Optima Health
OptimaFit
Individual and Family Plan
On Exchange

Effective Date:

Evidence Of Coverage

Underwritten by Optima Health Plan

4417 Corporation Lane
Virginia Beach, VA 23462

Introduction And Welcome

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
1-804-371-9741
In-State Toll Free: 1-800-552-7945
Toll Free: 1-877-310-6560

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
E-Mail: ombudsman@scc.virginia.gov

Introduction And Welcome

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

In this EOC, You will find important information on:

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

Optima Health

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

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

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

How to Get Language Assistance

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

Optima Health Alternative Language Options for Notices and other Written Information

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

Amharic:
ማሳሰቢያ፡
አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260።

Arabic:

تنبيه:
إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجانًا. اتصل بالرقم 1-855-687-6260.

Bengali/Bangla:
লক্ষ্য করবেনঃ যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন– 1-855-687-6260।

Chinese (Mandarin):
注意：如果您讲中文普通话，可以免费获得语言协助服务。请拨打电话 1-855-687-6260。

French:
ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260.

German:
ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 zur Verfügung.

Gujarati:
ધ્યાન આપો : જો તમે ગુજરાતી બોલી છો તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કૉલ કરો.

Hindi:
ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 पर कॉल करें।

Hmong:
CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260.

Igbo:
GEE NT Ị: ọbụrụ na ị na-asụ Igbo, ị ga-enweta enyemaka n'efu site n'aka ndị ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

Japanese:
重要：日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260までお電話ください。

Korean:
주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260번으로 전화해 주십시오.

Kru/Bassa:
YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha I nyuu hola we. Sebel: 1-855- 687-6260.

Laotian:
ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນໍາໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

Mon-Khmer, Cambodian:
កំណត់សំគាល់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260។

Navajo:
SHOOH: Diné Bizaad bee yáníłti'go doo bą́ą́h ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'ą́. Kojį' hólne' 1-855-687-6260.

Persian/Farsi:
توجه:
اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 تماس بگیرید.

Portuguese:
ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260.

Russian:
ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260, и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:
ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260.

Turkish:
DİKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz. 1-855-687-6260 numaralı telefonu arayın.

Urdu:
توجہ دیں:
اگر آپ اُردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 کال کریں۔

Vietnamese:
CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260.

Yoruba:
KÉÉRE:
Ti o bá ń sọ èdè Yorùbá, iṣẹ́ ìrànlọ́wọ́ èdè wà fún ọ lọ́fẹ̀ẹ́. Pe 1-855-687-6260

Optima Health Evidence of Coverage Face Sheet

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 Health 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 face sheet or schedule of benefits, riders and Your enrollment 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 Definitions section to see what the word means. We may also explain what a word or term means in the chapter or section that it is used in. Whenever We use the word "We" or "Us", or "The Plan" that means this benefit plan or Optima Health. "You" or "Your" means the employee or Subscriber and each family member covered as a Dependent under the Plan.

Your Optima Health ID Card

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

Your Face Sheet 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. Your face sheet or schedule of benefits in this booklet lists Your out-of-pocket expenses. Please read Your entire face sheet or schedule of benefits, so You will understand what You will have to pay out-of-pocket for each service.

Section 1
How Your Plan Works

Benefit Limits

Some medical care and services are not covered under this Plan. If We do not cover Your medical care or service You will have to pay for those services. Some services are limited to a certain number of visits or by a dollar amount. You will have to pay for all services after You reach a benefit limit. Benefit limits are on Your face sheet or 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

Choosing a Provider

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. 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 Your health care is only covered when You use a Plan Provider. 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 at the In-Network Copayment or Coinsurance level. Cost sharing amounts You pay out-of-pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket Amounts. 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.

A list of the participating 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.

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 the 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. 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.

Primary Care Providers

When You enroll You and each of Your Dependents must choose 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.

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.

Section 1
How Your Plan Works

Specialty Care Providers

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

Accessing Care Outside of the Plan's Service Area

Emergency Care outside of the Plan's Service Area will be covered at the Plan's In-Network Copayment or Coinsurance level, and Members will be responsible for their In-Network cost sharing amounts. Cost sharing amounts You pay out-of-pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket Amounts.

All services that are not Emergency Services outside the service area must be received from Plan Providers to be covered.

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.

Section 1
How Your Plan Works

Other Attachments and Notices

Under state and federal law You are entitled to certain rights and information about Your health plan. We have attached this information in the back of this document. If You have any questions about any of the information found in the notices in this section, please call Member Services at the number on Your Plan identification (ID) card. The following notices and information are attached:

- **Notice of Insurance Information and Financial Information Practices**
- **Notice of Coverage for Reconstructive Breast Surgery**
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)**
- **Sentara Healthcare Integrated Notice of Privacy Practices**
- **Nondiscrimination and Accessibility Requirements**

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 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 Enrollment Application, questionnaire, form or other document provided or used in connection with Your Coverage.

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

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

ADVERSE BENEFIT DETERMINATION in the context of the internal appeals process means: (i) a determination by a health carrier or its designee utilization review entity that, based on the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the requested benefit; (ii) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review entity of a covered person's eligibility to participate in the health carrier's health benefit plan; (iii) any review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit; (iv) a rescission of coverage determination as defined in § 38.2-3438; 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 Optima Health determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers the 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. 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.

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.

Section 2
Definitions

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

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 Face Sheet or 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 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 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.

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

1. Help in walking, getting in and out of bed, bathing, eating by any method, exercising, dressing;
2. Preparing meals or special diets;
3. Moving the patient;
4. Acting as a companion; and
5. Administering medication which can usually be self-administered.

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

cures, respite care and home care provided by family members. The Plan will determine if a service or treatment is Custodial Care.

DEDUCTIBLE means the dollar amount of 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. Member cost sharing including Copayment and Coinsurance amounts for Essential Health Benefits will count toward the Deductible amount listed on the face sheet or schedule of benefits for this Plan.

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 a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e) (1) (A) of the Social Security Act (42 U.S.C. 1395dd (e) (1) (A)). That provision of the Social Security Act, refers to the following conditions: clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMERGENCY SERVICES means, with respect to an Emergency Medical Condition –
(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

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

ESSENTIAL HEALTH BENEFITS PACKAGE OR EHB PACKAGE OR ESSENTIAL HEALTH BENEFIT(S) means the scope of covered benefits and associated limits of a health plan offered by an issuer that provides at least the following ten statutory categories of benefits, as described in **PPACA:**

(1) Ambulatory patient services; (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care;(5) Mental health and substance use disorder services, including behavioral health treatment; (6) Prescription drugs; (7) Rehabilitative and habilitative services and devices; (8) Laboratory services; (9) Preventive and wellness services and chronic disease management; (10) Pediatric services, including oral and vision care.

