Newport News Public Schools

Health Plan by Optima Health

POS 1000

Equity 3000 (POS)

Group Health Plan Summary Plan Description

January 1, 2020

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Administrative Information

Important Plan Information:

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

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

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

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

Name of Plans:

POS 1000
Equity 3000 (POS)

Original Plan Effective Date: January 1, 2020

Restated Plan Effective Date: January 1, 2020

Type of Plan: Welfare group health plan

Name and Address of Company or "Plan Sponsor":

Newport News Public Schools
12465 Warwick Boulevard
Newport News, VA 23606-3041

Name, Address and Business Telephone Number of Plan Administrator:

Sentara Health Plans, Inc.
4417 Corporation Lane
Virginia Beach, Virginia, 23462

757-552-7110; 1-800-229-1199

Employer Identification Number (EIN): 54-1398784

Plan Number:

72821 - POS 1000
72822 - Equity 3000 (POS)

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

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

Method of Contribution:

Newport News Public Schools contributes approximately 75% of the aggregate cost of health coverage.

Plan Year:

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

Plan Provider Coordinator and Claims Processing:

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

Agent for Legal Process:

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

Funding For Accumulation of Plan Assets:

The Plan utilizes a fund for the accumulation of assets through which benefits are provided. Benefits are payable directly from assets from a fund established and maintained solely by the Plan Sponsor. Upon termination of offering health care coverage to employees/retirees, Newport News Public Schools will utilize plan assets to pay for incurred claims during the period that the plan was effective.

OPTIMA HEALTH
Notice Informing Individuals About Nondiscrimination and Accessibility Requirements
Discrimination is Against the Law

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

Optima Health:

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

If you need these services, contact:

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

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

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

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

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

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

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

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

Optima Health Alternative Language Options for Notices and other Written Information

Amharic:
ማሳሰቢያ፡
አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260 (TTY: 711) ።

Arabic:
تنبيه: إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجانًا. اتصل بالرقم 1-855-687-6260 (TTY: 711).

Bengali/Bangla:
লক্ষ্য করবেনঃ যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন– 1-855-687-6260 (TTY: 711) ।

Chinese (Mandarin):
注意：如果您讲中文普通话，可以免费获得语言协助服务。请拨打电话 1-855-687-6260 (TTY: 711)。

French:
ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260 (TTY: 711).

German:
ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 (TTY: 711) zur Verfügung.

Gujarati:
ધ્યાન આપો : જો તમે ગુજરાતી બોલી છો તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 (TTY: 711) પર કૉલ કરો.

Hindi:
ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 (TTY: 711) पर कॉल करें।

Hmong:
CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260 (TTY: 711).

Igbo:
GEE NT Ị: ọbụrụ na ị na-asụ Igbo, ị ga-enweta enyemaka n'efu site n'aka ndị ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260 (TTY: 711)

Japanese:
重要：日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260 (TTY: 711) までお電話ください。

Korean:
주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260 (TTY: 711) 번으로 전화해 주십시오.

Kru/Bassa:
YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha I nyuu hola we. Sebel: 1-855- 687-6260 (TTY: 711).

Laotian:
ເຊົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນໍາໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260 (TTY: 711).

Mon-Khmer, Cambodian:
កំណត់សំគាល់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260 (TTY: 711) ។

Navajo:
SHOOH: Diné Bizaad bee yáníłti'go doo bą́ą́h ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'ą́. Kojį' hólne' 1-855-687-6260 (TTY: 711).

Persian/Farsi:
توجه:
اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره (TTY: 711) 1-855-687-6260 تماس بگیرید.

Portuguese:
ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260 (TTY: 711).

Russian:
ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260 (TTY: 711), и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:
ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260 (TTY: 711).

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260 (TTY: 711).

Turkish:
DİKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz. 1-855-687-6260 (TTY: 711) numaralı telefonu arayın.

Urdu:
توجہ دیں:
اگر آپ اُردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ (TTY: 711) 1-855-687-6260 کال کریں۔

Vietnamese:
CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260 (TTY: 711).

