OptimaHealth

Welcome to Optima Health. We are looking forward to providing Your health benefits. Before You enroll in Our health plan we want to make sure you have information on how Your Optima Health plan will work. This is a sample Optima Health plan brochure, or what we call an Evidence of Coverage (EOC). Once You are enrolled in one of Our plans We will provide You a copy of Your actual plan EOC including a Face Sheet with Your plan specific out of pocket costs. For now You can find Your out of pocket costs including deductibles, copayments and coinsurance at the separate link to the Plan Summary of Benefits.

In this sample EOC You will find important information on:

- Covered and Non-Covered benefits and services;
- Optima Health provider networks;
- Definitions and terms of coverage;
- Eligibility and enrollment;
- Health benefits and services that must be pre-authorized before You receive them;
- When Your coverage will end;
- Instructions for filing a complaint or an appeal; and
- Other important information about Optima Health.

Please look over this document carefully and if you have any questions about Optima Health you can contact us by phone or email at:

- Health Reform Hotline number (757)687-6270 or toll free (855)687-6270.
- Health Reform email (healthreform@optimahealth.com)

The EOC begins on the next page. All Plans are Underwritten By Optima Health Plan

Optima Health

Individual and Family Plan
On Exchange

Evidence Of Coverage

Underwritten by Optima Health Plan

4417 Corporation Lane
Virginia Beach, VA 23462

OptimaHealth

IMPORTANT INFORMATION ABOUT YOUR INSURANCE

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

Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462
Main Phone Number: 757-552-7401 or 1-877-552-7401
TDD for the hearing impaired: 757-552-7120 or 1-800-225-7784

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

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

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

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 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.

Optima Health Evidence of Coverage Face Sheet

[Insert Plan 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 You have the right to choose any primary care provider who participates in our network and who is available to accept you or your family members. If you do not choose a PCP Optima Health will assign a PCP to you and your family until you choose a PCP. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, contact Optima Member Services at the number on your ID card, or log on to our website at www.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 www.optimahealth.com.

Your Evidence Of Coverage or EOC

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

Words or Terms We Use in this EOC

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

Your Optima Health ID Card

Everyone covered under Your plan will have an Optima 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 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 in this booklet lists Your out of pocket expenses. Please read Your entire face sheet so You will understand what You will have to pay out of pocket for each service.

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

Section 1
How Your Plan Works

Benefit Limits

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

Pre-Authorization

Some Covered Services under this Plan require Pre-Authorization to be covered. If You do not comply with these requirements Your benefits may not be covered or may be reduced. 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 under 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.

You can obtain a list of Plan Providers free of charge. 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 www.optimahealth.com.

Allowable Charge

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

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

Specialty Care Providers.

You don't need a referral from a PCP for specialist care; 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 benefit and Members will be responsible for their In-Network cost sharing amounts.

All non-emergency care outside the service area must be received from Plan Providers to be covered.

Pre-existing Conditions

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

Special Enrollment Opportunity for Children under Age 26.

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

Lifetime Limits and Opportunity to Enroll

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

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 Monday through Friday from 5 p.m. to 8 a.m. On Saturday, Sunday and holidays the program is available 24 hours a day. The After Hours Program can be reached by calling 757-552-7250 or 1-800-394-2237.

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 You Plan Identification Card. The following notices and information are attached:

- **Notice of Insurance Information and Financial Information Practices**
- **Notice of Coverage for Reconstructive Breast Surgery**
- **Sentara Health Plan Notice of Privacy Practices**

Stop Health Care Fraud!

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

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

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

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

Section 2
Definitions

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

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.

Section 2
Definitions

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.

CONVERSION is the process of changing a member's status from group to individual membership when he or she is no longer eligible for membership under the Group Agreement.

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

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

COVERAGE 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 which are rendered while the Member is under the direct care of a physician.

CUSTODIAL CARE means treatment or services which could be rendered safely and reasonably by a person not medically skilled 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.

Section 2
Definitions

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 (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.)

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

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

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

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 including palliative and supportive physical, psychological, psychosocial and other Health Services to individuals with a terminal illness, whose medical prognosis is death within six months.

HOSPITAL means an institution which:

1. Is accredited under one of the programs of the Joint Commission on Accreditation of 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 required to identify or treat a Member's Illness or injury and which, as determined by the Member's primary care Physician and the Plan, are:

1. consistent with the symptoms, diagnosis and treatment of the Member's condition, disease, ailment or injury;
2. in accordance with recognized standards of care for the Member's disease, ailment or injury;
3. appropriate with regard to standards of good medical practice;
4. not solely for the convenience of the Member, his or her primary care Physician, 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. 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.

Section 2
Definitions

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 the level of benefits a Member uses when he or she seeks care in a non-emergent situation from other than a Plan Provider.

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

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

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

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

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

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

PRIMARY CARE PHYSICIAN (PCP) means the participating Physician selected by a Member to provide and/or coordinate medical care, which includes internists, pediatricians, and family practitioners. At the time of enrollment each Member shall have the right to select a Primary Care Physician from among the Plan's affiliated Primary Care Physicians, subject to availability. Any Member who is dissatisfied with his Primary Care Physician shall have the right to select another Primary Care Physician from among the Plan's affiliated Primary Care Physicians, subject to availability. The Plan may impose a reasonable waiting period for this transfer.

REHABILITATIVE SERVICES include coverage for therapies to restore and in some cases, maintain capabilities lost due to disease, illness, injury, or in the case of speech therapy, loss additionally due to

congenital anomaly or prior medical treatment. 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.

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

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

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

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

Section 2
Definitions

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

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

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

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

YOU or YOUR means the employee or 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 live in Optima's Service Area; **and**
- You provide Us a complete enrollment application; **and**
- We have accepted Your application for coverage; **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 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

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

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

MAKING CHANGES TO YOUR PLAN

Some changes can only be made on your yearly anniversary date, or when a qualifying event happens. Effective dates are generally either the first of the month or the 15th of the month. So, for example, if Your Policy effective date was January 15th, 2010 then your yearly anniversary date would be January 15th each year after that as long as Your Policy remains in effect.

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

If you want to add or remove an optional coverage rider from Your Plan that can only be done at renewal on Your yearly anniversary date.

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 31 days of the birth. This also includes adopted newborns.

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

If You do not add the child within the first 31 days after birth or placement for adoption You may not be able to add the child until Your next anniversary date.

ADDING OTHER DEPENDENTS TO YOUR PLAN

You may apply to add an eligible Dependent within 31 days of a qualifying event. If we accept Your Dependent Coverage will begin on the first of the month following our acceptance as long as all required premiums are paid. After 31 days You will have to wait until Your next policy anniversary date to add the dependent. Qualifying events may include:

- Marriage;
- Divorce, legal separation, or annulment;
- Births, adoptions, or placement for adoption;
- 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.

Section 3
Eligibility, Renewal, and Termination of Coverage

SPECIAL LATE ENROLLMENT PROVISIONS.

The Plan provides special enrollment periods of 60 days from the date of a triggering event for qualified employees or dependents of qualified employees. 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;

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

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

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

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

7. 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; and

8. 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 employees or dependents who:

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

2. **Special enrollment for employees and dependents that lose eligibility under Medicaid or CHIP coverage.**

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

REMOVING A DEPENDENT FROM YOUR PLAN WHO IS NO LONGER ELIGIBLE.

You must notify us in writing when a dependent no longer eligible for coverage. Under the circumstances below a dependent is no longer eligible to continue coverage under Your Plan:

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

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

COVERAGE MANDATED BY COURT ORDER.

Coverage mandated by court order issues, including Qualified Medical Child Support Orders (QMCSOs), will begin on the date of the court order if the request is made and an 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

This Plan is guaranteed renewable and You may continue to stay covered under Your Plan at your option as long as you are eligible. However, under certain circumstances we may refuse to renew your Plan.

Failure to Pay Your Premiums

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

Fraud or Material Misrepresentation on Your Application for Coverage

We may refuse to renew your Plan. for fraud or material misrepresentation with respect to Your application for coverage.

After two years from the date of this Plan, only fraudulent misstatements in the application may be used to void the Plan or deny any claim for loss incurred or disability (as defined in the Plan) that starts after the two-year period.