Section 2
Definitions

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

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

EXCHANGE means the governmental agency or entity that makes Qualified Health Plans (QHPs) such as this Plan available to Qualified Individuals.

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

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

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. 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.

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

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

HOSPICE SERVICES means a coordinated program of home and inpatient care 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.

Section 2
Definitions

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 or MAXIMUM OUT-OF-POCKET AMOUNT means the total amount a Member and/or eligible Dependents pay during a year as specified on the face sheet or 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 face sheet or 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. When specifically applied to an inpatient, it further means that the Member's medical symptoms or condition requires that the diagnosis, treatment or service cannot be safely provided to the Member as an outpatient.

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. Member cost sharing including Copayments, Coinsurance, and Deductibles for Non-Essential Health Benefits will not count toward the Maximum Out-of-Pocket Amount listed on the face sheet or schedule of benefits for this Plan.

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

OUT-OF-NETWORK OR OUT-OF-NETWORK SERVICES means services from a Non-Plan Provider that are not Emergency Services. Out-of-Network Services from Non-Plan Providers are not covered.

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

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

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.

Section 2
Definitions

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

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

QUALIFIED HEALTH PLAN OR QHP means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

QUALFIED HEALTH PLAN ISSUER OR QHP ISSUER means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

QUALIFIED INDIVIDUAL means with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

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

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.

OPTIMAFIT SERVICE AREA means the geographic area in which the Plan has directly or indirectly arranged for the provision of Covered Services to be generally available to Members. The Plan's service area includes the following cities and counties:
Albemarle Co., Charlottesville City, Chesapeake City, Fluvanna Co., Franklin City, Gloucester Co., Greene Co., Halifax Co., Hampton City, Harrisonburg City, Isle of Wight Co., James City Co., Louisa Co., Madison Co., Mathews Co., Mecklenburg Co., Nelson Co., Newport News City, Norfolk City, Page Co., Poquoson City, Portsmouth City, Rockingham Co., Southampton Co., Suffolk City, Surry Co., Virginia Beach City, Williamsburg City, York Co.

Section 2
Definitions

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

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

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.

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 ambulatory 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

PERSONS WHO ARE ELIGIBLE FOR COVERAGE UNDER THIS PLAN

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

- You and Your Dependents are a Qualified Individual as determined by the Exchange; **and**
- You live in Optima Health's Service Area; **and**
- You provide a complete enrollment 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 may be 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.

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 grandparent Subscriber or spouse becomes the legal guardian or adoptive parent of that grandchild.

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

You signed up for this plan on the Federal Market Place at healthcare.gov. Your initial coverage effective date will be determined by the Market Place. Generally Your initial Coverage effective date is determined by when You complete Your enrollment application on the Market Place. Your Coverage will begin when We have received all the required information from the Federal Market Place and You have paid all required premiums by the due date.

MAKING CHANGES TO YOUR PLAN

You signed up for this plan on the Federal Market Place at healthcare.gov. If You need to make a change to Your plan You must go back to the Federal Market Place. You can go directly to healthcare.gov or call the Market Place directly. Changes that You must make on line include adding or removing a dependent, changing Your address, changing or ending Your Coverage.

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.

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 open enrollment period or qualifying event.

ADDING OTHER DEPENDENTS TO YOUR PLAN

You may apply to add an eligible Dependent within 60 days of a qualifying event. Your Dependent Coverage will begin on the first of the month 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 open enrollment period 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 or 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 or Dependent reports a change affecting eligibility for premium or cost share assistance.

5. 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;

6. 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;

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

8. 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;

9. 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;

10. 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;

11. 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;

12. 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

13. 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.

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.

Section 3
Eligibility, Renewal, and Termination of 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 is no longer eligible for coverage. You must also go back to the Federal Market Place and remove the Dependent from Your plan. You can go directly to healthcare.gov or call the Market Place directly. 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 Enrollment Application is submitted within 31 days of the order. Coverage mandated by the Child Support Act will begin on the first of the month following notification to the Plan. We require that both the child and the parent ordered to provide support enroll in the Policy.

RENEWAL OF COVERAGE

Coverage under this EOC is guaranteed renewable, except as permitted to be terminated, cancelled rescinded, or not renewed under the terms of our agreement with the Exchange and applicable state and federal law. Provided that the Member is a Qualified Individual as determined by the Exchange, and the QHP and this EOC have not been terminated by the Exchange, Members may continue to stay covered under the Plan. However, under certain limited 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 when they are due 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.

Annual Renewal Notices.

The Plan will send 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.

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 or

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 a.m. 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.

TERMINATION OF THE QUALIFIED HEALTH PLAN OR QUALIFIED HEALTH PLAN ISSUER

The Plan may terminate Coverage at any time under this EOC as permitted under the terms of our agreement with CMS and the Exchange and applicable state law. The Member will be notified by Us as required by applicable state and federal law.

WHEN YOU ASK US TO CANCEL YOUR PLAN

You may cancel this Plan at any time by written notice delivered or mailed to Us. You must also go back to the Federal Market Place and cancel Your plan. You can go directly to healthcare.gov or call the Market Place directly. 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 ID 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 ID card.

Section 3
Eligibility, Renewal, and Termination of Coverage

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 Rescission notice will include:

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 Plan's internal appeal process for Rescissions, including any applicable time limits; 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.

Section 3
Eligibility, Renewal, and Termination of Coverage

We will require acceptable proof of incapacity and dependency within 31 days of the Child's reaching the limiting age on Your face sheet or 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.

If any incapacitated Child becomes eligible for state or federal assistance, he or she must enroll and participate in such programs.

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. 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 no-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 apply to annual open enrollment periods and special enrollment periods. You will also have to pay any applicable initial binder payments for your ne 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 grace period.

GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENT OF PREMIUM TAX CREDITS

The Plan must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the Plan will:

1. Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period;

2. Notify HHS of such non-payment; and,

3. Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

Notice of non-payment of premiums. If an enrollee is delinquent on premium payment, the QHP issuer must provide the enrollee with notice of such payment delinquency.

Exhaustion of grace period. If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, the Plan will notify the enrollee that coverage will terminate. The last day of coverage will be the last day of the first month of the 3-month grace period.

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

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.

UNPAID PREMIUM

When We pay a claim under this Policy, We may deduct any Premium that is due and unpaid.

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.

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.

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

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 You or Your dependents pay during a year as specified on Your Plan's Schedule of Benefits. Deductible, Copayment and Coinsurance amounts for

certain services will be accumulated and will apply toward the maximum dollar amount listed on the face sheet or schedule of benefits.

We maintain a record of Your payments. When You have reached the Maximum Out-of-Pocket Amount, no further payments will be required for that year, except for those services listed on Your face sheet or 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 face sheet or 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 face sheet or 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 Copayment listed on the face sheet or schedule of benefits of Your Evidence of Coverage in certain circumstances.

