAP, CPAP, BPAP, and oral devices for sleep treatment.

EARLY INTERVENTION SERVICES

Pre-Authorization is required.

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

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

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

We may ask You to provide a copy of the certification. Deductible, Copayment, or Coinsurance amounts apply depending on what type of service is provided. This benefit is not subject to any Maximum dollar limits. **No therapy visit Maximums apply to Physical, Occupational, or Speech Therapy services received under this benefit.**

EMERGENCY SERVICES AND URGENT CARE SERVICES

If You are experiencing an Emergency please call 911 or visit the nearest Hospital or independent freestanding Emergency Department for treatment.

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

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

furnished) after a Member is stabilized as part of outpatient observation, or as part of an inpatient or outpatient stay with respect to the visit in which Emergency Services are furnished.

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.

Covered Services include Emergency Services defined above received in a Hospital Emergency room or an independent freestanding Emergency Department. This includes professional and Facility services needed to diagnose, treat and Stabilize a patient with an Emergency Medical Condition defined above. Covered Services include diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CT scans to evaluate and Stabilize a patient with an Emergency Medical Condition. 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;
- Shock.

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

Emergency Services do not require Pre-Authorization; and Emergency Services are covered whether You get care from an In-Network Plan Provider or an Out-of-Network Non-Plan Provider.

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 for Out-of-Network Emergency care will accumulate toward your Plan's In-Network Deductible and Maximum Out-of-Pocket Amounts.

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

You must notify Us within 48 hours or 2 business days when You receive Emergency Services and You are admitted to the Hospital from the Emergency Department. If You can't notify Us because of Your medical condition, have a friend or relative call Us. If Your medical condition prohibits You from notifying Us or You can't rely on a friend or relative, please notify Us as soon as You are able. You can use the number on the back of Your Optima Health ID card**.**

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

Emergency Ambulance Transportation

The Plan Covers Emergency Ambulance services. Please see Ambulance Services in this EOC**.**

Urgent Care Center Visits and Services

Urgent Care Services include 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 and do not call for the use of an Emergency Room. Covered Services include, but are not limited to:

- X-ray services;
- Tests such as for flu, urinalysis, pregnancy, rapid strep;
- Lab services;
- Stitches;
- Draining an abscess.

The After Hours Nurse Triage Program.

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

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

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

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

HEMOPHILIA AND CONGENITAL BLEEDING DISORDERS

Pre-Authorization is required for home treatment.

We Cover the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Covered Services include blood and the administration of blood products. We also Cover blood and the administration 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.

HOME HEALTH CARE SKILLED SERVICES

Pre-Authorization is required.

We Cover **Home Health Care Skilled Services** provided in the home or to the extent available through remote patient monitoring for Members who are homebound for medical reasons, physically unable to seek care on an outpatient basis, or in place of inpatient hospitalization. See Your Schedule of Benefits for visit limits. Physical, occupational and speech therapy services provided as part of home care are not subject to separate visit limits for therapy services. Physical, Occupational, and Speech Therapy under this benefit will count toward the Home Health Maximum visit limit. Home health care visit limits will not apply to home infusion therapy or home dialysis.

Section 6
What is Covered

We will only Cover services when they are provided by a certified **Home Health Care Agency** and included in a Member's Home Health Care Plan.

The following definitions apply to services under this section:

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

1. Is primarily engaged in providing skilled nursing services and other therapeutic services in the Member's home; and
2. Is duly licensed, if required, by the appropriate licensing facility; and
3. Has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered nurse (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.

"Home Health Care Plan" means a program:

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

"Home Health Care Skilled Services" means:

1. Part-time or intermittent skilled nursing services by an R.N. or L.P.N.;
2. Visits by other licensed health care professionals including home health aides and therapists working for the Home Health Care Agency to provide services under a Member's approved Home Health Care Plan;
3. Medical and social services;
4. Diagnostic services;
5. Nutritional guidance;
6. Physical, Occupational, Speech or other approved therapy services;
7. Medical supplies;
8. Durable Medical Equipment;
9. Infusion therapy;
10. Home dialysis;
11. Training of the patient and/or family/caregiver.

"Home Health Skilled Care Visit" means:

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

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

HOME PRIVATE DUTY NURSE SERVICES

Pre-Authorization is required.

Section 6
What is Covered

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

HOSPICE CARE

Pre-Authorization is required.

We Cover Hospice care and services for the palliative care of pain and other symptoms for Members with a terminal disease and likely less than six months to live. Services will be provided according to a written care plan developed by the Member's Physician and the licensed Hospice.

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**.**

Covered Services include the following:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of Palliative Care;
- Skilled nursing care;
- IV and infusion therapy services;
- Medications, equipment, and supplies for palliative care and pain management;
- Social and counseling services from a licensed social worker;
- Services of a home health aide or homemaker given under the supervision of a registered nurse;
- Short-term inpatient care, including procedures necessary for pain control and acute chronic symptom management and respite care. Respite care means non-acute inpatient care for the Covered Person in order to provide the Covered Person's primary caregiver a temporary break from caregiving responsibilities;
- Physical, speech, or occupational therapy provided by a licensed therapist (services provided as part of hospice care are not subject to Maximum visit limits for therapy services);
- Respiratory therapy provided by a licensed therapist, oxygen, and related supplies;
- Durable medical equipment;
- Routine medical supplies;
- Routine lab services;
- Nutritional support such as intravenous feeding and feeding tubes;
- Counseling, including nutritional counseling with respect to the Covered Person's care and death;
- Grief counseling services for immediate family members including a spouse, Children, parents, brothers and sisters both before and after the Covered Person's death for up to a year after the Member's death according to an approved treatment plan;
- Other Covered Services under the Plan may be given as palliative care and part of the approved treatment plan.

HOSPITAL SERVICES

Pre-Authorization is required.

Hospital Inpatient and Outpatient Services

We Cover surgery and services You receive during an inpatient stay, or as an outpatient at a free-standing outpatient facility, or a Hospital outpatient facility that are required to treat Your medical condition, Illness, or Injury including:

- General nursing care;
- Physician services;
- 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 and supplies;
- Anesthesia, oxygen and oxygen services;
- Inhalation therapy;
- Physical and occupational therapy;
- Dialysis; hemodialysis, peritoneal dialysis;
- Blood and blood products and their administration;
- Surgically implanted prosthetic devices;
- Outpatient ambulatory surgical or other services (i.e., observation room);
- Medical detoxification;
- Chemotherapy and radiation therapy;
- Other Habilitative and Rehabilitative therapy;
- Chiropractic/Osteopathic/Manipulation Therapy – Habilitative Services;
- Respiratory therapy;
- Injectable medications;
- Nuclear medicine services;
- Blood and Blood products and their administration to treat Hemophilia and congenital bleeding disorders;
- Outpatient office visits to a nurse or Physician assistant and walk-in appointments at an In-Network Plan participating retail health clinic;
- Other services approved by the Plan.

Inpatient Room and Board

We Cover room and board in a semi-private room including general nursing care, and meals and special diets. The Plan will Cover a private inpatient Hospital room if You need a private room because You have a highly contagious condition or are at greater risk of contracting an infectious disease because of Your medical condition. In all other situations the Plan will provide Coverage for a semi-private room. If You choose to occupy a private room You will pay the daily difference in cost between the semi-private room and the private room rates in addition to Your inpatient Hospital Copayment or Coinsurance amounts.

Inpatient Length of Stay Requirements

Your Coverage provides for minimum lengths of stay for covered Hospital Admissions for the conditions listed below. In each case the attending Physician in consultation with the patient may decide that a shorter stay is appropriate.

- Not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy.
- Not less than 48 hours for a vaginal hysterectomy.
- Not less than 48 hours for a patient following a radical or modified radical mastectomy for the treatment of breast cancer.
- Not less than 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.
- A minimum length of stay of 48 hours for a vaginal delivery, and 96 hours following a cesarean section.

Hospitalization And Anesthesia For Dental Procedures

Pre-Authorization is required.

We Cover hospitalization and anesthesia for dental procedures in certain circumstances. The Covered Person must be determined by a dentist, in consultation with their treating Physician, to require general anesthesia and Admission to a Hospital or outpatient facility. The Covered Person must also:

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

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

INFANT HEARING SCREENINGS

Pre-Authorization is required.

Covered Services include newborn infant hearing screenings and all necessary audiological examinations provided pursuant to the Virginia Hearing Impairment Identification and Monitoring System. Screenings and examinations in this section are covered using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Coverage also includes follow-up audiological examinations as recommended by a Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

INFUSION SERVICES

Pre-Authorization is required.

We Cover infusion therapy and medications administered intravenously or parenterally by a provider properly licensed or certified to provide the therapy service. Services are covered in inpatient, outpatient, Physician office, and home settings. Covered Services include:

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

LYMPHEDEMA

Pre-Authorization is required.

We Cover treatment of lymphedema including the following Covered Services:

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

Services must be prescribed by a health care professional legally authorized to prescribe or provide treatment. We will not impose upon any person receiving benefits pursuant to this section any Copayment, fee, policy year or calendar year, or durational benefit limitation or Maximum for benefits or services that is not equally imposed upon all individuals in the same benefit category.

MATERNITY AND NEWBORN CARE

Pre-Authorization is required for prenatal services.

We Cover maternity services and newborn care for You or Your covered Dependents. See also Preventive Care Services. Covered Services include:

- Pregnancy testing;
- Prenatal and postnatal Physician services for maternity care and maternity related checkups;
- Care and services related to complications of pregnancy including hospitalization as necessary;
- Prenatal screenings:
  - Fetal screenings for genetic and/or chromosomal status of the fetus;
  - Anatomical, biochemical, or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies;
  - Other United States Preventive Services Task Force recommended screenings with Grades A and B under the Plan's Preventive Care Benefits;
- Screening for pregnant women for anemia, gestational diabetes, Hepatitis B, Rh incompatibility, and urinary tract or other infection;
- Folic acid supplements;
- Tobacco intervention and counseling for pregnant users;
- Use of delivery room, and all inpatient Hospital labor and delivery services;
- Anesthesia services including services rendered by an anesthesiologist to provide partial or complete loss of sensation before delivery;
- Physician services for delivery;
- Routine Hospital nursery services for the newborn during the mother's stay;
- Initial examination of newborn;
- Circumcision of covered male Dependent;
- Postnatal care services for baby including:
  - Behavioral assessments and measurements;
  - Screenings for blood pressure and hearing;
  - Hemoglobinopathies screening;
  - Gonorrhea prophylactic medication;
  - Hypothyroidism screening;
  - PKU screening;
  - Rh incompatibility screening;
  - Covered US Preventive Services Task Force Grade A and B recommendations;
- Dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;

- 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;
- Delivery by midwife at freestanding birthing center services under contract with the Plan;
- Postpartum inpatient care; and a home visit or visits in accordance with medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists;
- Care and services related to a miscarriage;
- 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;
  - Costs for renting or purchase of one breast pump per pregnancy.

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

Members must pay Copayments for a confirmation of pregnancy visit. Members must also pay Copayments in effect at the time of delivery to the delivering obstetrician and any authorized specialist. The Member is entitled to a refund from the delivering OB provider if the total amount of the global OB Copayment as shown on the Schedule of Benefits is more than the total Copayments the Member would have paid on a per visit or per procedure basis for delivering obstetrician prenatal and postpartum services. Members must also pay their inpatient Hospital Copayment or Coinsurance. No cost sharing is required for Preventive Care Services described in this section.

MEDICALLY NECESSARY FORMULA AND ENTERNAL NUTRITION PRODUCTS

Pre-Authorization is Required.

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

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

Covered Services:

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

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

MEDICATIONS ADMINISTERED BY A MEDICAL PROVIDER

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

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

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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

The Plan does not apply financial requirements or treatment limits under mental health and substance use disorder services that do not also apply under other medical or surgical benefits within the same classification under the Plan. Classification generally means inpatient services, outpatient services, Emergency Services, Physician services, and other Plan services.

You can select any mental health or substance use disorder provider that is a Plan Provider. Call Member Services at the number on Your Optima Health ID card if You need help selecting a Plan Provider.

Emergency Mental Health or Substance Use Disorder Services are covered the same as Emergency medical care and do not require Pre-Authorization. The Plan determines what is a psychiatric Emergency based on the medical community's accepted standards. Please refer to Emergency Services in the EOC.

Outpatient Mental Health and Substance Use Disorder Services

Covered services include the following provided in an office based setting or other outpatient facility as Medically Necessary. Virtual Consults will be covered when furnished by providers who are approved by Optima Health to provide services.

- Diagnosis and treatment of psychiatric conditions, including psychotherapy, group psychotherapy, and psychological testing;
- Coverage for office visits, outpatient facility and Physician charges;
- Visits for medication checks.

Inpatient Mental Health and Substance Use Disorder Treatment, Detoxification and Rehabilitation Services

Covered Services include the following provided in an inpatient facility or substance use disorder treatment facility as Medically Necessary:

- Individual psychotherapy, group psychotherapy, psychological testing;

- Counseling with family members to assist with the patient's diagnosis and treatment;
- Convulsive therapy, detoxification and rehabilitation treatment;
- Hospital and inpatient professional charges in any Hospital or Facility required by state law.