Discontinuation of a product

We may refuse to renew your Plan if all policies with the same form number are discontinued or not renewed. If we do this we will send you written notice 90 days before your coverage will end. You will be able to enroll in another Optima Plan and you will not have to go through medical underwriting.

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'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.

Section 3
Eligibility, Renewal, and Termination of Coverage

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.

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. Material violation of the terms of the contract;

3. Failure to meet the eligibility requirements; or

4. Other good cause as agreed upon in the contract between the health care plan and the subscriber. Coverage shall not be terminated on the basis of the status of the enrollee's health or because the enrollee has exercised his rights under the plan's complaint or appeals system by registering a complaint against the health maintenance organization. Failure of the enrollee and the primary care health care professional to establish a satisfactory relationship shall not be deemed good cause unless the health maintenance organization has in good faith made an effort to provide the opportunity for the enrollee to establish a satisfactory patient-physician relationship, including assigning the enrollee to other primary care health care professionals from among the organization's participating providers.

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

1. For termination due to nonpayment of premium, the Plan’s grace period will apply;

2. For termination due to activities that endanger the safety and welfare of the Plan or its employees or providers, immediate notice of termination may be given; or

3. For termination due to change of eligibility status, immediate notice of termination may be given.

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

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

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

1. nonpayment of premiums when due under the Grace Period provision;
2. the date we receive a written request from the Subscriber to end the Plan or remove a

dependent from the Plan;

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

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

WHEN YOU ASK US TO CANCEL YOUR PLAN

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

ADDITIONAL TERMINATION PROVISIONS.

Fraud or Material Misrepresentation on Your Application for Coverage

We may terminate Your Plan for fraud or material misrepresentation with respect to Your application for coverage.

After two years from the date of this Plan, only fraudulent misstatements in the application may be used to void the Plan or deny any claim for loss incurred or disability (as defined in the Plan) that starts after the two-year period.

Misuse of Your Optima Plan Identification Card

We may terminate Your Plan if You knowingly let someone else, not listed as a covered person on your application for coverage, use an Optima ID card to get medical services.

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 fraud or intentional misrepresentation of material fact as prohibited by the terms of coverage. Optima will provide 30 days advance written notice if We rescind a Policy. If coverage is Rescinded Members may appeal the Plan's decision.

If coverage is rescinded a person losing coverage is entitled to a refund of any paid premiums from the date coverage is voided or rescinded.

Non-Payment.

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

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

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

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

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

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

PREMIUMS

Premiums for any member who is accepted for enrollment during any month are due and payable with respect to that month on or before the first day of the following month All other premiums are payable in advance on or before the first day of the month to which they apply.

We may change Premiums at any time but only if the same change is made for the Subscriber's class and age. If Premiums are going to change We will send Subscribers written notice at least 31 days before the effective date of the change. If the Premium will increase by more than 35%, We will send written notice at least 60 days before the change is effective.

Your Payment is deemed made when We actually received it, or when payment is verified as received electronically or via credit card by the Plan.

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

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. The Contract Holder shall be liable to the Plan for the payment of a pro rata premium for the time the contract was in force during the race period.

GRACE PERIOD FOR RECEIPENTS 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

If Your Policy is cancelled due to nonpayment of premium, We will send You a letter giving You a chance to have your coverage reinstated. Your letter will include a specific date by which We must receive a premium payment in order to have your coverage reinstated. Your payment must be in the form of cash, certified check, or money order. At our discretion We may accept another form of payment.

Once we receive payment coverage will be reinstated without a break in coverage.

We allow two instances of cancellation and reinstatement during any consecutive two year period. If for any reason a payment made for reinstatement is insufficient, that will count as an instance of cancellation. After two cancellations for non-sufficient payment the Policy will be cancelled. After one year Policy holders and Dependents may reapply for coverage under a new Optima Policy. Applicants must fill out a new application and are subject to all Optima Health underwriting requirements. The Subscriber and eligible dependents must be accepted for coverage and enrolled by the Plan before coverage under the new Plan becomes effective.

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's Allowable Charge for the Covered Service You receive.

ALLOWABLE CHARGE

Allowable Charge is the amount Optima 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 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 as an In-Network benefit. However, You may have to pay the difference between what the Non-Plan Provider's charges and the Plan's maximum allowable amount or Allowable Charge in addition to Your Emergency Care Copayment , Coinsurance and Deductible 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.

DEDUCTIBLE.

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

MAXIMUM OUT OF POCKET AMOUNT.

Maximum Out of Pocket Amount means the total amount Your or Your dependents pay during a year as specified on Your Plan's Schedule of Benefits. Copayment and Coinsurance amounts for certain services will be accumulated and will apply toward the maximum dollar amount listed on the Schedule of Benefits. Your Plan may have separate maximum amounts for In-Network Services and for Out of Network services.

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

EMERGENCY DEPARTMENT COPAYMENT.

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

INPATIENT HOSPITAL COPAYMENT.

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

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

OFFICE VISIT COPAYMENTS FOR PREVENTIVE CARE

Recommended Preventive Care under PPACA will be covered with no member cost-sharing when received from Plan Providers. However You may still have to pay your office visit copayment listed on the face sheet of your evidence of coverage in certain circumstances.

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

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. In some cases if You do not follow our requirements for Pre-authorization We may not pay for Your services. In most cases Your Physician or other provider is responsible for getting pre-authorization. We have instructions and procedures in place for providers to obtain Pre-Authorization.

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

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

- Inpatient and partial hospitalization services
- non-emergency ambulance transport;
- inpatient and outpatient surgery;
- surgery in a physician's office;
- single items of durable medical equipment and orthopedic and prosthetic appliances over $750;
- rental of durable medical equipment and orthopedic and prosthetic appliances;
- repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances;
- artificial prosthetic limbs;
- prenatal maternity services;
- home health care;
- skilled nursing facility care;
- physical, occupational, and speech therapy;
- cardiac, pulmonary, and vascular rehabilitation;
- iv therapy with medications;
- inhalation therapy;
- early intervention services;
- clinical trials for treatment studies on cancer;
- hospice services;
- oral surgery;
- tmj services;
- tubal ligation;
- hospitalization and anesthesia for dental procedures;
- treatment of lymphedema;

- magnetic resonance imaging (MRI);
- magnetic resonance angiography (MRA);
- positron emission tomography (PET) scans;
- computerized axial tomography (CT) scans;
- computerized axial tomography angiogram (CTA) scans;
- sleep studies;
- transplant services;
- injectable and infused medications, biologics, and IV therapy medications defined by our Pharmacy Committee;
- intensive outpatient programs (IOP);
- medical, psychological and neuro-psychological diagnostic procedures and testing;
- electro-convulsive therapy;
- other services including all orthodontia services under the Plan's Pediatric Oral benefit for children up to age 19.

PRE-SERVICE CLAIMS DECISIONS.

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

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

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

EXPEDITED DECISIONS FOR URGENT CARE CLAIMS.

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

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

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

EXPEDITED DECISIONS FOR CANCER PAIN MEDICATIONS.

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

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

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

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

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

RETROSPECTIVE REVIEW OF POST-SERVICE CLAIMS.

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

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

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

ADVERSE BENEFIT DETERMINATIONS.

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

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

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

Section 6
What is Covered

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

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

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 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.

ALLERGY CARE.

We cover the following Allergy Care services:

- performance and evaluation of scratch, puncture or prick allergy tests;
- allergy shots and serum;
- professional services for supervising and providing allergy serum antigens for allergy injections.

AMBULANCE, STRETCHER, & WHEELCHAIR SERVICES.

Pre-Authorization is required for non-emergency transportation.

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

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

Any person providing such services to a person covered under the Plan shall receive reimbursement for such services directly from the Plan, when the Plan is presented with an assignment of benefits by the person providing such services.

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 FOR TREATMENT STUDIES ON CANCER.

Pre-Authorization is required.

We cover Patient Costs incurred during participation in clinical trials, including ovarian cancer trials, for treatment studies on cancer if all of the following are true:

1. The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial.
2. The treatment must be provided by a clinical trial approved by:
   a) The National Cancer Institute;
   b) An NCI cooperative group or an NCI center;
   c) The FDA in the form of an investigational new drug application;
   d) The Federal Department of Veterans Affairs; or
   e) An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

3. The facility and personnel providing the treatment must be capable of doing so by virtue of their experience, training and expertise.