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

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

3. You will pay an office visit Copayment 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 You receive from an Out-of-Network Non-Plan Providers.

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

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

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

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

PRE-AUTHORIZATION

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

Pre-Authorization is an evaluation process We use to assess the Medical Necessity and coverage of proposed treatment. It also checks to see that the treatment is being provided at the appropriate level of care. Pre-Authorizations are approved or denied based on current medical practice. 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 face sheet or 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;
- Tubal ligation;
- TMJ services;
- 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;
- Other services including all orthodontia services under the Plan's Pediatric Oral benefit for children until the end of the month the child turns age 19;
- 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.

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 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.

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/Provider 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/Provider of Our decision within 24 hours of receipt of the request.

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

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

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

RETROSPECTIVE REVIEW OF POST-SERVICE CLAIMS

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

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

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

ADVERSE BENEFIT DETERMINATIONS

You have certain rights if We deny a request for Pre-Authorization or make other Adverse Benefit Determinations. We will provide written notice of Adverse Benefit Determinations. For Urgent claims

notification may be provided orally and then confirmed in writing up to three days after the oral notice. If Coverage is being Rescinded You will receive written notice 30 days prior to the Rescission. Written notification will include the following:

- The specific reason or reasons for the adverse benefit determination;
- 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 Your Right to File a Complaint or an Appeal**.

Section 6
What is Covered

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

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

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

Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency or during an authorized Admission will be covered under Your In-Network benefits. All other services You receive from Non-Plan Providers will be Covered under Your Out-of-Network benefits.

ALLERGY CARE, TESTING AND TREATMENT

We cover the following Allergy Care services:

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

AMBULANCE SERVICES

All ambulance services must be provided by a professional agency authorized to provide transportation service in a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. Ambulance services are subject to Medical Necessity reviews.

Emergency Transportation Ambulance 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 for Your condition. This includes ground and water transportation. Any person providing Emergency medical transportation services to a person covered under the policy will receive reimbursement when the Plan receives an assignment of benefits from the person providing the services. 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.
- We reserve the right to select the air ambulance provider. If You do not use the air ambulance Provider We select, the Out-of-Network Provider may bill You for charges.
- Air ambulance is not Covered for transportation to other facilities such as a skilled nursing facility, a doctor's office or Your home.

Non-Emergency Stretcher & Wheelchair Transportation Services

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

ANESTHESIA SERVICES

We cover general and regional anesthesia in an inpatient Hospital or outpatient facility. We cover supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure. We cover the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids, and/or blood and the usual monitoring services.

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 are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; 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. Please also see Pediatric Oral Care and Preventive Care for additional services for Children.

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;
- Home blood glucose monitors and control solution;
- Lancets, lancet devices and test strips;
- Insulin, syringes and needles;
- 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.

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), and Genetic testing and counseling. Pre-Authorization is not required for Sleep Studies, 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), QTC Bone Densitometry, PET/CT 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.
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 include 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. **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 for treatment.

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

Emergency Services means, with respect to an Emergency Medical Condition, (A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and (B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Covered Services include Emergency Services defined above received in a Hospital emergency room. 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 out-of-pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket Amounts.

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

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

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 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 Evidence of Coverage.

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:

- 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** for members who are homebound for medical reasons, physically unable to seek care on an outpatient basis, or in place of inpatient hospitalization. See Your face sheet or schedule of benefits for visit limits. 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.

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 (RN) to govern the services provided; and
4. Provides for full-time supervision of such services by a Physician or by a registered nurse (RN); and
5. Maintains a complete medical record on each patient; and
6. Has a full-time administrator.

"Home Health Care Plan" means a program:

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

"Home Health Care Skilled Services" means:

1. Part-time or intermittent skilled nursing services by an RN or LPN;
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.

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;
- 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.

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

INFUSION SERVICES

Pre-Authorization is required.

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

- Infusion therapy and medications;
- Professional nursing services and DME required for the infusion;
- Blood products and injectables that are not self-administered;

- Total Parenteral Nutrition (TPN);
- Enteral nutrition therapy;
- Antibiotic therapy;
- Chemotherapy;
- Pain care;
- Infusion of special medical formulas that are the primary source of nutrition for Members with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

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 following 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 face sheet or 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.

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.

Section 6
What is Covered

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 Evidence of Coverage.

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:

- 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 who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance use disorder counselor or substance use disorder counseling assistant, limited to the scope of practice set forth in § 54.1-3507.1 or § 54.1-3507.2 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 Non-Plan Provider if approved by the Plan;
- Office surgeries;
- Virtual Consults online by webcam, chat or voice when available and when provided by an Optima Health approved provider;
- Maternity care and related checkups;
- Outpatient office visits to a nurse or physician assistant and walk-in appointments at an In-Network Plan participating retail health clinic.

PREVENTIVE AND WELLNESS SERVICES

Annual Physicals

We cover one routine physical exam each year.

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 OB are not considered routine.

Screening Mammograms

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

Pap Smears

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

Prostate 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

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, 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 and iron.

➢ 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: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Generic contraceptives are covered with no Member out-of-pocket cost sharing.
- 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.

PREVENTIVE VISION CARE SERVICES FOR ADULTS

In-Network Coverage

We contract with EyeMed Vision Care to administer preventive vision benefits. We cover a routine eye examination every 12 months from an EyeMed provider.
To receive Covered Services:

1. Select a participating EyeMed network provider from the Plan's provider directory or by calling 1-888-610-2268. Automated location information is available 24 hours a day. Customer service representatives are available Monday through 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.

Out-of-Network Coverage

If You use a provider that is not in the EyeMed network for an examination You must pay the provider in full when You receive services. Only the eye examination is covered as listed on Your face sheet or schedule of benefits. For reimbursement call EyeMed Customer Service at 1-888-610-2268. EyeMed will verify eligibility and give You a claim form. Mail the completed form with a copy of Your bill to:

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

PROSTHETIC COMPONENTS AND DEVICES (Artificial Limbs)

Pre-Authorization is required for all services.

Covered Services include Medically Necessary Prosthetic devices and Components defined below. 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.

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;
- 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 frenectorny 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 of accidental dental injuries as listed under Dental Services (All Members/All Ages in the 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

Covered Services include interactive telemedicine services such as audio, video or other electronic technology or media for diagnosis, consultation or treatment of Covered Services.

Telemedicine services do 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.

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.

TEMPOROMANDIBULAR JOINT (TMJ) DIAGNOSTIC AND SURGICAL PROCEDURES

Pre-Authorization is required.

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 except for 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 face sheet or 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.

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 except as described under the Plan's benefits for Home Health Care Services. Services will not be provided for 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.

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

Chemotherapy, Radiation Therapy, IV Infusion Therapy, and Respiratory/Inhalation Therapy
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. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, and treatment planning.