Partial Day/Intensive Outpatient Services

Covered Services include an approved outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Programs will 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. This also includes 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.

Residential Treatment Facilities/Centers (RTFs or RTCs)

Coverage includes inpatient services for substance use disorder, eating disorders and other like conditions provided in a Hospital or treatment facility that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-day nursing care. Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly, and rehabilitation, therapy, education, and recreational or social activities. Care from a residential treatment facility (RTF) or other non-skilled, sub-acute setting will not be covered if the services are merely custodial, residential, or domiciliary in nature.

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 hour 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. Services include diagnosis and treatment of psychiatric conditions including psychotherapy, group psychotherapy, psychological testing, and visits for medication management checks. Treatment also includes services delivered through a partial hospitalization or intensive outpatient program as defined herein.

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

"Substance 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. 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 of the Code of Virginia, respectively, employed by a facility or program licensed to provide such treatment.

PHYSICIAN SERVICES, PRIMARY CARE AND SPECIALISTS

Includes Inpatient and Outpatient services for diagnosis and treatment of an Injury or Illness.

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

We Cover the Physician services listed below.

- Surgical, home, Hospital, and office visits, for diagnosis and treatment of an Injury or Illness;
- Covered preventive care and preventive screenings;
- Professional services received while You are receiving Covered Services in an Inpatient Hospital, Skilled Nursing Facility, Emergency Department, Urgent Care Center, a free-standing outpatient facility or a Hospital outpatient facility;
- Specialist care and consultations;
- A second opinion from a Plan Provider;
- A second opinion from a Non-Plan Provider if approved by the Plan;
- Office surgeries;
- Virtual Consults online by webcam, chat or voice when provided by an Optima Health approved provider;
- Webcam, chat or voice in place of a physical office visit, if Your Primary Care Provider makes these services available;

- Maternity care and related checkups;
- Outpatient office visits to a nurse, nurse practitioner, or Physician assistant and walk-in appointments at an In-Network Plan participating retail health clinic;
- Annual school and sports physicals.

PRESCRIPTION INSULIN DRUG COST SHARING

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

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

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

PREVENTIVE AND WELLNESS SERVICES

Annual Physicals

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

Annual Gynecological (GYN) exams

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

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

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

Screening Mammograms

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

Pap Smears

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

Prostate Testing and Digital Exams (PSA)

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

Colorectal Cancer Screening

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

- Annual occult blood test;
- Flexible sigmoidoscopy or colonoscopy;
- Radiologic imaging in appropriate circumstances.

Routine Hearing Screenings for Adults and Children

We Cover one annual routine hearing test.

Well Child Care

We Cover routine care and periodic review of a Child's physical and emotional status. Covered Services include:

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

Immunizations for Newborn Children from Birth to Age 36 Months

We Cover immunizations for each Child from birth to thirty-six months of age including:

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

Immunizations for older Children and Adolescents ages 7-18

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

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

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PREVENTIVE CARE SERVICES AND SCREENINGS FOR ADULTS, WOMEN, CHILDREN AND ADOLESCENTS (Recommended and Supported by USPTF and HRSA under the Affordable Care Act)

Covered Services include evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Service. Task Force (USPTF) and guidelines supported by the Health Resources & Services Administration (HRSA).
Members will not pay cost sharing for preventive care services received from In-Network Plan Providers. However, in some cases an office visit Copayment may apply.

Examples of Covered Services are listed below. Please use the following links for a complete list of USPTF and HRSA preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ and https://www.hrsa.gov/womensguidelines/.

- Preventive services and screenings for adults:
  - Screening for abdominal aortic aneurysm, alcohol misuse, colorectal cancer, high blood pressure, Type 2 diabetes, cholesterol, depression, Hepatitis B and C, HIV, lung cancer, obesity, syphilis, and tobacco use.
  - Counseling for alcohol misuse, nutrition, obesity, sexually transmitted infection prevention
  - Smoking and tobacco cessation products, including nicotine patches and gum when obtained with a prescription.
  - Aspirin use to prevent cardiovascular disease.

- Immunizations for Children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention;

- Preventive Services and Screenings for infants, Children and adolescents:
  - Assessments for alcohol and drug use and behavioral and oral health risk;
  - Medical history;
  - BMI measurements;
  - Screening for autism (18 and 24 months);
  - Screening for blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, Hepatitis B, HIV, lead, obesity, sexually transmitted infection (STI), tuberculin, and vision;
  - Counseling for obesity and STI;
  - Supplements for fluoride chemoprevention.

- Preventive Services and Screening for Women:
  - 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. One breast pump per pregnancy is covered.
  - Contraceptive Methods and Counseling including: All 18 Food and Drug Administration-approved contraceptive methods and sterilization treatments for women, including drugs, injectables, patches, rings and devices such as diaphragms, IUDs, and implants. Patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Generic contraceptives are covered with no Member out-of-pocket cost sharing. We Cover a prescription for up to a 12 month supply of hormonal contraceptive when dispensed or furnished at one time.
  - Screening and Counseling for domestic and interpersonal violence including annual screening and counseling for all women.

- Screening for 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.
- Screening for 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.
- Screenings for BRCA risk assessment and genetic testing; breast cancer mammography and cervical cancer screening.
- Counseling for breast cancer genetic testing (BRCA), breast cancer chemoprevention.
- Screening for Osteoporosis.
- 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.

PROSTHETIC COMPONENTS AND DEVICES (Artificial Limbs)

Pre-Authorization is required for all services.

Covered Services include Medically Necessary Prosthetic devices, including artificial limbs and Components. This also includes fitting. Repair and replacement are covered except when due to a Member's neglect, misuse or abuse.

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.

REPRODUCTIVE HEALTH SERVICES

Contraceptive Benefits

Covered Services include:

- All eighteen FDA approved contraceptive methods and sterilization treatments for women, including drugs, injectables, patches, rings and devices such as diaphragms, intra uterine devices (IUDs) and implants for women. This does not include abortifacient drugs;
- Patient education and counseling for all women with reproductive capacity.
- A prescription for up to a 12 month supply of hormonal contraceptive when dispensed or furnished at one time.
    - The Plan will Cover up to a 12-month supply of hormonal contraceptives when dispensed or furnished at one time for a Covered Person by an In-Network provider or pharmacy or at an location licensed or otherwise authorized to dispense drugs or supplies that participates in the Plan's provider network .

- Members will be responsible for payment of their outpatient prescription cost sharing based on a 12 month supply when the prescription is filled.
- Hormonal contraceptive means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration for such purpose.
- Provider means a facility, Physician or other type of health care practitioner licensed, accredited, certified or authorized by statute to deliver or furnish health care items or services.

Some contraceptive benefits are covered under the Preventive Care Benefit and the Outpatient Prescription Drug Benefit.

Sterilization Services

Covered Services include:

- Sterilization services such as Tubal Ligation and Vasectomy;
- Services to reverse non-elective sterilization that was the result of an Illness or Injury.

Reversal of elective sterilizations is not covered. Sterilizations for women are covered under the Preventive Care benefit.

Infertility Services

Covered Services are limited to the following services to diagnose and treat underlying conditions resulting in Infertility:

- Endometrial biopsies (Limited to 2 per lifetime);
- Semen analysis (Limited to 2 per lifetime);
- Hysterosalpingography (Limited to 2 per lifetime);
- Sims-Huhner test (smear) (Limited to 4 per lifetime);
- Diagnostic laparoscopy (Limited to 1 per lifetime).

Fertility treatments including assisted reproductive technologies (ART) and any diagnostic tests or drugs to support ART are not Covered Services. Examples of ART include artificial insemination (AI), in-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Interruption of Pregnancy

Elective termination of pregnancy is not an Essential Health Benefit (EHB) and is a Covered Service only in the following limited circumstances:

- When the life of the mother is endangered by a physical disorder, physical Illness, or physical Injury, including a life-endangering physical condition caused by or arising from the pregnancy itself or
- When the pregnancy is the result of an alleged act of rape or incest.

SHOTS AND INJECTIONS

We Cover shots and injections from a provider to treat Illness, or for routine vaccines and some other immunizations such as flu shots. We also Cover self-administered injections, and injections administered at authorized pharmacies such as flu shots.

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SKILLED NURSING FACILITY SERVICES

Pre-Authorization is required.

Covered Services include:

- Skilled convalescent care and Rehabilitative Services given in a licensed Skilled Nursing Facility (SNF) and ordered by a Physician;
- Semi-private room and board charges;
- A private room if You have a highly contagious condition or are at greater risk of contracting an infectious disease because of Your medical condition. In all other situations if You choose to occupy a private room You will pay the daily difference in cost between the semi-private room and the private room rates in addition to Your SNF inpatient Copayment or Coinsurance amounts;
- Drugs, biologicals, and supplies.

SMOKING AND TOBACCO CESSATION

The Plan includes Coverage of smoking and tobacco cessation counseling according to United States Preventive Task Force Guidelines Preventive Care Services.

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

SURGERY

Inpatient, Outpatient, and Office Surgeries

Pre-Authorization is required.

The Plan Covers surgical services on an Inpatient or outpatient basis. Office surgeries will also be covered if appropriate for your medical condition. Covered Services include:

- Accepted surgical and cutting procedures;
- Procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery;
- Invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of the brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Pre-operative and post-operative care;
- Hypodermic needles, syringes, surgical dressings, splints and other surgical supplies;
- Physician, nursing, and other support services;
- Services and anesthesia provided by an anesthesiologist when Medically Necessary and appropriate for your condition;
- Blood and blood products and administration.

Oral and Maxillofacial Surgery

Pre-Authorization is required.

Covered Services include:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Maxillary or mandibular frenectomy when not related to a dental procedure;
- Alveolectomy when related to tooth extraction;
- Orthognathic surgery because of a medical condition or Injury or for a physical abnormality that prevents normal function of the joint or bone and is Medically Necessary to attain functional capacity of the affected part;
- Treatment or correction of accidental dental injuries as listed under Dental Services (All Members/All Ages) section;
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures;
- Treatment of non-dental lesions including removal of tumors and biopsies;
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Pre-Authorization is required.

Covered Services include:

- Reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, Illness, Injury, or an earlier treatment to create a more normal appearance;
- Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would been a Covered Service under the Plan;
- Reconstructive breast surgery done at the same time or following a mastectomy including:
  - 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.

Reconstructive breast surgery is covered according to the Women's Health and Cancer Rights Act in a manner determined in consultation with the attending Physician and the Member. Members will pay the same out-of-pocket cost sharing that normally apply to surgeries under the Plan.

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, consulting with other health care providers regarding a patient's monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided. Telemedicine services does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. We will not exclude a service for Coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

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

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

TEMPOROMANDIBULAR JOINT (TMJ) DIAGNOSTIC AND SURGICAL PROCEDURES

Pre-Authorization is required.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles. Covered Services include:

- Medically Necessary diagnostic and surgical procedures to treat TMJ and craniomandibular disorders to attain functional capacity of the affected part;
- Removable appliances for TMJ repositioning and related medical care, diagnostic and surgical treatment.

Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth, fillings, or prosthetics including crowns, bridges, or dentures.

Members who choose to receive care from Non-Plan dentists or oral surgeons may be billed by the Non-Plan Provider for charges in excess of the Plan's fee schedule.

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

THERAPY SERVICES AND DEVICES (Rehabilitative and Habilitative Services)

Pre-Authorization is required.

Please see Your Schedule of Benefits for benefit visit limits. Covered Services include:

- Physical therapy (PT);
- Occupational therapy (OT);
- Speech therapy (ST);
- Cardiac rehabilitation;
- Pulmonary rehabilitation;
- Chiropractic/Osteopathic Manipulation therapy.

Rehabilitative PT, OT, ST Services

Rehabilitative Services include therapies and devices to restore and in some cases, maintain capabilities lost due to disease, Illness, Injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment. Services may be provided in a variety of inpatient and outpatient settings. To be Covered Services rehabilitation services must involve a specific treatment plan, duration and goals attainable and that a Member can reach in a reasonable period of time. Benefits will end when the treatment is no longer Medically Necessary and a Member stops progressing toward those goals. All services and treatments must be prescribed by a Physician and performed by a licensed therapist.

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Covered Services include:

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

Habilitative PT, OT, ST Services

Habilitative Services include services and devices that help a Member keep, learn or improve skills and functioning for daily living, and other services for people disabilities in a variety of inpatient and outpatient settings or facilities. Covered Services include:

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

Cardiac Rehabilitation

Covered Services include medical evaluation, training, supervised exercise and psychosocial support following a cardiac event. Services will not be provided for home programs (other than home health care services), on-going conditioning and maintenance care.

Pulmonary Rehabilitation

Covered Services include outpatient short term respiratory care to restore Your health following an Illness or Injury.