4. All of the following must also be true:
   a) There is no clearly superior, non-investigational treatment alternative; **and**
   b) The available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; **and**
   c) The Member and the Physician or health care provider who provides services to the Member conclude that the Member's participation in the clinical trial would be appropriate, pursuant to procedures established by the Plan and as disclosed in the policy and Evidence of Coverage.

We may choose to provide coverage on a case-by-case basis for Phase I clinical trials.

We determine reimbursement for patient costs incurred during participation in cancer treatment 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.

Definitions for this section include:

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

"FDA" means the Federal Food and Drug Administration.

"Member" means a policyholder, Subscriber, insured, or certificate holder or a covered Dependent of a policyholder, Subscriber, insured or certificate holder.

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

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

"Patient cost" means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Member for purposes of a clinical trial. "Patient cost" does not include (i) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

DENTAL CARE AND SERVICES (All Members/All Ages)

Please also see "Pediatric Oral Care" and "Hospitalization for Anesthesia and Dental Procedures" later in this section.

Pre-Authorization is required.

We cover the following services:

- Medically Necessary dental services as a result of accidental injury, regardless of the date of the injury. For injuries that happen on or after Your effective date of coverage, treatment must be sought within 60 days of the accident. A health care professional such as a nurse or a physician must document treatment;
- Medically Necessary dental services performed during an emergency department visit immediately after a traumatic injury and in conjunction with the initial stabilization of the traumatic injury subject to utilization review for Medical Necessity.
- Dental services and dental appliances for newborns to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Repair of dental appliances damaged in accidental injury to jaw, mouth or face;
- Dental services to prepare the mouth for radiation therapy to treat head and neck cancer.
- Preventive dental screenings for children as part of wellness screenings and visits.

DIABETES EQUIPMENT, SUPPLIES AND CARE MANAGEMENT

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

- insulin dependent diabetes;
- gestational diabetes;
- insulin using diabetes; and
- non-insulin-using diabetes.

Coverage for equipment and supplies includes the following:

- insulin pumps
- home blood glucose monitors

- lancets and blood glucose test strips
- syringes and hypodermic needles

We cover outpatient self-management training and education when provided in person. All training and education services must be provided by a certified, registered or licensed health care professional.

Nutritional counseling is covered when received as part of covered Preventive wellness service screening and diabetes education.

We cover routine diabetic foot care, treatment of corns, calluses, and care of toenails.

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. Members may call Liberty Medical Supplies at 1-866-691-9277 to arrange for prescribed supplies to be delivered to them at home.

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

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

Pre-Authorization is required for items over $750.

Pre-Authorization is required for all rental items.

Pre-Authorization is required for all repair and replacement.

We cover the rental or purchase, whichever is less expensive, of DME prescribed by an appropriate Physician. We also cover colostomy, iliostomy, and tracheostomy supplies, and suction and urinary Catheters .We only cover DME that is Medically Necessary. We do not cover DME used primarily for the comfort and well being of a Member. We will not cover DME if We deem it useful, but not Medically Necessary for Your care. We will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items. Covered DME includes the following types of equipment:

- **nebulizers**
- **hospital type beds**
- **wheel chairs**
- **traction equipment**
- **walkers**
- **crutches**

Coverage for Orthopedic appliances includes the initial appliance**.** We may also cover Medically Necessary customized splints and customized braces when pre-authorized by the Plan.

Coverage for Prosthetic appliances includes Medically Necessary surgically implanted prosthetic devices. Cochlear implants, built-up shoes attached to a leg brace, and head halters will be also be covered

EARLY INTERVENTION SERVICES.

Pre-Authorization is required.

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

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

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

We may ask You to provide a copy of the certification. Deductible, copayment, or coinsurance amounts apply depending on what type of service is provided.

No therapy visit maximum apply to physical, occupational, or speech therapy services received under this benefit.

EMERGENCY SERVICES

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

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

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.

The Plan covers Emergency Services in or out of network. Emergency Services do not require pre-authorization in or out of network. Your Copayment or Coinsurance amount will be determined by the type and place of service associated with the Emergency. Your face sheet or schedule of benefits lists Your out of pocket copayment or coinsurance rate for Emergency Services, inpatient hospital Admissions,

ambulance services and urgent care visits. If You receive Emergency Services Out of Network from a Non-Plan Provider You copayment or coinsurance rate cannot exceed the cost-sharing requirement that would apply if services were provided In-network from Plan Providers.

Emergency Care You get Out of Network from a Non-Plan Provider will be covered as an In-Network benefit. However, You may have to pay the difference between what the Non-Plan Provider's charges and the Plan's maximum allowable amount or Allowable Charge in addition to Your Emergency Care Copayment , Coinsurance and Deductible 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:

iv. The amount negotiated with In-Network Providers for the Emergency service;
v. 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
vi. 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, or if You are admitted to the hospital from the emergency department. If You can't notify Us because of Your medical condition, have a friend or relative call Us. You can use the number on the back of Your Optima ID card.

All Emergency, Urgent Care, Ambulance, and Emergency Mental Health Services may be subject to Retrospective Review to determine responsibility for payment. If We determine that Your condition was not an Emergency, We will not pay for the treatment and You will be responsible for all charges. In no event will We pay for services from Non-Plan Providers if the service would not have been covered had You received care from a Plan Provider.

Some examples of Emergency Medical Conditions include:

- heart attacks;
- severe chest pain;
- strokes;
- excessive bleeding;
- poisoning;
- major burns;
- loss of consciousness;
- serious breathing difficulties;
- spinal injuries; and
- shock.

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

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

Urgent Care Center Services means facility, physician, and other services provided during an urgent care center visit for treatment of medical conditions from an unforeseen Illness or injury which are non-life-

threatening, but Medically Necessary to prevent a serious deterioration of a Member's health. Members should get care at the nearest Plan urgent care center.

Retrospective Review means our review of Your medical records and any other supporting documentation after You have received emergency treatment. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the member received care from a Plan Provider.

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 Monday through Friday from 5 p.m. to 8 a.m. On Saturday, Sunday and holidays the program is available 24 hours a day. The After Hours Program can be reached by calling 757-552-7250 or 1-800-394-2237.

FAMILY PLANNING SERVICES.

We cover the following services:

- gynecological examinations;
- counseling and education for birth control options;
- tubal ligation services **(pre-authorization is required);**
- vasectomy services;
- depo-provera, lunelle injections or other injections approved by the plan;
- intrauterine devices (IUDs) and cervical caps and their insertion;

HEMOPHILIA AND CONGENITAL BLEEDING DISORDERS.

Pre-Authorization is required for home treatment.

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

Section 6
What is Covered

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

The following definitions apply to services under this section:

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

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

"Home Health Care Plan" means a program:

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

"Home Health Care Skilled Services" means:

1. Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.), if the services of a registered nurse are not available; or
2. Part-time or intermittent home health aide services which consist primarily of medical or therapeutic caring for the patient; or
3. Physical, speech, and occupational therapy; or
4. Surgical dressings, medical appliances, oxygen and supplies which are Medically Necessary for treatment of the Member at home, but only to the extent such items or services would have been covered under this Plan if the Member had been confined in a Hospital or Skilled Nursing Facility.

"Home Health Skilled Care Visit" means:

1. Each visit by an R.N. or by an L.P.N. to provide nursing care; or
2. Each visit by a certified home health aide; or
3. 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.

The Plan covers 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.

Section 6
What is Covered

HOSPICE CARE.

Pre-Authorization is required.

We cover **Hospice Services** for members whose condition has been diagnosed as terminal with a life expectancy of 6 months.

Covered Services include the following:

- skilled nursing care, including IV therapy services;
- drugs and other outpatient prescription medications for palliative care and pain management;
- services of a medical social worker;
- services of a home health aide or homemaker;
- short-term inpatient care, including procedures necessary for pain control and acute chronic symptom management.
- Physical, speech, or occupational therapy (services provided as part of hospice care are not subject to separate visit limits for therapy services.) Durable medical equipment;
- Routine medical supplies;
- Routine lab services;
- Counseling, including nutritional counseling with respect to the covered person's care and death; and
- Bereavement counseling for immediate family members both before and after the covered person's death

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

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

HOSPITAL SERVICES

Pre-Authorization is required.