- **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.**

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 cover the following transplants:

- Kidney;
- Heart;
- Cornea;
- Liver;
- Lung;
- Heart-lung;
- Kidney-pancreas;
- Bone marrow transplants for leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, severe combined immunodeficiency disease, aplastic anemia and Wiskott-Aldrich Syndrome;
- Dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for the treatment of breast cancer;
- Necessary acquisition procedures, mobilization, harvest and storage;
- Preparatory myeloablative therapy, reduced intensity preparatory chemotherapy, radiation therapy, or a combination of these therapies.

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

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

Organ Donor Benefits
When both the person donating the organ and the person 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.

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 and Transportation
We may cover the cost of reasonable and necessary travel and lodging costs if We have Pre-Authorized the costs and You need to travel more than 75 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. Covered Services will not include Child care, rental cars, buses, taxis or other transportation not approved by Us, frequent flyer miles, or any other travel services not related to the transplant.

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 email, interactive video, and telephone to connect a provider and a patient.

VISION CORRECTION AFTER SURGERY OR ACCIDENT

Pre-Authorization is required.

Covered Services include glasses or contact lenses when Medically Necessary as a result of surgery, or to treat an accidental injury. We cover exams and replacement of glasses or lenses if there is a change in the prescription required to treat the condition. 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.

Section 6
What is Covered

OUTPATIENT PRESCRIPTION DRUG COVERAGE

Closed Formulary Benefits
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/HIX4TierClosedIGformulary2018.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.

You can fill Your prescription at a Plan pharmacy. You can also use a Non-Plan pharmacy that has agreed to accept Our rates. Some drugs require Pre-Authorization by Your Physician before You can fill Your prescription.

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

Pre-Authorization and Step Therapy
At its sole discretion Optima Health's Pharmacy and Therapeutics Committee determines which drugs are included on the formulary and which Tier a covered drug is placed in. 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 preferred/standard drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.

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 proposer 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 is a process where We require that You use one type of Drug before we will cover another. We have established guidelines that make sure that certain drugs are prescribed correctly.

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

Pharmacy Tiers
Optima Health's Pharmacy and Therapeutics Committee places covered drugs into the Tiers defined below You will pay Your Copayment or Coinsurance depending on which Tier Your Drug is in.

- **Selected 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.

- **Selected 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-Selected 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 covered compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional. Specialty Drugs include the following:
    - Medications that treat certain patient populations including those with rare diseases;
    - Medications that require close medical and pharmacy management and monitoring;
    - Medications that require special handling and/or storage;
    - Medications derived from biotechnology and/or blood derived drugs or small molecules;
    - Medications that can be delivered via injection, infusion, inhalation, or oral administration;
    - Medications subject to restricted distribution by the U.S. Food and Drug Administration;
    - Medications that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

  Specialty Pharmacy

  Specialty Drugs are only available through Optima Health's Specialty mail order pharmacy. Proprium Pharmacy at 757-553-3568 or 1-855-553-3568. Specialty Drugs will be delivered to Your home address from Our 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.

  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.

Flu Shots
We cover flu shots including administration at authorized pharmacies.

Self-administered injectable Drugs
We cover self-administered injectable drugs 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, Supplies, Equipment, and Education
Self-injected insulin and related supplies including syringes, and needles are covered under the prescription drug benefit. Member cost sharing is determined by the applicable Tier.

Diabetic testing supplies including home blood glucose monitors, test strips, lancets, lancet devices, and control solution are covered with no Member cost sharing, and the Deductible does not apply. LifeScan products will be the sole preferred brand. Members can pick up supplies at any network pharmacy.

In-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law may be received at a Plan pharmacy authorized to provide these services. Contact Your pharmacy to see if they are certified to perform these services. Members may call 1-800-SENTARA for additional information on educational classes.

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

Women's Contraceptives
Covered Services include FDA approved contraceptive 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, and sterilization services for women are also covered under the Plan's Preventive Care Benefit earlier in this Evidence of Coverage.

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

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 should use the Plan's appeal process described later in the Evidence of Coverage.

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

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

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

- When the Member has been receiving the specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and the prescribing physician has determined that the formulary drug is an inappropriate therapy for the specific patient or that changing drug therapy presents a significant health risk to the specific patient.

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.

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.

Services of non-participating pharmacies
You may use a Non-Plan Out-of-Network Pharmacy that has previously notified the Plan of its agreement to accept reimbursement for its services at rates applicable to Our In-Network pharmacies including any 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 designee within thirty days of being requested to do so in writing by the Plan unless and until the pharmacy executes and delivers the agreement.

PEDIATRIC ORAL CARE

Optima Health contracts with Delta Dental to provide Pediatric Oral Care benefits under the Plan. Covered Services include Medically Necessary preventive and diagnostic dental care, basic dental care, major dental care and orthodontia.

Section 6
What is Covered

Children up to age 19 are eligible for Covered Services through the end of the month the Child turns 19. Pre-Authorization is required for all orthodontia services. All services must be received from participating dental providers.

For help in finding a participating dental provider please use the contact information below.

Member Service Telephone Number: (800) 237-6060

Website: **deltadentalva.com**

Mailing Address: 4818 Starkey Road, Roanoke, VA 24018

Hours of Operation: Monday through Thursday 8:15 am to 6:00 pm and Friday 8:15 am to 4:45 pm

All services must be Medically Necessary and consistent with professionally recognized standards of dental practice for the diagnosis and/or treatment of Your condition.

Your Copayment or Coinsurance amount for covered pediatric dental services is listed on Your face sheet or schedule of benefits. Covered pediatric oral services will count toward Your medical Deductible and medical Maximum Out-of-Pocket Amounts. Covered Services include the following:

Preventive and Diagnostic Dental Care	
1. Oral Exams	One routine oral evaluation per 6 months, beginning with the eruption of the first tooth
2. X-rays	
3. Diagnostic casts	
Basic Dental Care	
1. Cleanings	Once every 6 months
2. Topical Fluoride Treatments	Once every 6 months
3. Sealants	One per lifetime per tooth
4. Space maintainers	One per 2 years per quadrant (unilateral), per arch (bilateral)
Restorative Dental Care	
1. Fillings	One per tooth per surface per year
2. Porcelain/ceramic onlay	One per tooth per 5 years
3. Crowns	One per tooth per 5 years
4. Protective restorations	
5. Veneers	One per tooth per 5 years
6. Temporary crowns	
Major Dental Care	
1. Endodontic services	One per tooth per lifetime
a. Pulp caps, pulpotomy, pulpal therapy, pulpal debridement and pulpal regeneration	
b. Endodontic therapy, retreatment of previous root canal therapy	One per tooth per lifetime
c. Apicoectomy/periradicular surgery, retrograde filling	One per tooth per lifetime
2. Periodontal services	
a. Gingivectomy or gingivolplasty	One per two years per quadrant
b. Scaling and root planing	One per two years per quadrant
c. Full mouth debridement	One per year
d. Osseous surgery	One per five years per quadrant
e. Provision Splinting	