Chiropractic/Osteopathic/Manipulation Therapy

Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit. Covered Services may require approval by ASH Group as Medically Necessary. Your provider is responsible for ensuring services have been verified as Medically Necessary. To receive review and approval of Chiropractic services, your Provider should contact ASH Group at: ASH Provider Services (800) 678-9133 from 5:00 a.m. to 6 p.m. PST, Monday – Friday if they have questions. Members who have questions about these benefits can call ASH Member Services at (800) 678-9133 from 5:00 a.m. to 6 p.m. PST, Monday – Friday.

Covered Chiropractic Care includes Rehabilitative Services and Habilitative Services provided by a licensed credentialed Doctor of Chiropractic to diagnose and treat Musculoskeletal Disorders and Related problems of bones, joints of the extremities, joints of the spine, the nervous system, including the back.

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Covered Rehabilitative Services by a Doctor of Chiropractic

Thirty (30) office visits and related services delivered by a Doctor of Chiropractic that are determined to be Medically Necessary are covered per Benefit Year for rehabilitative therapy. Rehabilitative Services include therapy to diagnose and to treat Musculoskeletal and Related Disorders. Rehabilitative Services are health care services that help you get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include chiropractic rehabilitation services in a variety of outpatient settings. Services must involve goals that You, an Optima Member, can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and You stop progressing toward those goals.

Covered chiropractic Rehabilitative Services include:

- Evaluation & Management;
- Plain film radiology studies;
- Chiropractic Manipulative Therapy;
- Chiropractic Provided Physical Medicine Modalities and Procedures.

Covered Habilitative Services by a Doctor of Chiropractic

Thirty (30) office visits and related services delivered by a Doctor of Chiropractic that are determined to be Medically Necessary are covered per Benefit Year for habilitative therapy. Habilitative Services include therapy to treat Musculoskeletal and Related Disorders. Habilitative Services are health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a Child who isn't walking or talking at the expected age. These services may include physical medicine and evaluation procedures provided by a Doctor of chiropractic or other qualified professional for people with disabilities. This benefit includes services for people with disabilities in an outpatient chiropractic setting.

Covered chiropractic Habilitative Services include:

- Evaluation & Management;
- Chiropractic Manipulative Therapy;
- Chiropractic Provided Physical Medicine Modalities and Procedures limited to the following CPT codes. A CPT code is a common term health plans and medical providers use to describe Covered Services under Your health Plan:
    - Therapeutic Exercise 97110 or 97112
    - Therapeutic Procedures – Gait Training 97116
    - Therapeutic Activities – Improve Function 97530
    - Chiropractic Manipulative Treatment 98940 or 98941 or 98942 or 98943

Definitions:
The following definitions apply to benefits under this section:

Chiropractic Care. The Rehabilitative and Habilitative Services rendered or made available to a Member by a licensed Doctor of Chiropractic for treatment of problems of the Musculoskeletal Disorders and Related problems of bones, joints of the extremities, joints of the spine, the nervous system, including the back.

Chiropractic Manipulative Therapy: Manual therapy services provided by hand or instrument to adjust, manipulate, and mobilize the joints of the body.

Contracted Chiropractor/Doctor of Chiropractic. Contracted Chiropractor is a doctor of chiropractic who is duly licensed to practice chiropractic in the state or jurisdiction in which Chiropractic Services are

furnished and who has entered into an agreement with ASH Group to provide Covered Services to Members.

Emergency Services. Emergency Services consist of Covered Services that are Chiropractic Services provided to manage an Injury or condition with a sudden and unexpected onset, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health or medicine, could reasonably expect that the absence of immediate clinical attention to result in (1) 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; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) decreasing the likelihood of maximum recovery. ASH Group shall determine whether Chiropractic Services constitute Emergency Services.

Experimental or Investigational. Experimental or Investigational is care that is: (a) investigatory; or (b) an unproven service that does not meet generally accepted and professionally recognized standards of practice.

Medically Necessary Services. "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an Illness, Injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent and duration; and Considered Effective for the patient's Illness, Injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare practitioner.
For the purposes of the definition of "Medically Necessary Services" above:

"Prudent Clinical Judgment" are those (a) clinical decisions made on behalf of a patient by a practitioner in a manner which result in the rendering of necessary, safe, effective, appropriate clinical services; (b) clinical decisions that result in the appropriate clinical intervention considering the severity and complexity of symptoms; (c) decisions that result in the rendering of clinical interventions consistent with the diagnosis and are appropriate for the Member's response to the clinical intervention; and (d) decisions rendered in accordance with the practitioner's professional scope of license or scope of practice regulations and statutes in the state where the practitioner practices.

"Generally Accepted Standards of Medical Practice" means standards that are based on Credible Scientific Evidence published in peer-reviewed Medical Literature generally recognized by the relevant medical community, Physician and Healthcare Practitioner Specialty Society recommendations, the views of Physicians and healthcare practitioners practicing in relevant clinical areas, and any other relevant factors.

"Credible Scientific Evidence" is clinically relevant scientific information used to inform the diagnosis or treatment of a patient that (i) meets industry standard research quality criteria; (ii) is adopted as credible by an ASH Group clinical peer review committee; and (iii) has been published in an acceptable peer-reviewed clinical science resource.

"Medical Literature" means clinically relevant scientific information published in an acceptable peer-reviewed clinical science resource.

"Clinical services that are "Considered Effective" are those diagnostic procedures, services, protocols, or procedures that are verified by ASH Group as being rendered for the purpose of reaching a defined and appropriate functional outcome or Maximum Therapeutic Benefit; and rendered in a manner that appropriately assesses and manages the Member's response to the clinical intervention.

"Convenience of the Patient or Healthcare Practitioner" means considered to be an elective service. Examples of elective/convenience services include: (a) preventive maintenance services; (b) wellness services; (c) services not necessary to return the patient to pre-Illness/pre-Injury functional

status and level of activity; (d) services provided after the patient has reached Maximum Therapeutic Benefit.

"Maximum Therapeutic Benefit" is the patient's health status when returned to pre-clinical/pre-Illness daily functional activity and/or the patient's health status when the patient no longer demonstrates progressive improvement toward return to pre-clinical/pre-Illness daily functional activity.

A **"Healthcare Practitioner Specialty Society"** is a society of Specialty practitioners that represents a significant number of practicing practitioners or other academic or clinical research institutions for that Specialty.

Urgent Services. Urgent Services are Covered Services that are Chiropractic Services necessary to prevent serious deterioration of the health of a Member resulting from an unforeseen Illness, Injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Service Area.

OTHER THERAPY SERVICES

Pre-Authorization is required.

Covered Services include Chemotherapy, Radiation Therapy, IV Infusion Therapy, and Respiratory/Inhalation Therapy

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

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

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

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TRANSPLANT SERVICES

Pre-Authorization is required.

We Cover Medically Necessary human organ, tissue and stem cell/bone marrow transplants and infusions for Members who meet Medical Necessity criteria established by the Plan. We do not Cover transplants that are Experimental. We also Cover the following:

- Necessary acquisition procedures, mobilization, harvest and storage;
- Preparatory myeloablative therapy, reduced intensity preparatory chemotherapy, radiation therapy, or a combination of these therapies.

Donor Searches

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

Organ Donor Benefits

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

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

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

TRAVEL EXPENSES

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

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

VIRTUAL CONSULTS

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

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

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

VISION CORRECTION AFTER SURGERY OR ACCIDENT

Pre-Authorization is required.

Covered Services include the cost of exams and prescribed glasses or contact lenses and fittings when Medically Necessary as a result of surgery, or to treat an accidental Injury. We Cover cost of materials and fittings, exams and replacement of glasses or lenses when replacement is due to a prescription change related to the condition that required the original prescription. The purchase and fitting of glasses or contact lenses are covered in the following situations:

- When prescribed to replace the human lens lost due to surgery or Injury;
- Pinhole glasses for use after surgery for detached retina; or
- Lenses prescribed instead of surgery:
  1. Contact lenses prescribed instead of surgery for infantile glaucoma;
  2. Corneal or sclera lenses are prescribed in connection with keratoconus;
  3. Sclera lenses are prescribed to retain moisture when normal tearing is not possible or adequate; or
  4. Corneal or sclera lenses are required to reduce a corneal irregularity other than astigmatism.

OUTPATIENT PRESCRIPTION DRUG COVERAGE

Your Plan Formulary

Your Plan has a closed formulary. That means there is a specific list of Medically Necessary drugs and medications that are Covered Services. Please use the following link for a list of drugs included in Your Plan's Formulary:

https://www.optimahealth.com/exchangesbc/HIX4TierClosedIGformulary2022.pdf.

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

Choosing a Pharmacy to Fill Your Prescription

All drugs must be FDA approved an You must have a prescription. You will need to pay Your Copayment or Coinsurance when You fill Your prescription at the pharmacy. If You r Plan has a Deductible You must meet that amount before Your Coverage begins. Your drug Coverage has specific Exclusions and Limitations listed in Section 9.

Retail Pharmacy

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

Mail Order Pharmacy Benefit

Most Outpatient prescription drugs are available through the Plan's Mail Order Provider. This does not include Specialty Drugs. You may call Member Services at 757-552-7274 or 1-866-514-5916 to find out if a drug is available.

Specialty Pharmacy

Specialty Drugs are available through an Optima Health Specialty mail order pharmacy including Proprium Pharmacy at 757-553-3568 or 1-855-553-3568. Specialty Drugs can be delivered to Your home address from a Specialty mail order pharmacy. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Member Services at the number on Your Optima Health ID Card. You can also log onto optimahealth.com for a list of Specialty Drugs or a list of Optima specialty pharmacy providers.

Non-Plan Out-of-Network Pharmacies

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

Pharmacy and Therapeutics Committee

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

Pharmacy Tiers

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

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

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

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

- **Specialty Drugs (Tier 4)** includes those drugs classified by the Plan as Specialty Drugs. Tier 4 also includes therapeutic biological products. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs typically

require special dosing, administration, and additional education and support from a health care professional. Specialty Drugs include the following:

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

Tier 4 also includes covered compound prescription medications.

Compound Medications

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

Medications Requiring Pre-Authorization

The Plan uses a number of tools to determine if Your drug should be covered. Optima Health may limit the amount of some drugs You receive. Some drugs require Pre-Authorization to make sure proper use and guidelines are followed. Your Physician is responsible for Pre-Authorization. We will notify You and Your Physician of Our decision. If Pre-Authorization is denied You have the right to file an appeal. Please see Section 5 on Pre-Authorization and Section 10 on filing an internal or external appeal.

Step Therapy Protocols and Exception Requests

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

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

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

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

Optima Health will respond to a step therapy exception request within 72 hours of receipt, including hours on weekends. We will confirm that the request is approved, denied, or requires supplementation or

additional information. In cases where exigent circumstances exist, We will respond with our decision within 24 hours of receipt, including hours on weekends. A Member may appeal any step therapy exception request denial under the Plan's existing appeal procedures.

Quantity Limits

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

Refills

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

Prescription Cancer Drugs

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

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

Flu Shots and Other Covered Vaccines

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

Special Food Products or Supplements

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

Self-administered Injectable Drugs

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

Diabetic Insulin, Testing Supplies, Equipment, and Education

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

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

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

Women's Contraceptives

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

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

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

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

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

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

- If the formulary drug is determined by Us, after reasonable investigation and consultation with the prescribing Physician, to be an inappropriate therapy for the medical condition of the Member; or

- When the Member has been receiving the specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and the prescribing Physician has

determined that the formulary drug is an inappropriate therapy for the specific Member or that changing drug therapy presents a significant health risk to the specific Member.

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

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

Expedited Exception Request Based on Exigent Circumstances

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

External Exception Request Review

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

Synchronization of Medication

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

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

Lost or Stolen Medication

Pre-Authorization is required.

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

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

PEDIATRIC VISION CARE

Optima Health contracts with EyeMed Vision Care to administer this benefit. Coverage includes one exam each year for glasses or contact lenses. Coverage for vision materials includes one pair of standard single vision, bifocal, trifocal, or progressive eyeglass lenses and one frame every year from a limited frame collection, or contact lenses from a limited selection. Exams and materials must be received from EyeMed participating providers. Pediatric Vision Care is not Covered Out-of-Network.

This Plan only Covers a choice of contact lenses or eyeglasses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglasses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Covered low vision services will include one comprehensive low vision evaluation every 5 years and Coverage for items such as high-power spectacles, magnifiers and telescopes, and follow-up care.

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 Saturday 7:30 a.m. - 11 p.m., and Sundays 11 a.m. - 8 p.m.
2. Visit or call the participating provider and identify yourself as a participant by providing Your Member ID information. The provider will verify eligibility, Your Plan's Covered Services and any applicable Copayment or Coinsurance. Payment is due when You receive services.
3. If the vision provider determines that You need additional medical care You should contact Your PCP or other Physician for treatment options.

Section 7
What is Not Covered

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

A

Abortion is a Covered Service only in the following circumstances:

- When the life of the mother is endangered by a physical disorder, physical Illness, or physical Injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or
- When the pregnancy is the result of an alleged act of rape or incest.