Inpatient Room and Board.

We cover room and board in a semi-private room including general nursing care, and meals and special diets. 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.

Other Hospital and Outpatient Services.

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

- Physician, Surgical, and general nursing 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;
- Anesthesia and oxygen services;
- Inhalation therapy;
- Physical and occupational therapy;
- Dialysis; hemodialysis, peritoneal dialysis;
- Administration of whole blood and blood products;
- Surgically implanted prosthetic devices;
- Outpatient ambulatory surgical or other services (i.e., observation room);
- Medical detoxification;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Injectable medications;
- Nuclear medicine;
- Medical and Surgical supplies;
- Other services approved by the plan

Inpatient Length of Stay Requirements

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

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

HOSPITALIZATION AND ANESTHESIA FOR DENTAL PROCEDURES.

Pre-Authorization is required.

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

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

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

INFANT HEARING SCREENINGS

Pre-Authorization is required.

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

INFUSION SERVICES

Pre-Authorization is required.
We cover infusion therapy and medications administered intravenously or parenterally. This also includes enteral delivery of nutrients by tube. Services are covered in inpatient, outpatient and home settings. We cover nutrition infusion in the home and special medical formulas which are the primary source of nutrition for covered persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

MATERNITY SERVICES AND NEWBORN CARE

Pre-Authorization is required for prenatal services.

We cover the following maternity services for You or Your covered Dependents:

- Pregnancy testing;
- Prenatal and postpartum physician services for maternity care and maternity related checkups;
- Care and services related to complications of pregnancy including hospitalization as necessary;
- Prenatal screenings including fetal screenings for genetic and/or chromosomal status of the fetus; Also, anatomical, biochemical, or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies. Services covered as recommended for Grades A and B of United States Preventive Services Task Force.
- Use of delivery room, and all inpatient hospital labor and delivery services,
- Anesthesia services;
- 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 Hemoglobinopathies screening; Gonorrhea prophylactic medication; Hypothyroidism screening; PLU 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 clef lip, cleft palate, or ectodermal dysplasia.

- Minimum length of stay of 48 hours for a vaginal delivery, 96 hours following a cesarean section. The attending Physician and patient may decide that a shorter Hospital stay is appropriate. Pre-authorization is not required for delivery.

- Delivery by midwife at freestanding birthing center services under contract with the Plan;

- Postpartum inpatient care ; and a home visit or visits in accordance with the plan's medical criteria;

- Care and services related to a miscarriage;

- Breast feeding lactation counseling and equipment US Preventive Services Task Force Grade B recommendation.

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

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

MEDICAL SUPPLIES AND MEDICATIONS

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

- Hypodermic needles and syringes
- Prescription medications and infused medications
- Oxygen and equipment for administration of oxygen

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH TREATMENT

Pre-Authorization is required for all inpatient services, and partial hospitalization services. Pre-Authorization is required for intensive outpatient Program (IOP), psychological and neuro-psychological testing, and electro-convulsive therapy.

Your Plan does not apply and day or visit limitations for treatment under this benefit that does not also apply under other medical or surgical benefits under the Plan.

Section 6
What is Covered

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 listed earlier in this section.

Mental Health/Behavioral Health and Substance Use Disorder Outpatient Treatment Services

Covered services include the following provided in an office based setting or other outpatient facility as Medically Necessary:

- Outpatient facility professional services;
- Visits for medication checks;
- Diagnosis and treatment of psychiatric conditions, including psychotherapy, group psychotherapy, and psychological testing.

Mental Health/Behavioral Health and Substance Use Disorder Inpatient Treatment Services/Detoxification and Rehabilitation

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

- Inpatient facility professional services;
- Individual psychotherapy and group psychotherapy;
- Psychological testing;
- Counseling with family members to assist with the patient's diagnosis and treatment;
- Convulsive therapy treatment.

Partial Day/Intensive Outpatient Services

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

"Substance use disorder services" means treatment for alcohol or other drug dependence.

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

Section 6
What is Covered

ORAL SURGERY

We cover the following:

- surgical procedures required to repair accidental injuries to the jaws, mouth, lips, tongue or hard and soft palates;
- maxillary or mandibular frenectomy when not related to a dental procedure;
- alveolectomy when related to tooth extraction
- surgical services on the hard 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 fractures of the facial bones;
- excision including diagnostic biopsy of malignant and/or symptomatic tumors and cysts of the jaws, gums, cheeks, lips, tongue, hard and soft palates, and salivary glands;
- orthognathic surgical procedures such as osteotomy or other reconstruction of the jaws and/or facial bones (when associated with severe malocclusion) that are necessary to restore and maintain function;
- coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Inpatient and outpatient dental, oral surgical and orthodontic services which are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia will be covered

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

PHYSICIAN SERVICES (Inpatient and Outpatient)

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; ambulatory surgery, or other outpatient facility.
- Specialist care and consultations.
- A second opinion from a Non-Plan Provider if approved by the Plan.
- Virtual Consults when provided by an Optima Health approved provider.
- Maternity care and related checkups.

PREVENTIVE CARE SERVICES AND SCREENINGS.

Annual Physicals

We cover one routine physical exam each year.

Annual GYN exams

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

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

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

Screening Mammograms

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

Pap Smears

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

Prostrate Screening Tests

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

Colorectal Cancer Screening

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

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

Routine Hearing Tests

We cover one annual routine hearing test.

Well Child Care

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

- a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards;
- benefits will be provided at approximately birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, and 6 years;
- 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

ADULT PREVENTIVE VISION CARE SERVICES.

In-Network Coverage.

We contract with EyeMed Vision Services to administer preventive vision benefits. For adults age 19 and up 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 Friday 9 a.m. - 9 p.m., and Saturdays 9 a.m. - 5 p.m.
2. Visit or call the participating provider and identify yourself as a participant by providing Your Member ID information. The provider will verify eligibility, Your Plan's Covered Services and any applicable Copayment or Coinsurance. Payment is due when You receive services.
3. If the vision provider determines that You need additional medical care You should contact Your PCP or other physician for treatment options.

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 Services
P.O. Box 8504

Mason, OH 45040-7111
Attn: Vision Care Department

RECONSTRUCTIVE BREAST SURGERY.

Pre-Authorization is required.

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

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

SHOTS AND INJECTIONS

We cover shots and injections from a provider to treat illness, or for routine vaccines and some other immunizations. We also cover self-administered injections.

THERAPY, HABILITATIVE AND REHABILITATIVE SERVICES AND DEVICES

Pre-Authorization is required.

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.

We cover the following services:

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

See Your face sheet for benefit limits. All services must be Medically Necessary and done by a provider licensed or certified to do the services.

We cover therapy and rehabilitation services furnished to a Member on an outpatient or inpatient basis according to a specific written treatment plan that:

1. details the treatment to be rendered, its frequency, duration, and goals; and

2. provides for ongoing review

CHEMOTHERAPY, RADIATION THERAPY, IV THERAPY, AND INHALATION THERAPY.

Pre-Authorization is required.

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

SKILLED NURSING SERVICES.

Pre-Authorization is required.
We cover care given in a licensed Skilled Nursing Facility. The care must be ordered by a Physician. We cover semi-private room and board charges, drugs, biologicals, rehabilitative services, and other facility services and supply charges. See Your face sheet for the maximum number of days per year. Custodial Care is not covered.

BONES AND JOINTS (TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME).

Pre-Authorization is required.

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

TRANSPLANT SERVICES.

Pre-Authorization is required.

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

We cover Medically Necessary human organ transplants for members who meet all of our coverage criteria. We do not cover transplants that are experimental. We cover the following transplants and services:

- 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, harvest and storage, and preparatory myeloablative therapy
- When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive benefits under the Plan. Costs related specifically to transportation and lodging are covered.

LYMPHEDEMA.

Pre-Authorization is required.