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.

f. Grafting	
3. Removable prosthodontics	One per five years
a. Adjust, repair	
b. Reline denture	One per tooth per two years
c. Tissue conditioning	
4. Maxillofacial prosthetics (feeding aid)	
5. Fixed prosthodontics – Pontic, retainer, crown	One per tooth per 5 years
Oral and Maxillofacial Surgery	
1. Local anesthesia	
2. Extractions	
3. Tooth reimplantation and/or stabilization due to accident	
4. Biopsy	
5. Alveoloplasty	One per quadrant per lifetime
6. Removal of cysts, tumors, and growths	
7. Drainage of abscess	
8. Occlusal orthotic device for TMJ	
9. Frenulectomy/Frenuloplasty	One per lifetime
Medically Necessary Orthodontia	
1. Comprehensive orthodontia	One per lifetime
2. Removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	
3. Fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	One per lifetime
4. Replacement of lost or broken retainer	
Adjunctive Services	
1. Palliative (emergency pain) treatment	
2. Anesthesia/sedation	
3. Occlusal guard (for grinding and clenching of teeth)	

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. 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.

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

Administrative Charges including charges to complete claim forms, charges to get medical records or reportsand membership, administrative, or access fees charged by Doctors or other Providers are not Covered Services. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

Alternative or Complementary Medicine services or treatments are not Covered Services. This includes, but is not limited to:

- 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

Ambulance Service for transportation for services that are not Emergency Services is not a Covered Service unless We authorize the transportation service.
Non-medical **Ancillary Services** You are referred to are not Covered Services. Vocational rehabilitation services, employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education, or other non-medical services are not Covered Services.

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

Applied Behavioral Analysis is not a Covered Service**.**

Autopsies are not a Covered Service.

B

Batteries are not a Covered Service except for motorized wheelchairs and cochlear implants when authorized.

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

Birthing Center Services are Covered Services at contracted facilities only.

Blood Donors. We do not cover any costs for finding blood donors. We do not cover the cost of transportation and storage of blood in or outside the Plan's Service Area.

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

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.

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

Breast Augmentation or Mastopexy 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 a Covered Service.

Breast Milk from a donor is not a Covered Service.

C

Charges for services not described, documented or supported in your medical records are not Covered Services.

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

Section 7
What is Not Covered

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

Cosmetic Services are not Covered Services. This includes treatments, surgery, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change or improve how a person looks and not Medically Necessary. **We will not cover any of the following:**

- Services to preserve, change or improve how a person looks or to change the texture or look of skin, the size, shape or look of facial or body features;
- Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Any service or supply that is a direct result of a non-covered service;
- 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 a Covered Service under the Plan. 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 Services. This exclusion does not apply to services under the Plan's Pediatric Oral Care Benefit:

- Treatment of natural teeth due to disease;
- Routine dental care and 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 are not covered;
- Dental implants or dentures and any preparation work for them are not covered;
- Dental services performed in a Hospital or any outpatient facility are not covered. This does not include covered services listed under "Hospitalization and Anesthesia for Dental procedures."
- Oral surgery which is part of an orthodontic treatment program is not covered;
- Orthodontic care.

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

Donor Benefits are not Covered Services if the covered individual is donating an organ to a non-covered member. When the donor is a non-covered member and the person receiving the organ is covered, benefits are limited to benefits not available to the donor from any other source.

Driver Training is not a Covered Service.

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

The following are not Covered Services and are not included in the Plan's Coverage of Durable Medical Equipment (DME): appliances, devices, and medical supplies that have both a non-therapeutic and therapeutic use, including exercise equipment; air conditioners, purifiers, and humidifiers; first aid supplies or general use items such as heating pads, thermometers, and bandages; hypoallergenic bed lines; raised toilet seats; shower chairs; whirlpool baths, waterbeds and hot tubs; handrails, ramps, elevators, and stair glides; telephones; adjustments made to vehicles;; changes made to home or businesses; clothing articles, except those needed after surgery or injury; or repair or replacement of equipment lost or damaged through neglect. Durable Medical Equipment not appropriate for use in the home is not a Covered Service.

E

Electron Beam Computer Tomography (EBCT) is not a Covered Service.

Educational, Vocational, or Self-training services or supplies are not Covered Services. Services, treatment or testing required to complete **Educational Programs**, degree requirements, or residency requirements are not Covered Services.

Educational Testing, Evaluation, Screening, or tutorial services are not Covered Services. Any other service related to school or classroom performance is not a Covered Service**.** This does not include services that qualify as Early Intervention Services or when received as part of a covered wellness visit or screening.

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

Exercise Equipment is not a Covered Service. This includes bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment. This also includes pool, gym, or health club membership fees.

Section 7
What is Not Covered

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, and corrective or protective eyewear required for work are not a Covered Service.

Eye Exercises, Eye Movement Desensitization and Reprocessing Therapy are not Covered Services.

Eye Corrective Surgery such as Radial Keratotomy, PRK, or LASIK is not a Covered Service.

F

Services provided by **Family Members** are not Covered Services. This includes services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

Palliative or cosmetic **Foot Care Services** are not Covered Services 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

GIFT programs (Gamete Intrafallopian Transfer) are not a Covered Service.

Group Speech Therapy is not a Covered Service.

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

H

Health club memberships, health spa charges, exercise equipment or classes, charges from a physical fitness instructor or personal trainer, and other charges for services, equipment or facilities for developing or maintaining physical fitness, are not Covered Services. This exclusion applies even when services are ordered by a physician.

Hearing Aids are not Covered Services. Examinations, fittings, molds, batteries or other supplies are not Covered Services. This does not apply to cochlear implants or screenings covered under Preventive Care Benefits.

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**.** Services are limited as stated on Your Plan's face sheet or schedule of benefits. We do not cover any services after You have reached Your Plan's limit. We only cover services or supplies listed in Your home health care plan. We do not cover custodial care unless it is rendered as part of hospice care. We do not cover transportation. 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 are not covered unless You need a private room because You have a highly contagious condition or are at greater risk of contracting an infectious disease because of Your medical condition;
- Care by interns, residents, house physicians, or other facility employees that are billed separately from the facility.

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not Covered Services, unless such services are received as part of the covered preventive care services.

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

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/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.

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. 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 In-Network benefits.

Laser Therapy for Vitiligo **or any other cosmetic skin conditions** is not a Covered Service**.**

Lasik Surgery is not a Covered Service.

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

M

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

Maximum Benefit Limits are stated on Your Plan's face sheet or schedule of benefits. We do not cover any additional benefits after a benefit visit limit has been reached.