Acts of War, Disasters, or Nuclear Accidents - In the event of a major disaster, epidemic, war, orother event beyond our control, we will make a good faith effort to give you Covered Services. However, benefits may not be able to be provided or may be delayed in the event of a major disaster. The Plan will not be responsible for any delay or failure to give services due to lack of available Facilities or staff. Benefits will not be given for any Illness or Injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

Administrative Charges are not covered including charges or costs for:

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

Alternative Medicine services or treatments are not covered including:

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

Section 7
What is Not Covered

Non-emergency **air, ground water, or other Ambulance transport** services are not covered unless authorized by Us.
Non-medical **Ancillary Services** are not covered including;

- Vocational rehabilitation services;
- Employment counseling;
- Relationship counseling for unmarried couples;
- Pastoral counseling;
- Expressive therapies;
- Health education.

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

Autopsies are not a Covered Service.

B

Batteries are not a covered except for use in:

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

Biofeedback Therapy, neurofeedback, and related testing are not Covered Services unless We authorize them.

Birthing Center Services are Covered Services at contracted facilities only.

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

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

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

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

Botox injections are not Covered Services unless We have approved them.

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

Breast Ductal Lavage is not covered.

Breast Milk from a donor is not covered.

C

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

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

Cosmetic Services are not covered. This includes any treatments, surgery, services, Prescription Drugs, equipment, or supplies given for cosmetic services. **We will not Cover any of the following:**

- Services to preserve, change or improve how a person looks;
- Services to change the texture or look of skin, the size, shape or look of facial or body features;
- Surgery, reconstructive surgery, or other procedures that are not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Any service or supply that is a direct result of a non-covered service;
- 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 or insurance carrier are not Covered Services. We do not Cover the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of Covered Services in those cases where You received services in accordance with the Plan's authorization procedures. We will not Cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

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

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

D

Dentistry/Oral Surgery/Adult Dental Care

The following services are not covered:

- Treatment of natural teeth due to disease;
- Routine dental care;
- Routine dental X-rays;
- Dental supplies;
- Extraction of erupted or impacted wisdom teeth except to prepare the mouth for medical services and treatments;
- Oral surgeries or periodontal work on the hard and/or soft tissue supporting the teeth to help support structures;
- Periodontal, prosthodontal, or orthodontic care;

- Cosmetic services to restore appearance;
- Restorative services and supplies necessary to treat, repair or replace sound natural teeth;
- Dental implants or dentures and any preparation work;
- Dental services performed in a Hospital or any outpatient facility. This does not include Covered Services listed under "Hospitalization and Anesthesia for Dental procedures."
- Oral surgery which is part of an orthodontic treatment program;
- Orthodontic care.

Driver Training is not covered.

E

Electron Beam Computer Tomography (EBCT) is not covered.

The following **Educational Services** are not covered:

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

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

Examinations, testing or treatment required for employment, insurance, or judicial or administrative proceedings are not covered, unless such services are received as part of the covered preventive care services.

Experimental or Investigative drugs, devices, treatments, or services are not Covered Services. This does not apply to Covered Services for Clinical Trials. **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, surgery, and other services are not covered including:

- Corrective or protective eyewear required for work;

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

F

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

Palliative or cosmetic **Foot Care Services** are not covered including:

- Cleaning and preventive foot care when there is no Illness or Injury to the foot;
- Flat foot conditions;
- Foot orthotics, orthopedic and corrective shoes not part of a leg brace;
- Fitting, castings and other services related to devices of the feet, unless used for an Illness affecting the lower limbs;
- Subluxations of the foot;
- Treatment or removal of corns and calluses and care of toenails except for Members with Diabetes or vascular disease;
- Fallen arches;
- Weak feet;
- Tarsalgia;
- Metatarsalgia;
- Hyperkeratoses

Free Care is not a Covered Service. This includes services the Covered Person would not have to pay for if not covered by this Plan such as government programs, services received from jail or prison, services from free clinics, and Workers Compensation benefits, whether or not you Claim these benefits.

G

Genetic Testing and Counseling are not Covered Services unless authorized by the Plan. Counseling is a Covered Service only when part of the approved genetic test unless considered preventive care.

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

H

Hearing Aids and related services are not covered including:

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

Home Births are not covered. The Plan's provider network does not include midwives. Delivery by midwife is only covered at In-Network Plan participating birthing centers.

Home Health Care Skilled Services are not Covered Services unless You are homebound and under an approved home health care plan**.** Services and visits are limited as stated on Your schedule of benefits. We

do not Cover Custodial Care unless it is part of covered hospice care. We do not Cover homemaker services, food and home delivered meals.

Hospital Services listed below are not Covered Services:

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

Hypnotherapy is not covered.

I

Immunizations required for foreign travel or for employment are not covered unless under preventive care services.

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

Infertility Services listed below are not Covered Services:

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as covered;
- Services, tests, medications, and treatments for the enhancement of conception;
- In-vitro Fertilization programs;
- Artificial insemination or any other types of artificial or surgical means of conception;
- Drugs administered in connection with Infertility procedures;
- GIFT (Gamete Intrafallopian Transfer);
- ZIFT programs;
- Reproductive material storage;
- Treatment or testing related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage;
- Sperm washing;
- Services to reverse voluntary sterilization;
- Infertility Treatment or services from reversal of sterilization;
- Drugs used to treat Infertility;
- Surrogate pregnancy services when the person is not covered under Your Plan.

J

K

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

L

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

Long-Term Custodial Nursing Home Care is not covered**.**

M

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

Medical Equipment, Services, Exercise equipment, Devices and Supplies that are disposable, available over the counter, or for convenience are not covered including:

- Adaptations to Your home, car, van, other vehicle or office;
- Bicycles, treadmills, stair climbers, and other exercise equipment;
- Free weights, exercise videos and other training equipment;
- Air conditioners, purifiers, humidifiers and dehumidifiers;
- Whirlpool baths;
- Hypoallergenic pillows or bed linens;
- Under pads and diapers;
- Telephones;
- Televisions;
- Handrails, ramps, elevators, escalators, and stair glides;
- Orthotics not approved by Us;
- Adaptive feeding devices;
- Adaptive bed devices;
- Water 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;
- Heating pads, thermometers, pulse ox meters;
- Raised toilet seats;
- Shower chairs;
- Waterbeds;
- Pools, hot tubs, or spas;
- Pool, gym or health club membership fees;
- Personal trainers or other fitness instruction;
- Ice bags;
- Chairs or recliners;
- Other personal comfort or over the counter hygienic items.

Medicare Services are not Covered Services for those eligible for Medicare due to age. This includes services for which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Evidence of Coverage or as required by federal law, as described in the section titled "Medicare" in “General Provisions.” If you do not enroll in Medicare Part B, when you are eligible due to age, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out-of-pocket costs.

Mobile Cardiac Outpatient Telemetry (MCOT) is not covered.

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

N

Newborns or other Children of a covered Dependent Child are not covered unless the grandparent Subscriber or spouse are the legal guardian or adoptive parent of that grandchild.

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

O

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

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

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

P

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

PASS Devices (Patient Activated Serial Stretch) are not Covered Services.

Paternity Testing is not covered.

This policy does not provide the ACA-required essential **pediatric oral health** benefits.

Penile implants are not covered.

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

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

Private Duty Nursing in an Inpatient setting is not a Covered Service.

Prosthetics for sports or cosmetic purposes are not covered.

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

Section 7
What is Not Covered

Q

R

Reconstructive Surgery is not a Covered Service unless the surgery follows a trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. Emotional conflict or distress does not constitute Medical Necessity. This exclusion does not apply to reconstructive surgery required under the Women's Health and Cancer Rights Act.

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

S

Second Opinions – A second opinion from a Non-Plan Provider is covered only when authorized by the Plan.

Services – <u>We do not Cover any of the services or charges listed below.</u>

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

Sexual Dysfunction Treatment including drugs to treat sexual or erectile problems are not covered.

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

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

T

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

Section 7
What is Not Covered

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

Therapies - Physical, Speech, and Occupational **Therapies** are limited as stated on Your schedule of benefits. **The following are not Covered Services:**

- Group speech therapy programs;
- Lessons for sign language;
- Therapies available in a school program;
- Therapies available through state and local funding;
- Nature therapies;
- Recreational therapies such as hobbies, arts and crafts unless provided under a program of treatment in a licensed Residential Treatment Facility;
- Exercise or equine therapies;
- Driver evaluations as part of occupational therapy;
- Driver training;
- Functional capacity testing needed to return to work;
- Work hardening programs.

Total Body Photography is not a Covered Service.

Transplant Services - <u>We do not Cover any of the following</u>:

- 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 lodging services not approved by the Plan including child care, mileage, rental cars;
- Services and supplies for organ donor screenings, searches and registries.
- Services related to donor complications following a transplant are limited to Medically Necessary charges, not covered by any other source, for up to six weeks from the date of procurement.
- **Donor Benefits** are not Covered Services if the covered individual is donating an organ to a non-covered member.

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

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

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

U

Urea Breath Testing is not covered**.**

V

Vaccines are not covered unless approved by the Plan or covered under the Plan's preventive care benefits.

Treatment of **Varicose Veins** or **telangiectatic dermal veins** (spider veins) when services are considered by the Plan to be for cosmetic reasons are not covered.

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

Virtual Colonoscopy is not covered unless approved by the Plan.

Adult **Vision care** including routine vision exams, glasses, eyewear, services or supplies are not covered except when needed due to eye surgery or accidental Injury. Sunglasses or safety glasses and accompanying frames are not Covered Services.

Vitiligo Treatments by laser, light or other methods is not covered.

W

Weight Loss Surgery and Programs are not Covered Services including:

- Drugs or supplies related to weight loss or dietary control;
- Commercial Programs, whether or not under medical supervision including, but not limited to Weight Watchers, Jenny Craig, LA Weight Loss and fasting programs;
- Weight Loss Surgery/Bariatric surgery including, but not limited to:
    - Roux-en-Y (RNY);
    - Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum);
    - Gastroplasty (surgeries that reduce stomach size);
    - Gastric banding procedures;
    - Cosmetic services to improve appearance following gastric bypass surgery such as abdominoplasties, panniculectomies, and lipectomies.

Wigs or cranial prostheses for hair loss are not covered except for one wig per benefit year following cancer treatment.

Extraction of erupted or impacted **Wisdom Teeth** are 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 Services.

X

Y

Z

Section 7
What is Not Covered

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

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

Limitations.

1. Amounts You pay for any outpatient prescription drug after a benefit limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.
2. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage. However, the Plan may approve Coverage of limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included in the Plan's list of covered Preferred or Standard drugs.
3. Unless required by law, certain Prescription Drugs may not be covered under the Plan if You could use a "clinically equivalent drug." "Clinically equivalent drug" means a drug that for most individuals will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered by the Plan please call the Member Services number on the back of Your Optima Identification card. If You or Your doctor believes You need to use a different Prescription Drug, please have Your doctor contact Us. If We agree that it is Medically Necessary and appropriate We will Cover the other Prescription Drug instead of the "clinically equivalent drug" at the non-preferred tier.
4. Out formulary is a list of FDA-approved medications that we Cover. At its sole discretion, the Optima Health Pharmacy and Therapeutics Committee reviews medications for placement onto the formulary. The Plan's Pharmacy and Therapeutics Committee is composed of Physicians and pharmacists. For all drugs, including new drugs, the committee looks at the medical literature and then evaluates whether to add or remove a drug from the formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration.
5. Any Plan Maximum benefit does not apply to Physician prescribed diabetic supplies covered under the Plan's prescription drug benefit or the Plan's medical benefit.
6. Synchronization of Medication. For prescription drugs covered under the Plan We will permit and apply a prorated daily cost sharing rate to prescriptions that are dispensed by an In-Network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the Member, and the Member requests or agrees to a partial supply for the purpose of synchronizing the Member's medications. Proration will not occur more frequently than annually. The Plan will not deny Coverage for the dispensing of a medication by an In-Network pharmacy on the basis that the dispensing is for a partial supply if the prescribing provider or the pharmacist determines the fill or refill is in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the Member's medications.
7. Intrauterine devices (IUDs), implants, and cervical caps and their insertion are covered under the Plan's medical benefits.
8. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.

Prescription Drug Coverage Exclusions.

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

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications with no approved FDA indications are excluded from Coverage.

3. Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
4. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
6. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded form Coverage, unless authorized by the Plan.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage, unless authorized by the Plan.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage.
10. Medications for cosmetic purposes only, including but not limited to Retin-A for aging, are excluded from Coverage.
11. Medications for Experimental indications and/or dosage regimens determined by the Plan to be Experimental are excluded from Coverage.
12. Therapeutic devices or appliances, including but not limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
13. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded form Coverage.
18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage.
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an Emergency while traveling out of the country.
20. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage.
22. Over-the-counter medical foods are excluded from Coverage under the pharmacy benefit.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following standard reference compendia are not Covered Services:
    a. American Hospital Formulary Service Drug Information;
    b. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
    c. Elsevier Gold Standard's Clinical Pharmacology.
24. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
25. Non-Sedating antihistamines are excluded from Coverage.
26. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage.
27. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
28. Prescriptions written by a licensed dentist are excluded from Coverage, except for the prevention of infection or pain in conjunction with a covered dental procedure.
29. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription.
30. Sexual dysfunction drugs are excluded from Coverage.

31. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
32. Infertility drugs are excluded from Coverage.
33. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
34. Abortifacient drugs that cause abortions are not covered.
35. This plan uses a Closed Formulary. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are excluded from Coverage.

Non-formulary requests. You have the right to request a non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of covered drugs (formulary), or You have been receiving a specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing Physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your Physician must complete a medical necessity form and deliver it to the Optima Health pharmacy authorization department. After reasonable investigation and consultation with the prescribing Physician, Optima Health will make a determination. Optima Health will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.

CHIROPRACTIC CARE LIMITATIONS AND EXCLUSIONS

The following is a list exclusions and limitations under Your benefit for Chiropractic Care:

1. Any services or treatments that are furnished before the date the Member becomes eligible, or after the date the Member ceases to be eligible under the Member's Plan are not covered.

2. Services or treatments that are not approved by ASH Group as Medically Necessary, in accordance with ASH Group's Clinical Services Program are not covered. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; and (c) Emergency Services.

3. Any services or treatments for conditions caused by or arising out of the course of employment or covered under workers' compensation or similar laws are not covered.

4. Services provided by a chiropractor practicing outside the Service Area are not covered. This does not apply to Emergency Services or Urgent Services.

5. Services rendered in excess of visits or benefit Maximums are not covered.

6. Any services provided by a person who is an immediate Family Member are not covered. Immediate Family Member means a person who is related to the Covered Person in any of the following ways: spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or Child (includes legally adopted, step or foster Child).

7. Chiropractic services determined by ASH to be not Medically Necessary except for an initial examination and urgent services.

8. Chiropractic services determined to be Experimental or Investigational; procedures or services in the research stage as determined by ASH or Optima Health.

9. Chiropractic services not listed as a Covered Service under the Plan

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

11. Thermography.

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

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

14. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

15. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances.

16. Durable medical equipment, supports, orthotics, and/or prosthetics except as approved by ASH. Prescription drugs or other medicines, including a non-legend or proprietary medicine or medication not requiring a prescription order; also including topical drugs and medicines.

17. Hospitalization, anesthesia, or any inpatient or Hospital or surgical Facility service fees.

18. 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.

19. Services which do not require the supervision of or performance by a licensed Chiropractor.

20. Transportation costs to or from appointment(s).

21. Any service that is not permitted by state law with respect to the practitioner's scope of practice.

22. Treatment for conditions of the body not covered by the Optima benefit and not allowed by the applicable chiropractic scope of practice.

23. Any services rendered for elective or maintenance care including services provided to a Member whose treatment records indicate he or she has reached maximum therapeutic benefit, and Habilitative Services determined by ASH as not Medically Necessary.

24. Dietary and nutritional supplements, including vitamins; minerals; herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.

25. MRI, CT scans or other advance imaging ordered by a Doctor of Chiropractic.

PEDIATRIC VISION CARE AND SERVICES EXCLUSIONS AND LIMITATIONS

The following are excluded or limited under this Pediatric Vision Services Benefit:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing are not covered.
2. Aniseikonic lenses are not covered.
3. Medical and/or surgical treatment of the eye, eyes or supporting structures are covered under the Optima Health Medical Benefit.
4. Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment is not covered.
5. Safety eyewear is not covered.

Section 7
What is Not Covered

6. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof is not covered.
7. Plano (non-prescription) lenses and/or contact lenses are not covered.
8. Non-prescription sunglasses are not covered.
9. Two pair of glasses in lieu of bifocals are not covered.
10. Services rendered after the date an Insured Person ceases to be covered under the Policy are not covered, except when Vision Materials ordered before Coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
11. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Section 8
When You are Covered by More Than One Health Plan

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

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

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

When a Member is covered under more than one insurance Plan, the Plan that covers the Member as the Subscriber (not a spouse or Dependent) is normally the primary Plan. If the Plan that covers the person as the Subscriber is a government Plan, the law may require the other Plan to pay first. Depending on the circumstance We use the following rules to determine which plan is primary and which plan is secondary.

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

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

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

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

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

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

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

- **For Active and Inactive Employees the Plans pay in the following order:**

1. The health benefits Plan of an active employee (one not laid off or retired) and his or her Dependents pays its benefits first.
2. The Plan which covers a laid off or retired employee and his or her Dependents is the secondary Plan. Both Plans must have this rule for it to apply.

- **If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee longer are determined first.**

1. Two consecutive Plans are treated as one Plan if the person starts the second Plan within 24 hours of the termination of the first Plan.
2. The start of a new Plan does not include:
   a) A change in the amount or scope of a Plan's benefits; or
   b) A change in the entity paying, providing or administering Plan benefits; or
   c) A change from one type of Plan to another (e.g., single employer to multiple employer Plan).

EFFECT ON THE BENEFITS OF THIS PLAN WHEN WE ARE A SECONDARY PLAN

If this Plan is not the Primary Plan, We will coordinate benefits with the Primary Plan. We will pay the difference between what the Primary Plan(s) pay the provider and what We would pay if We were the primary Plan.

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

MEDICARE

Any benefits covered both under this Policy and Medicare will be paid according to Medicare Secondary Payor rules and regulations and Centers for Medicare and Medicaid Services (CMS) guidelines for Coordination of Benefits.

Except when federal law required this Policy to be the primary payor, the benefits under this Policy for Members age 65 and older, or for Members otherwise eligible for Medicare except End-Stage Renal Disease (ESRD), do not duplicate any benefit for which Members are entitled to under Medicare. This includes parts B and/or D of Medicare. If We provide services covered under Medicare, Medicare will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us. If a Member is eligible for Medicare due to age but has not enrolled in Medicare Parts B and/or D We will calculate benefits as if the Member had enrolled.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We require certain information to apply these COB rules. Each Member must submit to Us any completed consents, releases, assignments and/or other documents that are necessary for Us to coordinate benefits.

We may get information from other organizations or persons. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan all facts it needs to pay the Claim. We may release information to other persons and organizations in accordance with the Insurance Information and Privacy Protection regulations as set forth in the Code of Virginia 38.2-613. If You have questions about how We can get and use information please refer to the information on Our privacy practices notice in this document.

Section 8
When You are Covered by More Than One Health Plan

FACILITY OF PAYMENT

A payment made by another plan may include an amount which We should have paid. If it does, We may pay the other Plan that amount. We will then treat that amount as if it were a benefit paid under this Plan. If the "payment made" was in the form of services, "payment made" means the reasonable cash value of those services.

RIGHT OF RECOVERY

If We pay more than We should have paid under COB, We may recover the excess from one or more of:

- The person(s) it paid; or
- Health insurance companies or health maintenance organizations (HMOs).

We are not required to reimburse a Member in cash for the value of services provided.

BENEFITS UNDER OTHER PROGRAMS

Benefits available under **Worker's Compensation**. If We provide services covered under Worker's Compensation, Worker's Compensation will pay the provider of the services directly for those services. The Plan will coordinate benefits with the provider of the service. Any money received by Us belongs to Us.

Benefits available under **any other government program** (except Medicaid) unless required to do so by law. If We provide services under a government program, the government program will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us.

THE FOLLOWING DEFINITIONS APPLY TO THIS SECTION

"Plan" is any of the following which provide health benefits or services:

1. Group health insurance or group-type health coverage, whether insured or self-insured. This does not include Worker's Compensation.
2. A government health Plan, or Coverage required or provided by law. This does not include a state Plan under Medicaid.

Each contract or other arrangement for Coverage is a separate Plan. If a Plan has more than one part and COB rules apply to less than all of the parts, each of the parts is a separate Plan.

"This Plan" or "We" is the part of this Evidence of Coverage that provides benefits for health care expenses.

"Primary Plan/Secondary Plan". When this Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a secondary Plan, its benefits may be coordinated with any other health insurance or health care benefits or services that are provided by any other group policy, group contract, or group health care Plan so that no more than 100% of the eligible incurred expenses are paid. This Plan may recover from the primary Plan the reasonable cash value of services provided by this Plan.

"Allowable Expense" means an expense for which the Plan will pay. It is the usual and customary charge for an item or service covered at least in part by the Member's insurance. The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an allowable

expense unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

"Claim Determination Period" means a contract year. However, it does not include any part of a year during which a person has no Coverage under this Plan, or any part of a year before the date of this COB provision or a similar provision takes effect.

Section 9
Claims and Payments

WHEN YOU HAVE TO FILE A CLAIM FOR BENEFITS

Plan Providers will usually file Claims for You. You may have to file a Claim if Your Provider is unable to file for You, or if You see a Non-Plan Provider. We do not use Claim forms, but You must send Us complete written proof of loss. Proof of loss means that We have all the information We need to process Your Claim. You can provide proof of loss by sending Us an itemized bill for services You received. An example would be a bill from a doctor's office or Hospital listing the cost of services or tests You had done.

- **The bill must be in English and include all of the following:**

  - The name and address of the provider; and
  - The name, and Member number of the Member who received services; and
  - The date of the services; and
  - The diagnosis and type of services received; and
  - The charge for each type of service.

- **Send the itemized bill and any other information You have about Your Claim to**:

  MEDICAL CLAIMS
  Lason Systems
  P.O. Box 5028
  Troy, MI 48007-5028

TIMELY FILING OF CLAIMS AND WRITTEN PROOF OF LOSS

Proof of loss means that We have all the information We need to process Your Claim. You must submit written proof of loss to the Plan within 90 days after You receive the Covered Services. If You do not send written proof of loss within 90 days Your Claim will not be reduced or invalid as long as You send it to Us as soon as reasonably possible.

Unless You are not legally competent to act, We require that You send Us proof of loss no later than one year after the date of service or We will not provide benefits.

CLAIMS FROM NON-PLAN PROVIDERS

Non-Plan Providers must submit Claims for Covered Services provided to Members to:

MEDICAL CLAIMS
Lason Systems
P.O. Box 5028
Troy, MI 48007-5028

MENTAL HEALTH CLAIMS
Lason Systems
P.O. Box 1440
Troy, MI 48009-1440

Claims must be received by the Plan within 365 days of the date the Member received the Covered Service. We will not be liable for, or pay a Claim We receive from a Non-Plan Provider more than 365 days from the date of service.

Section 9
Claims and Payments

PROCESSING A CLAIM

We process Claims, make Coverage decisions, and provide notice according to the procedures and timeframes described in Section 5. All of Our requirements for Pre-Authorization apply. All of the Member's Coverage exclusions and limitations apply.

If We deny a Claim for benefits the Member has the right to a full and fair review of the Plan's determination according to Our appeal process in Section 10.

CLAIMS PAYMENT

We usually pay the provider or the Facility that provided the Covered Service. If a Member has provided proof that they paid the provider directly for a Covered Service We will reimburse the Member less any amounts We have already paid the provider for the Claim. We will pay the estate of the Member if the Member is dead.

CLAIMS PAID DIRECTLY TO MEMBERS FOR SERVICES FROM NONPARTICIPATING PHYSICIANS

If We send payment directly to a Member for a Claim for Covered Services from a non-plan Physician or osteopath, the Member must apply the plan payment to the Claim from the Non-Plan Provider. We will include the name and any last known address of the Physician or osteopath with any payment sent directly to the Member.

Section 10
Your Right to File a Complaint or Appeal

YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

We want You to be satisfied with Your health plan services. If You are not satisfied We have a formal complaint process to handle Your concerns. We also have an Internal and an External Appeal Process to resolve benefit disputes and respond to requests to reconsider Coverage decisions You find unacceptable.

Some examples of typical complaints or grievances are:

- You are unhappy with a doctor or Hospital;
- You feel You received poor care at a Hospital;
- You are unhappy with Our services.

Some examples of when You are entitled to an appeal are:

- We did not approve a request for Pre-Authorization;
- We did not Cover a treatment because it is Experimental;
- We did not Cover a service because it is not Medically Necessary;
- We did not pay for a treatment or service according to Your benefits.
- We have notified You that Your Coverage is being rescinded for fraud or material misrepresentation.

We suggest You call Member Services first and one of Our customer service representatives will assist You with the problem. Most problems can be handled in this manner. If You are still not satisfied You can file a formal written complaint or an appeal by following one of processes below.

Remember, You have the right to file a complaint or an appeal. We will not penalize You or cancel Your Coverage because You exercise Your rights.

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

Write:

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

Telephone:

Toll-Free: 1-877-310-6560
Richmond Metropolitan Area: 1-804-371-9032

E-Mail: ombudsman@scc.virginia.gov

HOW TO FILE A COMPLAINT

You can file a complaint anytime within 180 days from the date of Your concern with Your care or services. Remember to include any additional documentation that will help Us resolve Your concern. You

may have someone else, such as a doctor or family member, file a complaint for You. We may ask that You sign a form authorizing the other person to act for You.