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

- equipment,
- supplies,
- complex decongestive therapy,
- outpatient self-management training and education

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

DIAGNOSTIC, X-RAY, SLEEP STUDIES, AND LABORATORY SERVICES

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

Your benefits include coverage for the following procedures when ordered by your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms:

- Radiology including x-rays, mammograms, ultrasound or nuclear medicine;
- Laboratory and pathology services or tests;
- Diagnostic EKGs, EEGs;
- 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), SPECT scans, and nuclear cardiology;
- Professional services for test interpretation, x-ray reading, lab interpretation, and scan reading;

- BRCA and fetal screening;
- Genetic testing and counseling is covered when Medically Necessary;
- Sleep Studies including sleep testing and treatment for sleep disorders. Coverage includes oral appliances, CPAP, BIPAP as directed by the Physician for the treatment of sleep apnea. Home sleep studies are covered based on Medical Necessity.

TELEMEDICINE SERVICES.

We cover telemedicine services that we have Pre-Authorized. Emergent services do not require pre-authorization. Telemedicine services, as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission. 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.

PPACA RECOMMENDED PREVENTIVE CARE SERVICES

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

(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; and

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, such additional preventive care and screenings not described in item (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph including:

- **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers

during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

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

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

SMOKING AND TOBACCO CESSATION COUNSELING

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

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 FOLLOWING SURGERY OR ACCIDENT

Pre-authorization is required.

The Plan covers 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 of 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.

INFERTILITY

Includes the following services to diagnose and treat 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)

OUT PATIENT PRESCRIPTION DRUG COVERAGE

Your plan has a closed formulary. That means there is a specific list of drugs and medications that are covered. Some drugs and medications may not be covered. We have a process in place so that You can request coverage of a drug not on Our formulary. Our pharmacy committee places covered drugs into tiers. Your cost will depend on what tier your drug is in. You can fill your prescription at a plan pharmacy. You can also use a non-plan pharmacy that has agreed to accept our rates. Your Copayments, Coinsurances, Deductibles and maximum benefit are listed in the box below. You can call Member Services or check our website to see what tier a drug is in. Optima's website is www.optimahealth.com.

Tier Definitions

Tier 1 Preferred Drugs include: The majority of commonly prescribed and widely available generic drugs. Preferred drugs are covered at the lowest Copayment level. Some brand-name drugs may be included in this category if the Plan recognizes they show documented long-term decreases in Illness and death. Large published peer-reviewed clinical trials are used to make this determination.

Tier 2 Standard Drugs include: Brand-name drugs that are considered by the Plan to be standard therapy; and generic drugs with significantly higher costs than the average Preferred (Tier 1) generic drugs that are considered by the plan to be standard therapy.

Tier 3 Premium Drugs include: Those generic and brand name drugs not included by the Plan on another tier. These may include single source brand name drugs that do not have a generic equivalent or 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.

Coverage of Specialty Drugs.

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 are only available through Optima's specialty mail order pharmacy BriovaRx at 855-577-6512.

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; and
- Medications that can be delivered via injection, infusion, inhalation, or oral administration.

You will pay Your Copayment or Coinsurance depending on which Tier Your Specialty Drug is in. Your Specialty Drug will be delivered to Your home address. If you have a question or need to find out if your drug is considered a Specialty Drug please call Member Services at the number on Your Optima ID Card . You can also log onto www.optimahealth.com for a list of Specialty Drugs.

Requests for coverage of drugs or medications not on the Plan's formulary.

If You believe You need a prescription drug that is not on the formulary you can ask us to cover the drug. If You have been using a nonformulary drug for at least six months before we develop or change our formulary you can ask us to cover a non-formulary drug. Your doctor must have determined that our formulary drug is inappropriate for Your condition or that changing drugs is a significant health risk to You. Your doctor must send a medical necessity form to our pharmacy authorization department. We will consult with your doctor and make a decision within one business day of receipt of the request.

PEDIATRIC ORAL CARE (CHILDREN UP TO AGE 19)

Optima Health contracts with Delta Dental to provide Pediatric Oral Care benefits under the Plan. Children up to age 19 are eligible for these benefits.

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: **www.deltadentalva.com**

Mailing Address: 4818 Starkey Road Roanoke VA 24018

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

COVERED PEDIATRIC ORAL SERVICES

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

Section 6
What is Covered

Your Copayment or Coinsurance amount for covered pediatric dental services is listed on Your face sheet. Covered pediatric oral services will count toward your medical deductible and medical maximum out of pocket amounts. The services listed below are covered under Your Plan.

Preventive and Diagnostic Dental Care

- Oral Exams including one routine oral evaluation per 6 months, beginning with the eruption of the first tooth
- X-rays
- Diagnostic Casts

Basic Dental Care

- Cleanings once every 6 months
- Topical Fluoride Treatments once every 6 months
- Sealants limited to one per lifetime per tooth
- Space maintainers limited to once per year

Restorative Dental Care

- Filings limited to once per tooth per year
- Crowns limited to one per tooth per year
- Protective restorations
- Veneers limited to one per tooth per ~~lifetim~~5 years
- Temporary crowns

Major Dental Care

- Endodonic Services limited to one per tooth per lifetime including:
    - pulp caps, pulpal therapy, and pulpal regeneration;
    - apicoectomy/periradicular surgery once per tooth per lifetime.
- Gingivectomy or gingivolplasty limited to one per two years per quadrant
- Periodonatal services limited to one per two years per quadrant including:
    - Scaling and root planning limited to one per two years per quadrant
    - Full mouth debridement limited to one per year
    - Osseous surgery limited to one per five years per quadrant

- Provision splinting

- Removable prosthetics
- Fixed prosthetics limited to one per tooth per 5 years
- Local anesthesia
- Extractions

Orthodontia

- Orthodontia considered by the Plan to be Medically Necessary. Members must have a severe, dysfunctional, handicapping malocclusion.

PEDIATRIC VISION CARE (CHILDREN UP TO AGE 19)

Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one exam each year for glasses or contact lenses, and one pair of glasses, lenses and frames per year from a limited frame collection, or contact lenses from a limited selection instead of glasses. Exams and materials must be received from EyeMed participating providers.

To receive Covered Services:

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

CHIROPRACTIC COVERAGE FOR MANUAL MANIPULATION OF THE SPINE TO CORRECT SUBLUXATION

Optima Health contracts with American Specialty Health Networks (ASH) to administer this benefit. **Pre-authorization is required by ASH for all services.**

Covered services, including Urgent Services and Emergency Services, are limited to Manual manipulation of the spine for the treatment of subluxation as defined below.

Covered Services must be approved by ASH Group as Medically Necessary.

To receive services Members should contact ASH at: ASH Member Services (800) 678-9133 5:00am to 6pm PST, Monday – Friday.

Section 6
What is Covered

DEFINITIONS

Chiropractic Services. The services rendered or made available to a Member by a Contracted Chiropractor for manual manipulation for the course of treatment of Subluxation of the Spine diagnoses.

Contracted Chiropractor. Contracted Chiropractor is a chiropractor 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, site, 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, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.
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.

Subluxation of the Spine. Subluxation is a type of musculoskeletal or related disorder or condition typically categorized as a structural, degenerative, or inflammatory disorder, or biomechanical dysfunction of the joints of the spine and related neurological manifestations. Subluxation of the Spine must be documented through physical examination using the Replacement for Subluxation (P.A.R.T.) criteria published by CMS or demonstrated on X-ray.

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.

CLINICAL TRIALS FOR LIFE THREATENING DISEASES OR CONDITIONS

Coverage includes participation in an approved clinical trial and coverage for routine patient costs for items and services furnished in connection with participation in the clinical trial.

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

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

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

"Routine patient costs" means all items and services consistent with the coverage provided under the health benefit plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine

patient costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

We may require that a qualified individual participate in an approved clinical trial through a participating provider if such provider will accept the individual as a participant in the trial. However, We will not preclude a qualified individual from participating in an approved clinical trial conducted outside the state in which the individual resides.

PROSTHETIC COMPONENTS AND DEVICES

Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components. Pre-Authorization is required for all services.

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.

INTERRUPTION OF PREGNANCY SERVICES

Abortion is covered 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.]