Yoruba:
KÉÉRE:
Ti o bá ń sọ èdè Yorùbá, iṣẹ́ ìrànlọ́wọ́ èdè wà fún ọ lọ́fẹ̀ẹ́. Pe 1-855-687-6260 (TTY: 711)

Patient Protection Disclosure

The Health Plan of Newport News Public Schools generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Optima Health at www.OptimaHealth.com; or 757-552-7110 or 1-800-229-1199.

For children, you may designate 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, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Optima Health at www.OptimaHealth.com; or 757-552-7110 or 1-800-229-1199.

Newborns' and Mothers' Health Protection Act of 1996

Under federal law known as the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires the Plan to notify You of Your rights related to benefits provided by the Plan in connection with a mastectomy. Please retain this notice with your important health care records. If you have any questions regarding this Notice or the benefits you are entitled to under the Plan please call Member Services at the number listed on you Plan insurance identification card.

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

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

These benefits are subject to the exclusions, limitations, and conditions including Copayments, Coinsurances, and/or Deductibles set forth in this document.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2020)

HIPAA Privacy Practices Information

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

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

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

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

Newport News Public Schools
12465 Warwick Boulevard
Newport News, VA 23606-3041

If you have questions about the privacy of your health information please contact the plan sponsor:

Newport News Public Schools
12465 Warwick Boulevard
Newport News, VA 23606-3041

If you wish to file a complaint under HIPAA, please contact the plan sponsor:

Newport News Public Schools
12465 Warwick Boulevard
Newport News, VA 23606-3041

OPTIMA POS 1000

POINT OF SERVICE PLAN SUMMARY OF BENEFITS

Newport News Public Schools
Effective January 1, 2020

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Evidence of Coverage or Certificate of Insurance, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. There are two benefit columns. One column lists Your Copayment or the percent Coinsurance You will pay for In Network benefits from Plan Providers. The other column lists Your Copayment or the percent Coinsurance You will pay for Out of Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Summary plan document carefully.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT

	In-Network Benefits	Out-of-Network Benefits
Deductibles per Calendar Year[3]	$1,000 per Person $2,000 per Family	$3,000 per Person $6,000 per Family
Maximum Out-of-Pocket Limit per Calendar Year	$4,750 per Person[4] $9,000 per Family[4]	$6,000 per Person[5] $12,000 per Family[5]

PHYSICIAN SERVICES

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery**[6].

Physician Office Visits	In-Network Benefits Copayments/Coinsurance[2]	Out-of-Network Benefits Copayments/Coinsurances[2]
Primary Care Physician (PCP) Office Visit	You Pay $40	After Deductible You Pay 40%
Virtual Consults Must be furnished by approved Optima Health providers.	Covered at 100%	Virtual Consults are not Covered Out-of-Network
Specialist Office Visit	You Pay $60	After Deductible You Pay 40%
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 30%	After Deductible You Pay 40%
Preventive Care [10,11]	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Routine Annual Physical Exams **Well Baby Exams** **Annual GYN Exams and Pap Smears** [11] **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** **Women's Preventive Services**	Covered at 100%	After Deductible You Pay 40%

OUTPATIENT THERAPY AND REHABILITATION SERVICES		
You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit.		
Short Term Therapy Services[7]	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Physical Therapy **Occupational Therapy** **Pre-Authorization is required.[6]** Physical and Occupational Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 30% per visit	After Deductible You Pay 40% per visit
Speech Therapy **Pre-Authorization is required.[6]** Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 30% per visit	After Deductible You Pay 40% per visit
Short Term Rehabilitation Services[7]	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.[6]** Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 30% per visit	After Deductible You Pay 40% per visit
Other Outpatient Treatments	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	After Deductible You Pay 30%	After Deductible You Pay 40% per visit
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.	After Deductible You Pay 30%	After Deductible You Pay 40%

OUTPATIENT DIALYSIS SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Dialysis Services Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 30% per visit	After Deductible You Pay 40% per visit