Call Member Services and ask for a complaint form, or download the forms from Our Web site www.OptimaHealth.com. Mail or fax the completed forms and any additional documentation to:

Optima Health
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232
Toll Free: 866-472-3920

We will write to You and let You know We have received Your complaint. We will also tell You how long We think it will take Us to investigate Your complaint. When We have finished Our investigation We will write to You and let You know how We have resolved Your complaint.

If You have been unable to contact Us or obtain satisfaction here are some other places You can go for help.

- **Contact the Virginia Bureau of Insurance**:

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

- **Contact the Virginia Department of Health**:

  Virginia Department of Health
  Center for Quality Health Services and Consumer Protection
  3600 W. Broad Street, Suite 216
  Richmond, VA 23230-4920
  Toll-free Telephone: 1-800-955-1819

- **The Managed Care Ombudsman**:

  Write:
  Office of the Managed Care Ombudsman
  Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218

  Telephone:
  Toll-Free: 1-877-310-6560
  Richmond Metropolitan Area: 1-804-371-9032
  E-Mail: ombudsman@scc.virginia.gov

APPEALS OF AN ADVERSE BENEFIT DETERMINATIONS

An Adverse Benefit Determination means that We have made a decision not to pre-authorize, Cover, or pay (in whole or in part) for a service because:

- You are not eligible for benefits under the plan; or
- The service does not meet Our requirements for:
  - Medical necessity;
  - Appropriateness;
  - Health care setting;
  - Level of care;
  - Effectiveness; or
- The service is Experimental or Investigational; or
- Optima Health has notified You that Your Coverage is being rescinded.

You have the right to a full and fair appeal of an Adverse Benefit Determination. You have 180 days from Our notice to You of an Adverse Benefit Determination to ask for an appeal.

You can have someone else, such as a doctor or family member file an appeal for You. We may ask You to sign a form to authorize this person to act for You.

When We review Your appeal We will look at all comments, documents, records, and other information submitted to Us. We will do a new review without regard to the first review of Your case. Make sure You send Us any new information You want Us to review. You can submit new information to Us in writing or in person.

The person reviewing Your appeal will not have participated in the original Coverage decision.

Appeals involving a medical judgment, including whether a particular treatment, drug, or other service is Experimental, Investigational, or not Medically Necessary will be reviewed by a clinical peer reviewer who did not participate in the first Coverage decision.

Before We make Our final decision on your appeal We will provide you free of charge any new information We relied on, and We will give you time to provide comments.

Appeals of Pre-Service Claims

A Pre-Service Claim is a Claim for a benefit or service that requires Pre-Authorization before You receive care. An example would be obtaining Pre-Authorization for a diagnostic test or medical procedure.

For Pre-Service Claims, We will make a decision and notify You within 30 calendar days of receipt of Your written request for the appeal.

Reconsideration of an Adverse Decision

Your treating provider may request a reconsideration of an Adverse Decision on Your behalf. A request for reconsideration is optional, and available only to Your treating heath care provider. You or Your Authorized Representative may file an appeal regardless of whether Your provider requests a reconsideration. We will make a decision on a reconsideration and notify the provider and the member in writing within ten (10) working days of the date of receipt of the request. If we deny the reconsideration request the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate recommendation, and the Member's right to appeal the decision.

Appeals of Post-Service Claims

A Post-Service Claim is any Claim for a benefit that is not a Pre-Service Claim. An example would be a Claim for payment for a diagnostic test or other services You have already had done.

If Your appeal involves a Post-Service Claim, We will make a decision and notify You within 60 calendar days of receipt of Your written request for the appeal.

Appeals of Concurrent Claims or Review Decisions

A Concurrent Care Claim is a Claim for a benefit where We are reducing or ending a service previously approved. It can also be a request to extend a course of treatment. An example would be a review of an inpatient Hospital stay approved for five days on the third day to determine if the full five days is appropriate. Another example would be a request for additional outpatient therapy visits.

For Concurrent Care Claims, We will make a decision and notify You as soon as possible and prior to the benefit being reduced or terminated.

We will continue to provide Coverage during Your appeal of a Concurrent Review.

Expedited Appeals for Urgent Claims

You can request an expedited appeal if Your Claim for medical care or treatment is urgent and using Our normal appeal process would:

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

You or Your treating Physician can request an expedited appeal by telephone, fax, or letter. Please make sure to explicitly state "expedited appeal" in the request to initiate this process.

We will make a decision on an expedited appeal and notify You as soon as possible, but no later than:

- One business day after We receive all information necessary to make a decision; or
- Not later than 72 hours from the receipt of the request.

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

You also have the right to file an external review at the same time as Your request for an expedited internal appeal. **Please see the section below "YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR A FINAL ADVERSE BENEFIT DETERMINATION."**

Adverse Determinations Involving the Treatment of Cancer

If You receive an Adverse Determination involving the treatment of Cancer You are not required to exhaust Our internal appeal processes before requesting a standard or expedited independent external review. **Please see the section below "YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR A FINAL ADVERSE BENEFIT DETERMINATION."**

HOW TO BEGIN YOUR APPEAL

- **You can ask for forms to start a written appeal by:**

  1. Calling Member Services at the number on Your ID card; or
  2. Downloading the forms at www.optimahealth.com ; or
  3. Sending Us a fax at 757-687-6232 1-866-472-3920; or

4. Sending Us a letter by mail at:

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

- **For an Urgent care appeal You or Your treating Physician can request an expedited appeal by telephone, fax, or letter. Please make sure to explicitly state "expedited appeal" in the request to initiate this process.**

- **When You have completed the forms return them to Us. Remember to include all of the following with Your appeal forms:**

1. Your name, address, and telephone number;
2. Your Member number and group number;
3. The date of service, and place of service;
4. The name of the doctor or other service provider;
5. The charge related to the service; and
6. Any new additional written comments, documents, records, or other information You want Us to consider.

- **When We complete Your appeal We will send written notification of Our decision. If We don't change Our initial decision Our notice will include**:

1. The specific reason for Our decision; and
2. The specific plan provisions We based Our decision on; and
3. Information on any external appeal rights available to You.

- **You can also request the following free of charge:**

1. Reasonable access to, and copies of, all documents, records, and other information relevant to Your appeal; and
2. Copies of any internal rule, guideline, protocol, or other criteria We relied on for Our decision; and
3. For denials due to medical necessity, Experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to Your medical circumstances.

YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR A FINAL ADVERSE BENEFIT DETERMINATION

If We have denied Your request for the provision of, or payment for, a health care service or course of treatment You may have the right to have Our decision reviewed by health care professionals who have no association with Us if Our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested by submitting a request for external review to the Virginia State Corporation Commission's Bureau of Insurance .

State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218

Phone: 1-877-310-6560 Fax: (804)371-9915
Email: externalreview@scc.virginia.gov

We will send You copies of the forms and instructions that You need to file an external review or an expedited external review with Our notice of an Adverse Benefit Determination or final Adverse Determination. You can also get copies of the forms and instructions that You need by calling Member Services at the number on Your Optima Health ID Card or on our web site at optimahealth.com.

Depending on Your situation You or Your authorized representative can ask for an external review of an adverse or final Adverse Determination.

You may file a request for an External Review of an Adverse Determination in the following situations:

- If We have denied Your request for a Covered Service, or We have denied payment for a Covered Service or course of treatment, and Our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested
- If the Adverse Determination involves the treatment of cancer or a medical condition where the time frame for completion of an expedited internal appeal of an Adverse Determination would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, You, or Your authorized representative may file a request for an expedited external appeal.
- If the Adverse Determination involves a denial of Coverage based on a determination that the recommended or requested health care service or treatment is Experimental or Investigational and Your treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, You or Your authorized representative may file a request for an expedited external review.
- If You or Your authorized representative files a request for an expedited internal appeal with Us, You may file at the same time a request for an expedited external review of an Adverse Determination. The independent review organization assigned to conduct the expedited external review will determine whether the Covered Person shall be required to complete the expedited internal appeal prior to conducting the expedited external review;
- If You or Your authorized representative files a standard appeal with Our internal appeal process, and We do not issue a written decision by either 30 days from the date of filing for a Pre-Service Claim or by 60 days from the date of filing for a Post-Service Claim, and You or Your authorized representative did not request or agree to a delay, You or Your authorized representative may file a request for external review, and will be considered to have exhausted Our internal appeal process.

You or Your authorized representative can request an external review of a final Adverse Benefit Determination in the following situations:

- You have a medical condition where the time frame for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, You or Your authorized representative may file a request for an expedited external.
- If the final Adverse Determination involves an Admission, availability of care, continued stay, or health care service for which You received Emergency Services, but have not been discharged from a Facility, You or Your authorized representative may request an expedited external review.
- If the final Adverse Determination involves a denial of Coverage based on a determination that the recommended or requested health care service or treatment is Experimental or Investigational,

You or Your authorized representative may file a request for a standard external review; or if Your treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, You or Your authorized representative may request an expedited external review.

You have 120 days from the date You receive notice of Your right to request an External appeal from the Bureau of Insurance (BOI).

You must have exhausted Our internal appeal process. Exhaustion of the internal appeal process will not be required if the Adverse Determination is related to the treatment of cancer. Depending on Your situation exhausted means:

- You have filed an internal appeal and We have notified You of Our final adverse benefit decision; or
- You filed an internal appeal, and We have not given You a response on Our determination by either 30 days from the date of filing for a Pre-Service Claim or by 60 days from the date of filing for a Post-Service Claim. This does not apply if You agreed to give Us more time to work on Your appeal; or
- You filed an expedited or urgent appeal with Us. At the same time You can request an External review; or
- We have agreed to waive the exhaustion requirement for Your appeal.

How Your External Appeal will be handled

When the BOI receives Your appeal, they will ask Us to verify that Your case is eligible for external appeal, and that Your appeal request is complete.

You will have to authorize the release of any medical records needed to reach a decision on the external review.

If any additional information is needed to complete Your request or verify eligibility, We will ask You to provide the specific information needed. We will give You a timeframe to submit this information. If You do not submit this information to Us a timely manner, Your request for an external review may be concluded.

If We determine that Your request is not eligible for an external appeal, You may appeal that determination to the BOI.

You will be notified that Your request is complete and eligible for external review. The BOI will randomly select an Independent Review Organization (IRO) to perform Your appeal. The IRO performing Your appeal will not be affiliated with Optima Health so that there is no conflict of interest with Your case. You will have 5 business days from notification to submit any additional information You would like the IRO to review about Your case. We will also submit all of our documents and information We used to make Our decision on Your internal appeal to the IRO for review.

The IRO will notify You and Optima Health of its decision on Your external appeal. The decision is binding on Us. The decision is also binding on You except to the extent the Covered Person has other remedies available under applicable federal or state law.

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

Section 10
Your Right to File a Complaint or Appeal

We may reconsider any final Adverse Benefit Determination that is the subject of an external review at any time. Reconsideration by Us will not delay or end the external review.

SOURCES FOR ADDITIONAL HELP

If You have been unable to contact Us or obtain satisfaction here are additional places You can go for help:

- Virginia State Corporation Commission
  Life & Health Division, Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  (877) 310-6560
  http://www.scc.virginia.gov/boi
  bureauofinsurance@scc.virginia.gov

- You may contact the Office of the Managed Care Ombudsman to seek assistance in understanding and exercising Your right to appeal an Adverse Determination at:

  Office of the Managed Care Ombudsman
  Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  Toll Free Telephone Number: 877-310-6560
  Email Address: ombudsman@scc.virginia.gov

- You may Contact the Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection at 1-800-955-1819.

You may have the right to bring civil action under Section 502 (a) of the Employee Retirement Income Security Act if all required reviews of Your appeal have been completed and Your appeal has not been approved. Members of government or church-sponsored groups do not have this right. Additionally, You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency. Contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration Toll-free at 1-866-275-7922 or visit their website at www.dol.gov.

Section 11
General Provisions

MAJOR DISASTERS AND OTHER CIRCUMSTANCES BEYOND THE PLAN'S CONTROL

In the event that circumstances not within the Plan's control including, but not limited to, a major disaster, epidemic, or civil insurrection, result in the facilities, personnel or resources used by the Plan being unable to provide or arrange for the care and services the Plan has agreed to provide, the Plan shall make a good faith effort to arrange for an alternative method of providing such care and services insofar as practical and according to its best judgment. In such circumstances, however, neither the Plan nor participating providers shall incur any liability or obligation for delay, or failure to provide or arrange for such services.

INCONTESTABILITY

In the absence of fraud, all statements made by a Member shall be considered representations and not warranties and no statement shall be the basis for voiding Coverage or denying a Claim after the contract has been in force for two years from its effective date, unless the statement was material to the risk and was contained in a written Application.

SEVERABILITY

In the event that any provision of this Evidence of Coverage is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this EOC which shall continue in full force and effect in accordance with its remaining terms.

POLICIES AND PROVISIONS

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

MODIFICATIONS

Alterations to the Plan, the Evidence of Coverage and its attachments may be made, in accordance with the terms herein. Enrollees will be notified of a Deductible increase seventy-five (75) days in advance of the change.