DIALYSIS

The Plan covers dialysis treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis. Covered Services include home dialysis equipment and supplies, and dialysis treatments in a facility or doctor's office.

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. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

A

Abortion is covered 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.]

Acupuncture is not covered**.**

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

Ambulance Service for non-emergency transportation is not covered unless We authorize the service.

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

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

Applied Behavioral Analysis is not covered.

Aromatherapy is not covered.

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

Autopsies are not covered.

B

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

Biofeedback is not covered unless We authorize it.

Birthing Center Services are covered 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 unless We have approved them.

Breast Augmentation, Gynecomastia, or Mastopexy is not covered unless We have approved them based on Medical Necessity. Cosmetic procedures or surgery for breast enlargement or reduction are not covered. Procedures for correction of cosmetic physical imperfections are not covered. Breast implants are not covered. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Breast Ductal Lavage is not covered.

Breast Milk from a donor is not covered.

C

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

Chiropractic Care including spinal or other manual medical interventions for an illness or injury other than musculoskeletal are not covered.

Circumcision is not covered after age six weeks unless Medically Necessary.

Cold Therapy Machine is not covered.

Cosmetic Surgery and Cosmetic Procedures are not covered. We do not cover medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **We will not cover any of the following:**

- surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- 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 are not covered. 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.

Section 7
What is Not Covered

Court ordered examinations or treatments are not covered unless they are determined to be medically necessary and We have authorized them.

Custodial Care is not covered. **We will not cover any of the following if the services are merely custodial, residential or domiciliary in nature:**

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

D

Dentistry/Oral Surgery/Dental Care

The following services are not covered. This exclusion does not apply to services covered 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;
- oral surgeries or periodontal work on the hard and/or soft tissue supporting the teeth to help support structures;
- periodontal, prosthodontal, or orthodontic care;
- Cosmetic services to restore appearance;
- Restorative services and supplies necessary to treat, repair or replace sound natural teeth;
- Dental implants or dentures and any preparation work for them;
- Dental services performed in a hospital or any outpatient facility except for services listed under "Hospitalization and Anesthesia for Dental procedures;"
- Oral surgery which is part of an orthodontic treatment program.

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

Donor Searches for organ and tissue transplants, including compatibility testing or potential donors who are not immediate blood-related family members are not covered.

Driver Training is not covered.

Drugs for certain clinical trials are not covered.

The following are not covered. 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; hypoallergenic bed lines; whirlpool baths and hot tubs; handrails, ramps, elevators, and stair glides; telephones; adjustments made to vehicles; foot orthotics; changes made

to home or businesses; or repair or replacement of equipment lost or damaged through neglect. Durable Medical Equipment not appropriate for use in the home is not covered.

E

Electron Beam Computer Tomography (EBCT) is not covered. We do not cover any **other diagnostic imaging test where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.**

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

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

Enteral or Parenteral Feeding supplements are not covered unless they are used as the sole **or major** source of nutrition. We do not cover over the counter supplements.

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

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

Experimental or Investigative drugs, devices, treatments, or services are not covered. 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 required for work are not covered. Corrective or protective eyewear required for work is not covered.

Eye Glasses and contact lenses are not covered. This does not apply to covered services under Pediatric Oral benefits or lenses following cataract surgery including contact lenses, or placement of intraocular lenses or eyeglass lenses only.

Eye Movement Desensitization and Reprocessing Therapy is not covered.

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

F

We **do not cover** the following **Foot Care Services** unless We authorize them:

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

We **do not cover** any of the following **Foot Care Services** except for Members with Diabetes or severe vascular problems:

- removal of corns or calluses;
- nail trimming;
- treatment and services for or from flat-feet, fallen arches, weak feet, or chronic foot strain;
- foot Orthotics of any kind;
- customized or non-customized shoes, boots, and inserts.

G

Genetic Testing and Counseling is not covered unless We have authorized the services.

GIFT programs (Gamete Intrafallopian Transfer) are not covered.

Group Speech Therapy is not covered.

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

H

Hearing Aids are not covered. Fittings, molds, batteries or other supplies are not covered. This does not apply to cochlear implants.

Home Births are not covered.

Home Health Care Skilled Services are not covered 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. We do not cover transportation. We do not cover homemaker services, food and home delivered meals.

Hospital Services listed below are not covered:

- 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 covered.

I

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

Implants for cosmetic breast enlargement are not covered. 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.

Incarceration - We do not cover services and treatments done during incarceration in a Local, State, Federal or Community Correctional Facility or prison.

Infertility Services listed below are not covered:

- 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;
- semen analysis;
- Sims-Huhner test (smear);
- drugs used to treat infertility.
- Surrogate pregnancy services.

J

K

Keloids from body piercing or pierced ears are not covered.

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 covered**.**

Lasik Surgery is not covered.

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

M

Massage Therapy is not covered.

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.

Medically Necessary Treatments - Any services, supplies, treatments, or procedures determined not to be Medically Necessary are not covered.

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not covered. **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 is not covered except when provided as part of diabetes education or when received as part of covered wellness services or screening visits. Nutritional formulas and dietary supplements that are available over the counter and/or without a written prescription are not covered.

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

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

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

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

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

O

Oral Surgery services listed below **are not covered** 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.

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.

P

Paternity Testing is not covered.

Penile implants are not covered.

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

Physician Examinations are limited as follows:

- physicals for employment, insurance or recreational activities are not covered.
- executive physicals are not covered.
- school physicals are not covered except when You have not had a health assessment with a physician during the calendar year.
- a 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.

Physician's Clerical Charges are not covered**. C**harges 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.

Private Duty Nursing in an Inpatient setting is not covered.

Q
R

Reconstructive surgery - is not covered unless services follow trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is covered.

Residential or Sub-Acute Level of Care or treatment is not covered. Your coverage does not include benefits for rest cures, custodial, residential, or domiciliary care and services. Your coverage does not include benefits for care from a residential treatment center or other non-skilled settings 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.

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 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.

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

Sex Change Operations and treatment of gender identity disorders are not covered.

Sterilization

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

T

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

Services delivered under a **TDO (Temporary Detention Order)** are not covered.

Therapies. Physical, Speech, and Occupational **Therapies** are limited as stated on Your face sheet or schedule of benefits. Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. **We do not cover any of the following:**

- lessons for sign language;
- therapies available in a school program;
- therapies available through state and local funding;
- recreation therapies;
- art, dance, or music, therapies;
- exercise, or equine, therapies;
- sleep therapies;
- driver evaluations as part of occupational therapy;
- driver training;
- functional capacity testing needed to return to work;
- work hardening programs;

Total Body Photography is not covered.

Transplant Services. We do not cover any of the following:

- organ and tissue transplant services not listed as covered;
- organ and tissue transplants not medically necessary;
- organ and tissue transplants considered experimental or investigative;
- services from non-contracted providers unless pre-authorized by the plan;
- services and supplies for organ donor screenings, searches and registries.

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

U

Urea Breath Testing is not covered**.**

V

Vaccines are not covered unless approved by the Plan.

Treatment of **varicose veins** or **telangiectatic dermal veins** (spider veins) when services are rendered for cosmetic purposes.

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

Virtual Colonoscopy is not covered unless approved by the Plan.

Vision Materials not listed under Covered Services are not covered**.**

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

W

Section 7
What is Not Covered

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

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

X

Y

Z

OUTPATIENT PRESCRIPTION DRUG COVERAGE EXCLUSIONS AND LIMITATIONS

- Some drugs are covered only at a generic level. If you or your doctor asks for a brand-name or a higher costing generic you must pay the difference between the cost of that drug and the generic drug plus the Copayment charge.
- All drugs must be approved by the U.S Food and Drug Administration.
- Optima may limit the amount of some drugs you receive.
- All drugs require a prescription by state or federal law.
- Some drugs require your doctor to get Pre-Authorization from the Plan before you receive them.
- Prescription contraceptive drugs and devices are covered. Depo-Provera and Lunelle injections, Intrauterine devices (IUDs), and cervical caps and insertion are covered under medical benefits.
- Some over the counter drugs may be covered. You must have a doctor's prescription for the drug. The drug must be listed on the formulary.
- The following is a list of exclusions, Limitations and other conditions that apply to Your drug benefit.