OUTPATIENT SURGERY		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Outpatient Surgery **Pre-Authorization is required.[6]** Coinsurance or Copayment applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible You Pay 30%	After Deductible You Pay 40%

OUTPATIENT DIAGNOSTIC PROCEDURES		
Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Diagnostic Procedures	After Deductible You Pay 30%	After Deductible You Pay 40%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 30%	After Deductible You Pay 40%
Lab Work	After Deductible You Pay 30%	After Deductible You Pay 40%

OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Magnetic Resonance Imaging (MRI) **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)** **Sleep Studies** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Pre-Authorization is required for all procedures except MRS, SPECT and Nuclear Cardiology.[6]** Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	After Deductible You Pay 30%	After Deductible You Pay 40%

Maternity Care		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Maternity Care [8, 10,11] **Pre-Authorization is required for prenatal services.[6]** Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	You Pay $500 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 40%

Inpatient Services		
Inpatient Services	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Hospital Services **Pre-Authorization is required.[6]**	After Deductible You Pay 30%	After Deductible You Pay 40%
Transplants **Pre-Authorization is required.[6]**	After Deductible You Pay 30%	After Deductible You Pay 40%
Skilled Nursing Facilities/Services[7] **Pre-Authorization is required.[6]** Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined with In-Network and Out-of-Network benefits per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services.[7]	After Deductible You Pay 30%	After Deductible You Pay 40%

Ambulance Services		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Ambulance Services[9] **Pre-Authorization is required for non-emergent transportation only.[6]** Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	After Deductible You Pay 30%	After Deductible You Pay 30%

Emergency Services		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Emergency Services [2, 9] **Pre-Authorization is not required.** Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.	After Deductible You Pay 30%	After Deductible You Pay 30%

Urgent Care Center Services		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Urgent Care Services[9] **Pre-Authorization is not required.** Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay an Emergency Services Copayment or Coinsurance.	You Pay $60	After Deductible You Pay 40%

MENTAL/BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. **Pre-Authorization is required for Inpatient Services**, **partial hospitalization services, intensive outpatient program (IOP), electro-convulsive therapy, and Transcranial Magnetic Stimulation (TMS).[6]**		
Mental/Behavioral Health/Substance Use Disorder	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Services **Pre-Authorization is required[6]**	After Deductible You Pay 30%	After Deductible You Pay 40%
Outpatient Office Visits	You Pay $40	After Deductible You Pay 40%
Virtual Consults Must be furnished by approved Optima Health providers.	Covered at 100%	Virtual Consults are not Covered Out-of-Network
Other Outpatient Visits **(Includes Hospital Outpatient and Freestanding Outpatient Centers)**	After Deductible You Pay 30%	After Deductible You Pay 40%

DIABETES TREATMENT		
Coverage includes benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating Eye Med Provider at the applicable office visit Copayment or Coinsurance amount.		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Insulin Pumps **Pre-Authorization is required.[6]**	After Deductible You Pay 30%	After Deductible You Pay 40%
Pump Infusion Sets and Supplies **Pre-Authorization is required.[6]**	After Deductible You Pay 30%	After Deductible You Pay 40%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution.	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit
Insulin, Needles, and Syringes	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit
Outpatient Self-Management Training and Education and Nutritional Therapy	After Deductible You Pay 30%	After Deductible You Pay 40%

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

Autism Spectrum Disorder **Pre-Authorization is required.**[6] Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder. "Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of Autism Spectrum Disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder. "Treatment for Autism Spectrum Disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) **Applied Behavioral Analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.** "Applied Behavioral Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. **Coverage for Applied Behavioral Analysis under this benefit is limited to an annual maximum benefit of $35,000.**[6]	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.
Clinical Trials **Pre-Authorization is required.**[6] Coverage of routine patient costs for phase I, II and III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.
Durable Medical Equipment (DME) and Supplies **Orthopedic Devices and Prosthetic Appliances** **Pre-Authorization is required for single items over $750.**[6]	After Deductible You Pay 30%	After Deductible You Pay 40%