ENTIRE CONTRACT

The Evidence of Coverage together with all exhibits and amendments thereto, the individual Application of Members, and any other questionnaire, form or other document provided in execution with the Evidence of Coverage shall constitute the entire agreement between the parties. No statements or representations may be used in any legal dispute regarding the terms of Coverage or any exclusions or limitations hereunder unless contained in such documents. No alteration of the Evidence of Coverage and no waiver of any of its provisions shall be valid unless evidenced by a written endorsement or amendment signed by a duly authorized officer of the Plan. Any insurance agent or broker licensed through the Plan who may have assisted in the contract for this Plan is not an authorized officer of the Plan for this or any other purpose.

OMISSIONS

Neither the Subscriber nor any other Member is an agent or representative of the Plan, and neither shall be liable for any acts or omissions of the Plan, its agents or employees, or of any provider, or any other person or organization with which the Plan, its agents or employees, has made or hereafter shall make arrangements for the performance of services under this agreement.

Section 11
General Provisions

RELATIONSHIP BETWEEN THE PLAN AND HOSPITALS

The relationship between the Plan and Hospitals is that of an independent contractor. Hospitals are not agents or employees of the Plan nor is the Plan or any employee of the Plan an employee or agent of Hospitals. Hospitals shall maintain the Hospital-patient relationship with Members and are solely responsible to Members for all Hospital services.

RELATIONSHIP BETWEEN THE PLAN AND HEALTH PROFESSIONALS

The relationship between the Plan and health professionals is that of an independent contractor except in such cases whereby the health professional is employed by the Plan. Independently contracted health professionals are not agents or employees of the Plan nor is the Plan, or any employee of the Plan, an employee or agent of its health professionals. Health professionals shall maintain professional patient relationships with Members in accordance with the terms hereof and applicable law, and are solely responsible to Members for all medical services.

ASSIGNMENT OF BENEFITS FOR DENTISTS AND ORAL SURGEONS

The Plan will accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by You. Assignment of Benefits means the transfer of dental care coverage reimbursement benefits or other rights under the Policy to a dentist or oral surgeon. The assignment of benefits will not be effective until You notify the Plan in writing of the assignment.

PRESCRIPTION DRUG BENEFITS

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

The Plan will not exclude Coverage for any prescription drug solely on the basis of the length of time since the drug obtained FDA approval.

Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy or its intermediary that has agreed to accept as payment in full reimbursement from the Plan or its Pharmacy Benefit Manager at the same level as the Plan or its Pharmacy Benefit Manager gives to participating pharmacies.

NOTICE IN WRITING

From the Plan to You

Section 11
General Provisions

A notice sent to You by the Plan is considered "given" when mailed to Your last known address as shown in the Plan's enrollment records. Notices include any information which the Plan may send You, including identification cards.

From You to the Plan

Notice by You is considered "given" when actually received by the Plan. The Plan will not be able to act on this notice unless the subscriber's name and identification number are included in the notice.

LIMITATIONS OF DAMAGES

In the event a Member or his representative sues the Plan, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what Coverage and/or benefits, if any exist under this Evidence of Coverage, the damages shall be limited to the amount of the Member's Claim for benefits. The damages shall not exceed the amount of any Claim not properly paid as of the time the lawsuit is filed. This policy does not provide Coverage for punitive damages, or damages for emotional distress or mental anguish; provided, however, this provision is not intended, and shall not be construed, to affect in any manner any recovery by You or Your representative of any non-contractual damages to which You or Your representatives may otherwise be entitled.

THE PLAN'S CONTINUING RIGHTS

On occasion, We may not insist on Your strict performance of all terms of this Evidence of Coverage. This does not mean We waive or give up any future rights We have under this Evidence of Coverage.

CONTINUITY OF CARE

If a provider leaves the Plan's network, except for cause, the Member may continue to receive care from that provider subject to the following conditions:

A. For a period of 90 days from the date of the notice of a provider's termination for Members who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider;
B. Through the provision of postpartum care directly related to the delivery for Members who have entered the second trimester of pregnancy at the time of a provider's termination;
C. For the remainder of the Member's life for care directly related to the treatment of terminal Illness. "Terminally ill" is defined under §1861 (dd) (3) (A) of the Social Security Act.

The Plan will pay a provider according to the Plan's agreement with the provider existing immediately before the provider's termination of participation.

CONSIDERATION OF MEDICAID ELIGIBIITY PROHIBITED

The Plan shall not, in determining the eligibility of an individual for Coverage, consider the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

The Plan shall not, in determining benefits payable to, or on behalf of an individual covered under the Plan, take into account the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

Section 11
General Provisions

DISCRIMINATION

The Plan will not unfairly discriminate against an enrollee on the basis of the age, sex, gender identity or status as a transgender individual, health status, race, color, creed, national origin, ancestry, religion, marital status, or lawful occupation of the enrollee, or because of the frequency of utilization of services by the enrollee. However, nothing shall prohibit the Plan from setting rates or establishing a schedule of charges in accordance with relevant actuarial data.

The Plan will not unreasonably discriminate against Physicians as a class or any class of providers listed in § 38.2-4312 of the Code of Virginia when contracting for specialty or referral practitioners, provided the plan Covers services that the class of providers are licensed to render. Nothing in this section shall prevent a health maintenance organization from selecting, in the judgment of the health maintenance organization, the number of providers necessary to render the services offered by the health maintenance organization, or from limiting certain specialty services to particular types of practitioners, provided these services are within the scope of their license.

THIS IS THE END OF YOUR EVIDENCE OF COVERAGE.

Attachments

Under state and federal law Optima Health Members are entitled to certain information about their health plan benefits. Your employer may be required to provide You additional notices or information about Your coverage rights. On the following pages You will find the following:

Notice of Maternity Coverage (NMHPA)

Under Federal and state law You have certain rights and protections regarding Your maternity benefits under the Plan.

Notice of Coverage for Reconstructive Breast Surgery (WHCRA)

This notice provides information on the Member's rights and availability of benefits for the treatment of mastectomy related services, including reconstructive surgery, prostheses, and physical complications, including lymphedemas under the Plan.

Sentara Healthcare Integrated Notice Of Privacy Practices

Optima Health is part of the Sentara Healthcare integrated health care system. This system is made up of companies owned by Sentara Healthcare. Every member of the Sentara Healthcare family, including Optima Health, must comply with the basic privacy principles found in the "Sentara Healthcare Integrated Notice of Privacy Practices." A copy of the notice is attached to this booklet. In the notice there is an explanation of how the Sentara Healthcare system uses and safeguards Your personal and medical record information.

Notice Of Protection Provided By Virginia Life, Accident And Sickness Insurance Guaranty Association

This notice provides **a brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

Notice of Insurance Information and Financial Information Practices

This notice will help You understand how We may collect information about You, the type of information that may be collected, and what information may be disclosed about You to the Plan's affiliates and to non-affiliated third parties.

Balance Billing Consumer Rights

This notice will help You understand balance billing protection for Out-of-Network Services

Notice of Maternity Coverage (NMHPA)

Under Virginia law and under federal law You have certain rights and protections regarding Your maternity benefits under the Plan.

Under federal law known as the **"Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act)** group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Under Virginia State law Your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally.

Notice of Coverage for Reconstructive Breast Surgery (WHCRA)

In the Commonwealth of Virginia and under a federal law known as The Women's Health and Cancer Rights Act of 1998 (WHCRA) We are required to notify You of Your rights related to benefits provided by the Plan in connection with a mastectomy. This notice provides information on the Member's rights and availability of benefits for the treatment of mastectomy related services, including reconstructive surgery, prostheses, and physical complications, including lymphedemas under the Plan.

You should keep this information with Your important health care records. If You have any questions regarding this Notice or the benefits You are entitled to under the Plan please call Member Services at the number listed on Your Plan insurance identification card.

As a Member of the Plan You have rights to coverage to be provided in a manner determined in consultation with Your attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the exclusions, limitations, and conditions including Copayments, Coinsurances, and/or Deductibles set forth in this document. Coverage shall have durational limits, dollar limits, Deductibles and Coinsurance factors that are no less favorable than for physical illness generally.

Sentara HealthCare Integrated Notice of Privacy Practices

SENTARA HEALTHCARE INTEGRATED NOTICE OF PRIVACY PRACTICES

Effective Date: June 2, 2005. Revised: August 1, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the office of the Sentara Privacy Contact Person.

Sentara HIPAA Privacy Contact Person
PO Box 2200
Norfolk, VA 23501
1-800-981-6667

Who Will Follow This Notice.

This notice describes Sentara Healthcare's privacy practices including:

- All divisions, affiliates, facilities, medical groups, departments and units of Sentara Healthcare;
- Any member of a volunteer group we allow to help you while you are in a Sentara Healthcare facility;
- All employees, staff and other Sentara Healthcare personnel; and
- Sentara hospital-based residents, medical students, physicians and physician groups with regard to services provided and medical records kept at a Sentara facility (all together "Sentara" or "we").

Our Pledge Regarding Medical Information:
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.
We create a medical record of the care and services you receive at Sentara care sites. We need this record to provide you with quality care and to comply with certain legal requirements.
This notice applies to all of the Sentara Healthcare medical records of your care generated by a Sentara entity, whether made by Sentara personnel or your personal provider. Your personal provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.
This notice tells you about the ways in which we may use and disclose your medical information. It also describes your rights and certain obligations we have regarding use and disclosure of information.

We Are Required By Law to:

- Make sure that all of your medical information and that which identifies you is kept private;
- Give you this notice of our legal duties and privacy practices; and
- Follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information About You.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and give examples. Not every use or disclosure in a category will be listed, however all of the ways we are permitted to use and disclose information fall within one of the categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Sentara personnel and

care providers who are involved in your care. Among those caring for you are medical, nursing and other health care personnel in training who, unless you request otherwise, may be present during your care as part of their education. We may use still or motion pictures and closed circuit television monitoring of your care. We may also share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, X-rays and emergency medical transportation, as well as with family members or others providing services that are part of your care.

- **For Payment.** Sentara may use and disclose your medical information so that it or other entities involved in your care may obtain payment from you, an insurance company or a third party for treatment and services you receive. We and your physician(s) may disclose your medical information to any person, Social Security Administration, insurance or benefit payor, health care service plan or workers' compensation carrier which is, or may be, responsible for part or all of your bill. For example, we may give your insurer information about surgery you received at a Sentara hospital so they will pay us or reimburse you. We may also tell your insurer about a treatment you are going to receive to obtain prior approval, to determine whether your plan will cover the treatment, or to resolve an appeal or grievance. Information on members of Sentara managed care plans may be used and disclosed to determine if services requested or received are covered benefits under its insurance, and to underwrite your group's health plan. Sentara is required to agree, if you request, to restrict disclosure of PHI to a health plan for any healthcare item or service which you have paid in full out of pocket.
- **For Health Care Operations.** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to run Sentara and make sure that all of our patients and members receive quality services. For example, we may use medical information to review our treatment and services, to evaluate the performance of our staff, and to survey you on your satisfaction with our treatment and/or services. We may combine medical information to decide what additional services or health benefits Sentara should offer, what services are not needed, and whether certain new treatments are effective. We may disclose information to doctors, nurses, technicians, students training with Sentara, and other Sentara personnel for review and learning purposes. We may combine the medical information we have with medical information from other health care entities to compare how we are doing and see where we can make improvements in the care and services we offer. Sentara may also disclose information to private accreditation organizations, including, but not limited to, the Joint Commission on Accreditation of Healthcare Organizations and the National Committee, Det Norske Veritas (DNV) Hospital Accreditation Program, Quality Assurance, or other accreditation entities, in order to obtain accreditation from these organizations. We may use your information to credential providers in our health plan network and to grant hospital privileges to providers. We may also provide to others de-identified information that does not identify you, to be used in healthcare studies.
- **Appointment Reminders.** We may use and disclose your information to remind you of an appointment at a Sentara location.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose your information to tell you about health related benefits or services.
- **Fundraising Activities.** We may use and disclose medical information about you so that we or a foundation related to Sentara may contact you in an effort to raise money for Sentara. We only release information such as your name, address and phone number and the dates you received treatment or services. You have the right to be removed from any fundraising listing so that you will not be contacted. Opting out of fundraising activities will in no way affect any access or level of care

to any patient. Once a patient opts-out of the fundraising listing, Sentara Healthcare will avoid contacting you unless the patient at a later time decides to opt-in for fundraising contact. Opting out or in for fundraising can be done by phone or email.