    1. Any prescription drugs, over the counter drugs, or devices that are not included on the Formulary are not covered.
    2. Medications that do not meet the Plan's criteria for Medical Necessity are excluded form Coverage.
    3. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out of Pocket Limit.
    4. Amounts You pay for any outpatient prescription that is excluded from Coverage and will not count toward any Plan Maximum Out of Pocket Amount.
    5. 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.
    6. 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. Medications with no approved FDA indications are excluded from Coverage.

7. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage.
8. The Plan may approve Coverage of Limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs
9. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. Benefits for Covered Services may be reduced or denied for not complying with the Plan's Pre-Authorization requirements.
10. At its sole discretions Optima'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. 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.
11. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
12. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
13. Non-durable disposable medical supplies and items such as bandages, cotton swabs, and durable medical equipment not listed as covered are excluded from Coverage.
14. Insulin, syringes, and needles are covered under the prescription drug benefit. Diabetic supplies and equipment, 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, other than those listed as covered under this prescription drug benefit are covered under the Plan's medical benefit.
15. Immunization agents, biological sera, blood, or blood products are covered under the Plan's medical benefit.
16. Injectables (other than those self-administered and insulin) are covered under the Plan's medical benefit.
17. Medication taken or administered to the Member in the Physician's office is covered under the Plan's medical benefit.
18. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is covered under the Plan's medical benefit..
19. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
20. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
21. Replacement prescriptions resulting from loss, theft, or breakage are excluded from Coverage.
22. Therapeutic devices or appliances, including but not Limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
23. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
24. 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.

25. 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.
26. 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.
27. Infertility drugs are excluded from Coverage.
28. Medications for smoking cessation, including but not Limited to Nicorette gum, nicotine patches, nicotine spray are excluded from Coverage.
29. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.

CHIROPRACTIC CARE LIMITATIONS AND EXCLUSIONS

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

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. If the Member's plan requires the Member to obtain a primary care physician referral for Chiropractic Services, any Chiropractic Services or treatments furnished without the required primary care physician referral are not covered.
3. 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.
4. Services or treatments delivered by a non-Contracted Practitioner are not covered. This does not apply for the following: (a) Emergency Services; (b) Urgent Services; (c) services that are provided pursuant to a continuity of care plan approved by ASH Group; or (d) services that are provided upon referral by ASH Group in situations where such services are not available and accessible to a Member from a Contracted Practitioner within the Service Area.
5. Services, exams, and/or treatments for conditions other than Subluxation of the Spine are not covered.
6. 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.
7. Services provided by a chiropractor practicing outside the Service Area are not covered. This does not apply to Emergency Services or Urgent Services.
8. Services rendered in excess of visits or benefit maximums are not covered.
9. Any services provided by a person who is a Family Member are not covered. 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.

10. Any services rendered for elective or maintenance care are not covered. Elective or maintenance care mean services provided to a Member whose treatment records indicate he or she has reached Maximum Therapeutic Benefit.

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 Dental Necessity. Dental Necessity is determined 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 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. Dental Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are not covered. Such services include but are not limited to equilibration and periodontal splinting.
21. Dental Services, procedures and supplies needed because of harmful habits are not covered. An example of a harmful habit includes clenching or grinding of the teeth.
22. Amounts assessed on dental services and/or supplies by state or local regulation are not covered.
23. 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 Medical Benefit.
4. Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment is not covered.
5. Safety eyewear is not covered.

Section 7
What is Not Covered

6. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof is not covered.

7. Plano (non-prescription) lenses and/or contact lenses are not covered.

8. Non-prescription sunglasses are not covered.

9. Two pair of glasses in lieu of bifocals are not covered.

10. Services rendered after the date an Insured Person ceases to be covered under the Policy are not covered, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.

11. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

We require certain information to apply these COB rules. Each Member must submit to Us any completed consents, releases, assignments and/or other documents that are necessary for Us to coordinate benefits.

We may get information from other organizations or persons. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan all facts it needs to pay the claim. We may release information to other persons and organizations in accordance with the Insurance Information and Privacy Protection regulations as set forth in the Code of Virginia 38.2-613. If You have questions about how We can get and use information please refer to the information on our privacy practices notice in this document.

FACILITY OF PAYMENT.

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

RIGHT OF RECOVERY.

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

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

We are not required to reimburse a Member in cash for the value of services provided.

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

WE DO NOT COVER ANY OF THE FOLLOWING:

- Benefits available under **Worker's Compensation**.

- Benefits available under **Medicare Parts A, B, or C** unless required to do so by federal law. If We provide services covered under Medicare, Medicare will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us.

- Benefits available under **any other government program**, unless required to do so by law. If We provide services under a government program, the government program will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us.

THE FOLLOWING DEFINITIONS APPLY TO THIS SECTION.

"Plan" is any of the following which provide health benefits or services:

1. Group 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

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

You can file a complaint anytime within 180 days from the date of Your concern with Your care or services. Remember to include any additional documentation that will help Us resolve Your concern. You may have someone else, such as a doctor or family member, file a complaint for You. We may ask that You sign a form authorizing the other person to act for You.

Call Member Services and ask for a complaint form, or download the forms from our Web site www.OptimaHealth.com. Mail or fax the completed forms and any additional documentation to:

Optima Health
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232
Toll Free: 866-472-3920

We will write to You and let You know We have received Your complaint. We will also tell You how long We think it will take Us to investigate Your complaint. When We have finished our investigation We will write to You and let You know how We have resolved Your complaint.

If You have been unable to contact Us or obtain satisfaction here are some other places you can go for help.

- **Contact the Virginia Bureau of Insurance**:

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

- **Contact the Virginia Department of Health**:

  Virginia Department of Health
  Center for Quality Health Services and Consumer Protection
  3600 W. Broad Street, Suite 216
  Richmond, VA 23230-4920
  Toll-free Telephone: 1-800-955-1819

- **The Managed Care Ombudsman**:

  Write:
  Office of the Managed Care Ombudsman
  Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218

  Telephone:
  Toll-Free: 1-877-310-6560
  Richmond Metropolitan Area: 1-804-371-9032
  E-Mail: ombudsman@scc.virginia.gov

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 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.

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR 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 www.optimahealth.com ; or
3. Sending Us a fax at 757-687-6232 1-866-472-3920; or
4. Sending Us a letter by mail at:

Optima Health
APPEALS DEPARTMENT
P.O. Box 62876

Virginia Beach, VA 23466-2876

- **For an Urgent care appeal You or Your treating physician can request an expedited appeal by telephone, fax, or letter. Please make sure to explicitly state "expedited appeal" in the request to initiate this process.**

- **When You have completed the forms return them to Us. Remember to include all of the following with Your appeal forms:**

    1. Your name, address, and telephone number;
    2. Your member number and group number;
    3. The date of service, and place of service;
    4. The name of the doctor or other service provider;
    5. The charge related to the service; and
    6. Any new additional written comments, documents, records, or other information You want Us to consider.

- **When We complete Your appeal We will send written notification of our decision. If We don't change our initial decision our notice will include**:

    1. The specific reason for our decision; and
    2. The specific plan provisions We based our decision on; and
    3. Information on any external appeal rights available to You.

- **You can also request the following free of charge:**

    1. Reasonable access to, and copies of, all documents, records, and other information relevant to Your appeal; and
    2. Copies of any internal rule, guideline, protocol, or other criteria We relied on for our decision; and
    3. For denials due to medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to Your medical circumstances.

YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR A FINAL ADVERSE BENEFIT DETERMINATION. .

If We have denied your request for the provision of or payment for a health care service or course of treatment You may have the right to have our decision reviewed by health care professionals who have no association with Us if Our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested by submitting a request for external review to the Virginia State Corporation Commission's Bureau of Insurance .

State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
Phone: 1-877-310-6560 Fax: (804)371-9915
Email: externalreview@scc.virginia.gov

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

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 ID Card or on our web site at optimahealth.com.

Depending on your situation You or Your authorized representative can ask for an external review of an adverse or final adverse determination.

You may file a request for an External Review of an adverse determination in the following situations:

- If we have denied Your request for a covered service, or We have denied payment for a covered service or course of treatment, and our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested

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

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

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

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

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

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

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

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

You have 120 days from the date you receive notice of your right to request an External appeal from the Bureau of Insurance (BOI).