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not Covered Services. **We do not cover any of the following:**

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

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

Medical Nutritional Therapy and nutrition counseling are not Covered Services except when provided as part of diabetes education or when received as part of covered wellness services or screening visits, or Hospice Care. 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.

Services and supplies deemed **Not Medically Necessary** are not Covered Services.

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.

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

Charges for **Missed Appointments or Cancelled Appointments** are not Covered Services.

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

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

N

Neuropsychological Services including psychological examinations, testing or treatment to obtain or keep employment or insurance, or related to judicial or administrative proceedings are not Covered Services unless approved by the Plan.

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

Nutritional or Dietary Supplements are not Covered Services except for those we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that You can buy over the counter and those You can get without a written Prescription or from a licensed pharmacist.

O

Obesity surgery, services, drugs or supplies related to weight loss or dietary control are not Covered Services**.** Any service or supply that is a direct result of a non-covered service is also not a Covered

Service. Services to improve appearance following gastric bypass surgery, such as abdominoplasties, panniculectomies, and lipectomies are not Covered Services.

Oral Surgery services listed below are not Covered Services unless covered under the Plan's Pediatric Oral Benefits:

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

Orthoptics or vision or visual training and any associated supplemental testing are not Covered Services.

Out-Of-Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers are not covered. 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 In-Network benefits.

Over the counter convenience and hygienic items are not Covered Services**.**

P

Paternity Testing is not Covered Services.

Penile implants are not Covered Services.

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

Physician Examinations <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.

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

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

Prosthetics for sports or cosmetic purposes are not Covered Services. This includes wigs and scalp hair prosthetics except for one wig per benefit year following cancer treatment.

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

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 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;
- Virtual Consults except when provided by Optima Health approved providers;
- Charges for missed appointments;
- Charges for completing forms;
- Charges for copying medical records;
- Any service or supply that is a direct result of a non-covered service.

Sexual Dysfunction treatment including drugs to treat sexual or erectile problems are not Covered Services.

Inpatient services during a temporary leave from a **Skilled Nursing Facility** are not Covered Services unless authorized by the Plan. Private rooms are not Covered Services unless Medically Necessary.

Reversal of voluntary **Sterilization** is not a Covered Service. Infertility services required because of a voluntary reversal are not Covered Service.

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.

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

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

- 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;
- Sleep therapies;
- Driver evaluations as part of occupational therapy;
- Driver training;
- Functional capacity testing needed to return to work;
- Work hardening programs;
- Gambling therapies.

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.

Travel and Lodging expenses are not Covered Services unless authorized by the Plan for Members traveling for Transplant Services. Treatment and Covered Services, other than Emergency Services, received outside of the United States of America while You are traveling are not covered.

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

U

Urea Breath Testing is not a Covered Service**.**

V

Vaccines are not covered unless approved by the Plan.

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 Services.

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

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

Adult **Vision** services or supplies are not Covered Services unless needed due to eye surgery or accidental injury, including routine vision care and materials except as outlined in the document and eyeglasses and

eyewear except as outlined in this document. Sunglasses or safety glasses and accompanying frames are not Covered Services**.**

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

W

Weight Loss Programs are not Covered Services. This includes programs, whether or not under medical supervision including, but not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Weight Loss Surgery/Bariatric surgery is not a Covered Surgery. This includes but is not limited to Roux-en-Y (RNY),Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomachcapacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

Wigs or cranial prostheses for hair loss for any reason are not Covered Services except for one wig per benefit year following cancer treatment.

Extraction of erupted or impacted **Wisdom Teeth** are not Covered Services unless covered under the Plan's Pediatric Oral Care Benefits**.**

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

X

Y

Z

OUTPATIENT PRESCRIPTION DRUG COVERAGE EXCLUSIONS AND LIMITATIONS
Prescription Drug Coverage Limitations and Other Coverage Terms and Conditions

The following is a list of limitations and conditions on Your Outpatient Prescription Drug Covered Services:

1. At its sole discretion Optima Health's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. For all drugs including those new to market the committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
2. Only drugs and self-administered injectables 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. 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. See "Medications Administer By A Medical Provider" in the Evidence of Coverage.

3. Members must pay Copayment, Coinsurance and Deductible amounts directly to the pharmacy provider for a Covered prescription drug.

4. Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies. Drugs that are Specialty Drugs are only available through the Plan's Specialty Pharmacy provider.

5. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law.

6. Amounts You pay for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.

7. All compounded prescriptions require Pre-Authorization and must contain at least one prescription ingredient in order to be covered.

8. Some Covered Services require Pre-Authorization by the Provider before You receive services. We have instructions and procedures in place for Providers to obtain Pre-Authorization. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.

9. 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.

10. 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.

11. 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.

12. 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.

13. We may approve Coverage of limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs. Medications that are required to be covered under state and federal law under the Plan's Preventive benefits will be covered at the generic product level with no Member cost sharing when received from Plan Providers.

14. Self-injected insulin and related supplies including syringes, and needles are covered under the prescription drug benefit. Member cost sharing is determined by the applicable Tier. Diabetic testing supplies including home blood glucose monitors, test strips, lancets, lancet devices, and control solution, are covered with no Member cost sharing and the Deductible does not apply. LifeScan products will be the sole preferred brand. Members can pick up supplies at any network pharmacy. Diabetes education and nutritional therapy are covered under the Plan's Medical Benefits.

Section 7
What is Not Covered

Prescription Drug Coverage Non-Covered Services List of Exclusions

The following is a list of exclusions of Non-Covered Services that apply to Your Outpatient Prescription Drug benefits.

1. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are not Covered Services.
2. Medications that do not meet the Plan's criteria for Medical Necessity are not Covered Services.
3. Prescription medications ordered and administered by Your Provider as part of a doctor's visit, home health care visit or at an outpatient or impatient facility are Covered only under the Plan's medical benefits. This includes, but is not limited to immunization agents, biological sera, blood, or blood products covered under the Plan's medical benefits. A drug covered under the Plan's medical benefits will not also be covered under the Plan's Outpatient Prescription drug benefit.
4. Medications with no approved FDA indications are not Covered Services.
5. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are not Covered Services.
6. 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 not Covered Services. This does not apply to OTC medications We are required by state or federal law to cover under Preventive Care benefits.
7. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are not Covered Services.
8. Injectables (other than those self-administered and insulin) are not Covered Services under the Plan's prescription drug benefit.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is not a Covered Service under the Plan's prescription drug benefit.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are not Covered Services.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be Experimental are not Covered Services.
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 not Covered Services.
13. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are not Covered Services.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are not Covered Services.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are not Covered Services when alternative products are commercially available.
17. Cosmetic health and beauty aids are not Covered Services.
18. Drugs purchased from Non-Plan Providers over the internet are not Covered Services.
19. Drugs purchased through a foreign pharmacy are not Covered Services unless approved by the Plan for an emergency while traveling out of the country.
20. Flu symptom drugs are not Covered Services unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature is not a Covered Service.