- **Hospital Directory.** We may include your name, location in the hospital, and your general condition (e.g., fair, stable, etc.) in the hospital directory while you are a patient at a Sentara hospital. The directory information may be released to people who ask for you by name so your family, friends and clergy can visit you in the hospital and generally know how you are doing. You may ask to restrict some or all of the information contained in the directory.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, must be reviewed and approved by either an institutional review board (IRB) or privacy board. In limited situations, your medical information may be reviewed by a researcher preparing to conduct a research study.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law. This includes, but is not limited to, disclosures to mandated patient registries.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to a person able to help prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **To Sponsors of Group Health Plans.** We may disclose your medical information to the sponsor of a self-funded group health plan, as defined under ERISA. We may also give your employer information on whether you are enrolled in or have dis-enrolled from a health plan offered by the employer.
- **Marketing.** We must obtain your prior written authorization to use your protected health information for marketing purposes except for a face-to-face encounter or a communication involving a promotional gift of nominal value. We are prohibited from selling lists of patients and enrollees to third parties or from disclosing protected health information to a third party for the marketing activities of the third party without your authorization. We may communicate with you about treatment options or our own health-related products and services. For example, our health care plans may inform patients of additional health plan coverage and value-added items and services, such as special discounts.
- **Activities Requiring Authorization -** Sentara requires specific patient authorization for disclosure of Protected Health information in the event of 1) Disclosures that constitute a sale of PHI, 2) Disclosure of PHI for Marketing Purposes and, 3) disclosures of psychotherapy notes. You may revoke an authorization at any time.

Special Situations

- **Organ and Tissue Donation.** We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** We may release medical information about members of the domestic or foreign armed forces as required by the appropriate military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.
- **Public Health Activities.** We may disclose medical information about you for public health activities. These activities include the following:
- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;

- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence where you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, but are not limited to, audits, investigations, examinations, inspections, and licensure.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or reasonable efforts have been made by the party seeking the information to secure a qualified protective order. We also may disclose your information to Sentara's attorneys and, in accordance with applicable state law, to attorneys working on Sentara's behalf.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the location of a Sentara entity; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of person(s) who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner, medical examiner or funeral director as necessary for them to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Uses and Disclosures Regarding Food and Drug Administration (FDA)-Regulated Products and Activities.** We may disclose protected health information, without your authorization, to a person subject to the jurisdiction of the FDA for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products.
- **Genetic Information.** Consistent with the Genetic Information Nondiscrimination Act (GINA),your health plan is prohibited from using or disclosing genetic information for underwriting purposes.

- **School Immunization Admission Requirements.** You do not need to provide an authorization for schools to receive immunization information.
- **All Other Uses & Disclosures of PHI.** Any other use and/or disclosure of your PHI not specified in this notice will require a signed authorization prior to use.

Your Rights Regarding Medical Information We Maintain About You.

You have the following rights regarding your medical information:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing on a form provided by Sentara to the Heath Information Management (HIM) department. You have a right to obtain a paper or electronic copy. Your request should indicate in what form you want the information. You may also request where the information is to be sent. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Sentara will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for a Sentara entity. To request an amendment, your request must be made in writing on a form provided by Sentara and submitted to the Heath Information Management (HIM) department. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for a Sentara entity;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. It does not include disclosures made for treatment, payment, health care operations, disclosures you authorize or other disclosures for which an accounting is not required under HIPAA. To request this list or accounting of disclosures, you must submit your request in writing on a form provided by Sentara to the Heath Information Management (HIM) department. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically.) The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing on a form provided by Sentara to the Heath Information Management (HIM) department.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, i.e. disclosures to your spouse.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work or by mail. To request confidential communications, you may make your request in writing to the Heath Information Management (HIM) department. You may also telephone the office of the Privacy Contact Person, however in order to protect your privacy we may not be able to accommodate requests made by telephone. We will not ask you the reason for your request, and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice at anytime, even if you have previously agreed to receive this notice electronically. To obtain a paper copy of this notice, please write or call the Heath Information Management (HIM) department.
- **Right to Breach Notification**. In the event that unsecured protected health information is inappropriately disclosed, an investigation of the event will be conducted. If it is determined to be a breach of your information, you will receive notification of the breach by first class mail.
- **Underwriting.** Sentara will not use patient's genetic information in an adverse manner for underwriting purposes.
- **Rights of the Deceased.** PHI of an individual that has been deceased for 50 years or more is NOT covered by HIPAA. Covered Entities are permitted to disclose a deceased person's PHI to family members and others who were involved in the care or payment for care if not contrary to prior expressed preference.

Change to this Notice

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice with the effective date at Sentara health care treatment facilities. We will post a current updated copy of this notice on our website, WWW.SENTARA.COM. In addition, each time you have an appointment at, register at, or are admitted to a Sentara hospital or other Sentara treatment location for treatment or health care services, we will offer you a copy of the current notice. If you are a member of a Sentara health plan, your Evidence of Coverage or Certificate of Insurance will contain the version of the notice in effect as of the printing of those documents, plus any amendment to the notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Sentara or with the Secretary of the Department of Health and Human Services. To file a complaint with Sentara, contact the Privacy Contact Person. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

Other Uses of Medical Information.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care and services that we provided to you.

Sentara HealthCare Integrated Notice of Privacy Practices

Additional Notices.

If you have insurance through Optima Health Plan, Optima Health Group, or Optima Health Insurance Company, please refer to your Evidence of Coverage or Certificate of Insurance for the Notice of Insurance Information Practices and notice of Financial Information Practices required by Virginia law.

State Laws

Sentara will also comply with relevant state laws that may govern the privacy of your information.

Sentara HIPAA Privacy Contact Person
PO Box 2200
Norfolk, VA 23501
1-800-981-6667

Virginia Life, Accident and Sickness Insurance Guaranty Association

This notice provides **a brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 In cash surrender and withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 In other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts. is $350,000, except for health benefit plans, for which the limit is Increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.0. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945 http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia

Notice of Insurance Information Practices
And
Financial Information Practices

Our Privacy Policy

The Plan takes our responsibility to protect the privacy and confidentiality of Your Personal, Privileged, Medical Record, and Financial information very seriously. Our commitment to protecting Your privacy is not new. We have specific policies in place to safeguard information about You and Your family.

We are providing this notice to You to help You understand how we may collect information about You, the type of information that may be collected, and what information may be disclosed about You to the Plan's affiliates and to non-affiliated third parties.

What We Mean By Personal, Privileged, Medical Record, And Financial Information

"Personal Information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical-record information, but does not include (i) privileged information or (ii) any information that is publicly available.

"Privileged Information " means any individually identifiable information that (i) relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual, and (ii) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual.

"Medical-record Information " means personal information that:

1. Relates to an individual's physical or mental condition, medical history, or medical treatment; and
2. Is obtained from a medical professional or medical-care institution, from the individual or from the individual's spouse, parent, or legal guardian.

"Financial Information" means personal information other than medical record information or records of payment for the provision of health care to an individual.

How We Protect Your Information

We treat Your information in a confidential manner. We restrict access to nonpublic personal and financial information about You to those employees and other persons hired by us who need to know the information to provide services to You. Our employees are required to protect the confidentiality of Your information. We maintain physical, electronic and procedural safeguards that comply with applicable laws and regulations to store and secure information about You from unauthorized access, alteration and destruction.

We may enter into agreements with other companies to provide services to us to make services available to You. Under these agreements, the companies must safeguard information about You and they may not use it for purposes other than helping us to improve our service to You.

Why We Collect Information About You

Your Plan needs to know general information about You, such as Your name and the names of Your dependents, Your address, Your age, Your marital status, and other more specific medical information for business purposes, including, but not limited to, processing claims, evaluating eligibility for covered services, administering health benefit plans, educational programs, disease management programs, and other transactions related to Your health care services.

Notice of Insurance Information Practices
And
Financial Information Practices

We may collect and use certain financial information about You such as name, birth date, mailing address, employment, social security number, marital status, and checking account information. We need this type of information to administer Your health benefits, process claims and/or premium payments and collections, market products, and/or as part of our enrollment process.

We get most of this information directly from You on Your Application or other forms. When You completed and signed Your Application for coverage, You authorized Your physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of Your health or Your dependents' health to give to the Plan any such personal medical information for the purpose of underwriting and claims payment.

We may also receive information about You from Your employer, from Your or Your employer's insurance broker, or, if You receive insurance coverage through a governmental program, from local, state or federal agencies or their representatives. In some instances, we may receive coverage information about You from another insurance carrier with which You have insurance (this is done to coordinate payment of Your medical bills.)

Medical Record information and financial information about You in our files is private. We will not give this data or privileged or personal information about You collected or received in connection with an insurance transaction unless You have provided written authorization or as permitted by law.

How We Disclose Personal, Privileged, Medical And Financial Information

To administer Your health coverage we may need to disclose information about You. According to law we may disclose information about an individual collected or received in connection with an insurance transaction, without written authorization, if the disclosure is:

1. To insurers, agents, or insurance support organizations. Data must be reasonably needed for them or us: (a) to detect or prevent a crime, fraud or material misrepresentation or nondisclosure; or (b) to perform our or their function relating to Your insurance such as determining an individual's eligibility for benefits or payment of claims.
2. To a medical care institution or medical professional for the purpose of: (a) verifying insurance coverage or benefits; or (b) informing You of a medical problem of which You may not be aware; or (c) conducting an operations or services audit.
3. To a state or federal insurance regulatory authority.
4. To a law enforcement authority or other government authority to prevent or prosecute fraud or other unlawful activities.
5. In response to facially valid administrative or judicial order, including a search warrant or subpoena.
6. To those engaged in actuarial or research studies, provided: (a) no names will be used in their report; (b) all data is destroyed or returned to us after use; and (c) no data will be disclosed unless it is authorized by law.
7. To a nonaffiliated third party whose only use of such information will be in connection with the marketing of a nonfinancial product or service, provided: (a) no medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from the information is disclosed (b) the individual has been given the opportunity to indicate that he or she does not want financial information disclosed for marketing purposes and has given no indication that he does not want the information disclosed and (c) the nonaffiliated third party receiving the information agrees not to use it except in connection with the marketing of the product or service.
8. To a group policyholder for reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit.

Notice of Insurance Information Practices
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9. To a government authority in order to determine eligibility for health benefits for which it may be liable.
10. To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction.
11. Pursuant to any federal Health Insurance Portability and Accountability Act privacy rules promulgated by the United States Department of Health and Human Services.
12. To others as permitted or required by law.

Your Right Of Access To Information

1. You have the right to request access to data about You in our files. Your request must: (a) be sent to us or our agent; (b) be in writing; (c) clearly describe the data You want; (d) clearly describe the purpose for which You want the data; and (e) be for data which we or our agent can reasonably locate and retrieve.
2. We will respond to Your request within 30 business days from the date Your request is received. Our response will: (a) inform You of the nature and substance of the recorded personal information in writing, by telephone, or by other oral communication; (b) permit You the right to see and copy, in person, the recorded personal information pertaining to You or to obtain a copy of the recorded personal information by mail, whichever You prefer, unless the recorded personal information is in coded form, in which case an accurate translation in plain language will be provided in writing; and (c) disclose the identity, if recorded, of those persons to whom we have disclosed the personal information within two years prior to the request, and if the identity is not recorded, the names of those insurance institutions, agents, insurance-support organizations or other persons to whom such information is normally disclosed; (d) give You the rights, as described below, regarding correction, amendment, or deletion of recorded personal information.
3. Medical Record Information supplied by a medical care institution or medical professional and requested by You, together with the identity of the medical professional or medical care institution that provided the information, will be provided to the medical professional designated by You and licensed to provide medical care with respect to the condition to which the information relates. We will notify You, at the time of disclosure, that we have provided the information to the medical professional.
4. We may charge a reasonable fee for providing copies of data in our files.

Your Rights Regarding Correction, Amendment Or Deletion Of Information

1. If You feel data about You in our files is wrong, you can request correction, amendment or deletion. You must make Your request in writing.
2. We will have 30 business days from receipt of Your request to respond. Our response will either: (a) confirm that we have made the changes You asked for; or (b) inform You of our refusal to change our records.
3. If we correct, amend or delete recorded personal information about You we will notify You in writing and furnish the corrections, amendment, or fact of deletion to: (a) any person specifically designated by You who, within the preceding two years, may have received the recorded personal information; (b) any insurance-support organization whose primary source of personal information is insurance institutions if the insurance-support organization has systematically received the recorded personal information from the insurance institution within the preceding seven years. The correction, amendment, or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and (c) any insurance-support organization that furnished the personal information that has been corrected, amended or deleted.
4. If we refuse to change our records, You can send us a written statement for our files. In it, You can state: (a) what You think is the correct, relevant or fair information; and/or (b) why You disagree with our refusal. If You send us such a statement, we will (a) keep it with Your file so that it will be seen by any-one reviewing the file; (b) include it with any data sent to others about You; and (c) send it to anyone described in subsection 3, above.

5. The above rights do not extend to data connected with or in preparation for a claim or civil or criminal proceeding involving You.

Whom You Should Contact If You Have Additional Questions About This Notice

If You have any questions or comments concerning this Privacy Statement, please contact us by mail at:
Optima Health Member Services
4417 Corporation Lane
Virginia Beach, VA 23462

Balance Billing Consumer Rights

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at in in-network facility, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs,such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference betweenwhat your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" or "balance billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stablecondition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network facility
When you get services from an in-network facility, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, laboratory, surgeon and assistant surgeon services, and professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers can't balance bill you and can't ask you to give up your protectionsnot to be balance billed.

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

You're <u>never required</u> to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Balance Billing Consumer Rights

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you believe you've been wrongly billed, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**.

Visit cms.gov/nosurprises for more information about your rights under federal law.

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.