You must have exhausted Our internal appeal process. 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 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.

Section 10
YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

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

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

SOURCES FOR ADDITIONAL HELP.

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

- Virginia State Corporation Commission
  Life & Health Division, Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  (877) 310-6560
  http://www.scc.virginia.gov/boi
  bureauofinsurance@scc.virginia.gov

- You may contact the Office of the Managed Care Ombudsman to seek assistance in understanding and exercising your right to appeal an adverse determination at:

  Office of the Managed Care Ombudsman
  Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  Toll Free Telephone Number: 877-310-6560
  Email Address: ombudsman@scc.virginia.gov

- You may Contact the Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection at 1-800-955-1819.

You may have the right to bring civil action under Section 502 (a) of the Employee Retirement Income Security Act if all required reviews of your appeal have been completed and your appeal has not been approved. Members of government or church-sponsored groups do not have this right. Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency. Contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration Toll-free at 1-866-275-7922 or visit their website at www.dol.gov.

Section 11
Individual Conversion

INDIVIDUAL CONVERSION.

If Coverage ends under the Plan, Members are entitled to convert to an individual subscriber Plan within 31 days after issuance of written notice by Optima Health, but in no event beyond the 60-day period following the date of termination of the enrollee's coverage under the individual policy.

A. Members must complete an application for the individual Subscriber Plan and make the first premium payment within 31 days after issuance of written notice by Optima Health, but in no event beyond the 60-day period following the date of termination of the enrollee's coverage under the individual policy. Coverage under the individual Subscriber Plan will then be effective on the date Coverage ended under the individual policy.

B. Coverage will be provided without additional evidence of insurability.

C. The Plan's Conversion Coverage may be different from Coverage under this Evidence of Coverage. The Member will be subject to the terms of the Conversion Plan in effect at the time application for Conversion is made.

Members will not be eligible for Conversion if any conditions below are true.

A. The Member is covered by, or is eligible for benefits under Title XVIII, under the United States Social Security Act.

B. The Member is covered by, or is eligible for substantially the same level of Hospital, medical, and surgical benefits under state or federal law.

C. The Member is covered by substantially the same level of Hospital, medical, and surgical benefits under any policy, contract, or Plan for individuals in a group.

D. The Member has not been continuously covered during the three-month period immediately preceding the Member's termination of Coverage.

E. The Member was terminated by the Plan for any of the following reasons.

1. Failure to pay the amounts due under the contract, including failure to pay a premium required by the contract as shown in the contract or evidence of coverage;
2. Fraud or material misrepresentation in enrollment or in the use of services or facilities;
3. Material violation of the terms of the contract;
4. Engaging in activities that endanger the safety and welfare of the Plan or its employees or providers;
5. Failure of the Member to establish a satisfactory relationship with the Primary Care Physician provided the Plan has made an effort to provide the opportunity for the Member to establish a satisfactory patient-Physician relationship, including assigning the Member to another Primary Care Physician from among the Plan's providers.

Section 12
General Provisions

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

In the event that circumstances not within the Plan's control including, but not limited to, a major disaster, epidemic, or civil insurrection, result in the facilities, personnel or resources used by the Plan being unable to provide or arrange for the care and services the Plan has agreed to provide, the Plan shall make a good faith effort to arrange for an alternative method of providing such care and services insofar as practical and according to its best judgment. In such circumstances, however, neither the Plan nor participating providers shall incur any liability or obligation for delay, or failure to provide or arrange for such services.

INCONTESTABILITY.

In the absence of fraud, all statements made by a Member shall be considered representations and not warranties and no statement shall be the basis for voiding Coverage or denying a claim after the contract has been in force for two years from its effective date, unless the statement was material to the risk and was contained in a written application.

SEVERABILITY.

In the event that any provision of this Evidence of Coverage is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this EOC which shall continue in full force and effect in accordance with its remaining terms.

POLICIES AND PROVISIONS.

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

MODIFICATIONS.

Alterations to the Plan, the Evidence of Coverage and its attachments may be made, in accordance with the terms herein. The Plan will provide 60 days advance notice to enrollees before the effective date of any material modification such as changes in preventive benefits, other benefit changes, premium changes, member cost sharing changes, or changes to the service area.

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 12
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 identification cards.

From You to the Plan.

Notice by You is considered "given" when actually received by the Plan. The Plan will not be able to act on this notice unless the subscriber's name and identification number are included in the notice.

LIMITATIONS OF DAMAGES.

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

TIME LIMITS ON LEGAL ACTION.

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

THE PLAN'S CONTINUING RIGHTS.

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

CONTINUITY OF CARE.

If a provider leaves the Plan's network, except for cause, the Member may continue to receive care from that provider with a valid referral or authorization from the Plan:

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 (did) (3) (A) of the Social Security Act.

D. The Plan will pay a provider according to the Plan's agreement with the provider existing immediately before the provider's termination of participation.

CONSIDERATION OF MEDICAID ELIGIBIITY PROHIBITED

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

The Plan shall not, in determining benefits payable to, or on behalf of an individual covered under the Plan, take into account the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

Section 12
General Provisions

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 you Plan Identification 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.

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.
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.

Notice of Insurance Information Practices
and
Financial Information Practices

4. If we refuse to change our records, you can send us a written statement for our files. In it, you can state: (a) what you think is the correct, relevant or fair information; and/or (b) why you disagree with our refusal. If you send us such a statement, we will (a) keep it with your file so that it will be seen by any-one reviewing the file; (b) include it with any data sent to others about you; and (c) send it to anyone described in subsection 3, above.
5. The above rights do not extend to data connected with or in preparation for a claim or civil or criminal proceeding involving you.

Whom You Should Contact If You Have Additional Questions About This 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 identification card.

As a Member of the Plan You have rights to coverage to be provided in a manner determined in consultation with Your attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the exclusions, limitations, and conditions including Copayments, Coinsurances, and/or Deductibles set forth in this document. Coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

Sentara HealthCare Integrated Notice of Privacy Practices

Sentara Healthcare Notice of Privacy Practice

Effective Date: June 2, 2005

Review Date: February 13, 2009 by Enterprise Security Committee

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.

Who Will Follow This Notice?

This notice describes Sentara Healthcare's practices and that of:

- 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 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 records of your care generated by a Sentara entity, whether made by Sentara personnel or your personal doctor. Your personal doctor 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 medical information that 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.
- **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, such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee on Quality Assurance, 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 information that does not identify you so that they may use it to study health care.
- **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. If you do not want Sentara to contact you for fundraising efforts, please notify the Privacy Contact Person.
- **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, regardless of the funding for such research. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research the project will have been approved through this research approval process. However, we may disclose medical information about you to, for example, people preparing to conduct a research project to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Sentara facility.
- **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.** Sentara Health Plans, Inc., on behalf of Optima Health Plan, Optima Health Group, or Optima Health Insurance Company, 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 disenrolled 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.

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 Risks.** 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. We also may disclose your information to Sentara's attorneys and, in accordance with applicable state law, to attorneys working on Sentara's behalf.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

· In response to a court order, subpoena, warrant, summons or similar process;
· To identify or locate a suspect, fugitive, material witness, or missing person;
· About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
· About a death we believe may be the result of criminal conduct;
· About criminal conduct at the location of a Sentara entity; and
· In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of person(s) who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner, medical examiner or funeral director as necessary for them to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special

investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Uses and Disclosures Regarding Food and Drug Administration (FDA)-Regulated Products and Activities.** We may disclose protected health information, without your authorization, to a person subject to the jurisdiction of the FDA for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products.

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 Privacy Contact Person. Your request should indicate in what form you want the information (for example, on paper, electronically.) 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 Privacy Contact Person. 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 Privacy Contact Person. 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 on a in writing on a form provided by Sentara to the Privacy Contact Person. 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 Privacy Contact Person. 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 Privacy Contact Person.

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 in Sentara health care treatment facilities. 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. Subsequent amendments will be mailed to you.

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.

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.

Sentara HIPAA Privacy Contact Person
PO Box 2200
Norfolk, VA 23501
757-857-8494