22. Medical Foods, nutritional formulas and dietary supplements that can be purchased over the counter, or which by law do not require either the written prescription or dispensing by a licensed pharmacist are not Covered Services.

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 not Covered Services unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.

25. Pharmaceuticals approved by the FDA as a medical device not Covered Services.

26. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan are not Covered Services.

27. Prescriptions written by a licensed dentist are not Covered Services, except for the prevention of infection or pain in conjunction with a Covered dental procedure.

28. Raw powders or chemical ingredients are not Covered Services unless approved by the Plan or submitted as part of a compounded prescription.

29. Drugs to treat sexual dysfunction including erectile dysfunction drugs are not Covered Services.

30. Onychomycosis drugs (toenail fungus) are not Covered Services except when we allow it to treat members who are immune-compromised or diabetic.

31. Travel related medications, including preventive medication for the purpose of travel to other countries are not Covered Services.

32. Infertility drugs are not Covered Services.

33. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are not Covered Services.

34. Charges for delivery of drugs.

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.

Section 7
What is Not Covered

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 provided by a person who is a family member. 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). A family member also includes individuals who normally live in the covered person's household.

24. 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.

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

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

PEDIATRIC ORAL SERVICES EXCLUSIONS AND LIMITATIONS

The following are not Covered Benefits **unless specifically identified** as a Covered Benefit:

1. Services or supplies that are not considered Dental Services are not covered under the Pediatric Oral benefit.
2. Services or treatment provided by someone other than a licensed Dentist or a qualified licensed dental hygienist working under the supervision of a Dentist are not covered.
3. A Dental Service that is determined not to be necessary or customary for the diagnosis or treatment of Your condition will not be covered. In making this determination, the Plan will take into account generally accepted dental practice standards based on the Dental Services provided. In addition, each Covered Benefit must demonstrate Medical Necessity and be determined to be in accordance with generally accepted standards of dentistry.
4. Dental Services for injuries or conditions that may be covered under workers compensation, similar employer liability laws or other medical plan coverage are not covered.
5. Benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity are not covered.
6. Dental services provided before the date You enrolled under this plan are not covered.
7. Dental services provided after the date You are no longer enrolled or eligible for coverage are not covered.
8. Except as otherwise provided, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia are not covered under the Pediatric Oral Care benefit. Prescription drugs may be covered under the Plan's medical benefits.
9. Charges for inpatient or outpatient Hospital services; any additional fee that the Dentist may charge for treating a patient in a Hospital, nursing home or similar facility are not covered under the pediatric oral benefit.
10. Charges to complete a claim form, copy records, or respond to requests for information are not covered.
11. Charges for failure to keep a scheduled appointment are not covered.
12. Charges for consultations, by phone or by other electronic means are not covered.

13. Dental services to the extent that benefits are available or would have been available if You had enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act are not covered.
14. Complimentary services or dental services for which You would not be obligated to pay in the absence of the coverage under this plan or any similar coverage are not covered.
15. Services or treatment provided to an immediate family member by the treating dentist are not covered. This would include a dentist's parent, spouse or child.
16. Dental services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices) are not covered.
17. Cosmetic surgery or dentistry for cosmetic purposes is not covered.
18. Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis including but not limited to hereditary ectodermal dysplasia or not related to a medical diagnosis is not covered under the Pediatric Oral benefit.
19. Experimental or investigative dental procedures, services, supplies as well as services and/or procedures due to complications thereof are not covered. Experimental or investigative procedures, services or supplies are those which, in the judgment of the Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice, or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the Enrollee's condition.
20. Amounts assessed on dental services and/or supplies by state or local regulation are not covered.
21. Non-medically necessary orthodontic treatment is not covered.

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.
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.

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

- **For Active and Inactive Employees the Plans pay in the following order:**

    1. The health benefits Plan of an active employee (one not laid off or retired) and his or her Dependents pays its benefits first.
    2. The Plan which covers a laid off or retired employee and his or her Dependents is the secondary Plan. Both Plans must have this rule for it to apply.

- **If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee longer are determined first.**

    1. Two consecutive Plans are treated as one Plan if the person starts the second Plan within 24 hours of the termination of the first Plan.
    2. The start of a new Plan does not include:

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

EFFECT ON THE BENEFITS OF THIS PLAN WHEN WE ARE A SECONDARY PLAN

If this Plan is not the Primary Plan, We will coordinate benefits with the Primary Plan. We will pay the difference between what the Primary Plan(s) pay the provider and what We would pay if We were the primary Plan.

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

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

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

You have questions about how We can get and use information please refer to the information on Our privacy practices notice in this document.

FACILITY OF PAYMENT

A payment made by another plan may include an amount which We should have paid. If it does, We may pay the other Plan that amount. We will then treat that amount as if it were a benefit paid under this Plan. If the "payment made" was in the form of services, "payment made" means the reasonable cash value of those services.

RIGHT OF RECOVERY

If We pay more than We should have paid under COB, We may recover the excess from one or more of:

- the person(s) it paid; or
- insurance companies; or
- other organizations.

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 insurance or group-type 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.

RIGHT OF EXAMINATION AND AUTOPSY

While We are processing a claim We have the right to have the member examined when and as often as reasonably required. We will pay the cost of examination. We also have the right, at Our expense, to investigate a member's death or request an autopsy unless prohibited by law.

CLAIMS PAID DIRECTLY TO MEMBERS FOR SERVICES FROM 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.

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

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 Website 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

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

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.

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 refer to the section below for information on how to file an External Review.

HOW TO BEGIN YOUR APPEAL

- **You can ask for forms to start a written appeal by:**

1. Calling Member Services at the number on Your ID card; or
2. Downloading the forms at optimahealth.com ; or
3. Sending Us a fax at 757-687-6232 or 1-866-472-3920; or
4. Sending Us a letter by mail at:

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

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

- **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 website at optimahealth.com.

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

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 You have a medical condition where the time frame for completion of an expedited internal appeal of an adverse determination would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, You, or Your authorized representative may file a request for an expedited external appeal.

- If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and Your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, You or Your authorized representative may file a request for an expedited external review.

- If You or Your authorized representative files a request for an expedited internal appeal with Us, You may file at the same time a request for an expedited external review of an adverse determination. The independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited internal appeal prior to conducting the expedited external review;

- If You or Your authorized representative files a standard appeal with Our internal appeal process, and We do not issue a written decision by either 30 days from the date of filing for a pre-service claim or by 60 days from the date of filing for a post-service claim, and You or Your authorized representative did not request or agree to a delay, You or Your authorized representative may file a request for external review, and will be considered to have exhausted Our internal appeal process.

You or Your authorized representative can request an external review of a final adverse benefit determination in the following situations:

- You have a medical condition where the time frame for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, You or Your authorized representative may file a request for an expedited external.

- If the final adverse determination involves an admission, availability of care, continued stay, or health care service for which You received Emergency services, but have not been discharged from a facility, You or Your authorized representative may request an expedited external review.

- If the final adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, You or Your authorized representative may file a request for a standard external review; or if Your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, You or Your authorized representative may request an expedited external review.

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

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. Depending on Your situation exhausted means:

1. You have filed an internal appeal and We have notified You of Our final adverse benefit decision; or

2. You filed an internal appeal, and We have not given You a response on Our determination by either 30 days from the date of filing for a pre-service claim or by 60 days from the date of filing for a post-service claim. This does not apply if You agreed to give Us more time to work on Your appeal; or

3. You filed an expedited or urgent appeal with Us. At the same time You can request an External review; or

4. We have agreed to waive the exhaustion requirement for Your appeal.

How Your External Appeal will be handled

When the BOI receives Your appeal, they will ask Us to verify that Your case is eligible for external appeal, and that Your appeal request is complete.

You will have to authorize the release of any medical records needed to reach a decision on the external review.

If any additional information is needed to complete Your request or verify eligibility, We will ask You to provide the specific information needed. We will give You a timeframe to submit this information. If You do not submit this information to Us a timely manner, Your request for an external review may be concluded.

If We determine that Your request is not eligible for an external appeal, You may appeal that determination to the BOI.

You will be notified that your request is complete and eligible for external review. The BOI will randomly select an Independent Review Organization (IRO) to perform Your appeal. The IRO performing Your appeal will not be affiliated with Optima Health so that there is no conflict of interest with Your case. You will have 5 business days from notification to submit any additional information You would like the IRO to review about Your case. We will also submit all of Our documents and information We used to make Our decision on Your internal appeal to the IRO for review.

The IRO will notify You and Optima Health of its decision on Your external appeal. The decision is binding on Us. The decision is also binding on You except to the extent the covered person has other remedies available under applicable federal or state law.

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

We may reconsider any final Adverse Benefit Determination that is the subject of an external review at any time. Reconsideration by Us will not delay or end the external review.

SOURCES FOR ADDITIONAL HELP.

If You have been unable to contact Us or obtain satisfaction here are additional places You can go for help:

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

- 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 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 Evidence of Coverage 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 Enrollment Applications 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.

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 that has agreed to accept as payment in full reimbursement from the Plan at the same level as the Plan gives to participating pharmacies.

NOTICE IN WRITING

From the Plan to You

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 ID cards.

Section 11
General Provisions

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 ID number are included in the notice.

LIMITATIONS OF DAMAGES

In the event a Member or his representative sues the Plan, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any exist under this Evidence of Coverage, the damages shall be limited to the amount of the Member's claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. This policy does not provide coverage for punitive damages, or damages for emotional distress or mental anguish; provided, however, this provision is not intended, and shall not be construed, to affect in any manner any recovery by You or Your representative of any non-contractual damages to which You or Your representatives may otherwise be entitled.

TIME LIMITS ON LEGAL ACTION

No action at law or suit in equity shall be brought against the Plan more than one year after the date the cause of action first accrued with respect to any matter relating to this Evidence of Coverage, the Plan's performance under this Evidence of Coverage, or any statements made by an employee, officer, or director of the Plan concerning the Evidence of Coverage or the benefits available.

THE PLAN'S CONTINUING RIGHTS

On occasion, We may not insist on Your strict performance of all terms of this Evidence of Coverage. This does not mean We waive or give up any future rights We have under this Evidence of Coverage.

CONTINUITY OF CARE

If a provider leaves the Plan's network, except for cause, the Member may continue to receive care from that provider 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 ELIGIBILITY PROHIBITED

The Plan shall not, in determining the eligibility of an individual for coverage, consider the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

Section 11
General Provisions

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.

DISCRIMINATION

The Plan will not unfairly discriminate against an enrollee on the basis of the age, sex, 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 § 38.2-4221 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 health Plan members are entitled to certain information about their health Plan benefits. If You have any questions about any of the information found in the notices in this section please call Optima Health Member Services at the number on Your Plan ID card. The following notices are provided:

Notice of Insurance Information Practices 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.

Notice of Coverage of Reconstructive Breast Surgery

This notice provides information on the availability of benefits for the treatment of mastectomy related services, including reconstructive surgery, prostheses, and physical complications, including lymphedemas under the Plan.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If You or Your Children are eligible for Medicaid or CHIP and You're eligible for health coverage from Your employer, Your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If You or Your Children aren't eligible for Medicaid or CHIP, You won't be eligible for these premium assistance programs, but You may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

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. In order to ensure uniformity throughout the system, every member of the Sentara Healthcare family, including this Plan, must comply with the basic privacy principles found in the Sentara Healthcare Integrated Notice of Privacy Practices.

In the "Sentara Healthcare Integrated Notice of Privacy Practices" You will find an explanation of how the Sentara Healthcare system use and safeguard Your personal and medical record information. If You have any questions about this notice, please contact the Sentara Privacy Contact Person at:

Sentara HIPAA Privacy Contact Person
P.O. Box 2200
Norfolk, VA 23501
(757) 857-8494

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.

Notice of Insurance Information Practices
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5. The above rights do not extend to data connected with or in preparation for a claim or civil or criminal proceeding involving You.

Whom You Should Contact If You Have Additional Questions About This Privacy Policy

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

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 ID 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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If You or Your Children are eligible for Medicaid or CHIP and You're eligible for health coverage from Your employer, Your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If You or Your Children aren't eligible for Medicaid or CHIP, You won't be eligible for these premium assistance programs but You may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If You or Your Dependents are already enrolled in Medicaid or CHIP and You live in a State listed below, contact Your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If You live in one of the following states, You may be eligible for assistance paying Your employer health plan Premiums. The following list of states is current as of July 31, 2016. Contact Your State for more information on eligibility -

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/ index.html CHIP Phone:1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/indexes.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/ HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-costhealth-care/program-administration/premiumpayment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Option 4, Ext. 61565

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

Sentara HealthCare Integrated Notice of Privacy Practices

Sentara Healthcare Notice of Privacy Practice
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 to 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.

Sentara HealthCare Integrated Notice of Privacy Practices

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 any time, 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

Nondiscrimination and Accessibility Requirements

OptimaHealth

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

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

Optima Health:

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

If you need these services, contact:

Civil Rights Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462
1-844-801-3779, 757-552-7116 Fax
languagehelp@sentara.com

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

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

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

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

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

Complaint forms are available at hhs.gov/ocr/office/file/index.html