Pre-Authorization is required for all rental items.[6] **Pre-Authorization is required for repair and replacement.**[6] Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.		
Early Intervention Services **Pre-Authorization is required.**[6] Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.
Home Health Care Skilled Services[7] **Pre-Authorization is required.**[6] You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.	After Deductible You Pay 30%	After Deductible You Pay 40%
Hospice Care **Pre-Authorization is required.**[6]	After Deductible You Pay 30%	After Deductible You Pay 40%
Preventive Vision Services[7] Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 12 months when done by a participating EyeMed Provider. To contact EyeMed about participating Providers call 1-888-610-2268.	Covered at 100% Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit unless services are considered an Essential Health Benefit (EHB) for children.	For eye examinations from Out-of-Network Non-Plan Providers, Members will be reimbursed up to $30 for an eye examination only. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit.

Telemedicine Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.
Chiropractic Care Rider [7] Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit. To use this benefit call ASH's Member Services at 1-800-678-9133. Representatives are available 8:00 AM to 9:00 PM Monday-Friday. Coverage is limited to a combined maximum benefit with In-and Out-of-Network benefits of 30 visits per calendar year. This benefit also includes coverage of Chiropractic appliances up to a combined maximum benefit with In-and Out-of-Network benefits of 1 appliance per Person per calendar year when medically necessary. For providers not in the ASH network the Member will be responsible for payment of all charges in excess of ASH's allowable charge in addition to any Coinsurance amount. Allowable charge is the lesser of the provider's actual charge or ASH's In-Network fee schedule for the same services.	After Deductible You Pay 30% of ASH's fee schedule	After Deductible You Pay 40% of ASH's fee schedule

Notes

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

Children are covered up to the end of the year in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your benefits. This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

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

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

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

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.

2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

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

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

   - If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits.

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

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

3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. Your Plan may have separate Deductible amounts You have to meet for In-Network Covered Services and for Out-of-Network Covered Services. Amounts applied to an In-Network Deductible will apply toward the Plan's In-Network Maximum Out of Pocket Limit. Amounts applied to an Out-of-Network Deductible will apply toward the Plan's Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage You must satisfy the individual member coverage Deductible before coverage begins. If You have family coverage You and Your family must satisfy the family coverage Deductible. This Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. Amounts You are required to pay for preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to

Preventive Care Visits and Screenings You receive from In-Network Plan Providers. Cost sharing amounts You pay for some Covered Services will not count toward any Deductible. Deductibles will not be reimbursed under the Plan;

4. **Maximum Out of Pocket Limit for In-Network Benefits** means the total dollar amount You and Your family pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's Out-of-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out of Pocket Amount Optima Health will cover most In-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Plan In-Network benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out of Pocket Amount Optima Health will cover most In-Network benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayments or Coinsurances or any other charges for the following will not count toward Your In-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Balance billing amounts from Non-Plan Providers;
    4. Premium amounts;
    5. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available;
    6. Except for Emergency Services, amounts You pay for Out-of-Network Services;
    7. Cost Sharing amounts including Copayments, Coinsurance, and Deductibles for the following:
        i. Amounts You pay for Vision care unless services are considered an Essential Health Benefit (EHB) for children;
        ii. Amounts You pay for any benefits covered under a plan rider including riders for Vision Care and Materials unless services are considered an Essential Health Benefit (EHB) for children, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction unless services are considered an Essential Health Benefit (EHB) for children.

5. **Maximum Out of Pocket Limit for Out-of-Network Benefits** means the total dollar amount You and Your family will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's In- Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Deductibles, Copayments, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Amounts You pay for In- Network Benefits;
    4. Amounts You pay for Vision care;
    5. Amounts You pay for any benefits covered under a plan rider including riders for Infertility Treatment, Vision Care and Materials, Hearing Aids, Chiropractic Care, Oral Surgery/Wisdom Teeth Extraction
    6. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available. Ancillary charges are not Covered Services;
    7. Amounts applied to Your In-Network Deductible;
    8. Balance billing amounts that exceed the Plan's Allowable Charge for a Covered Service from a Non-Plan Provider;

9. Premium amounts;
10. Amounts You pay for transplant services from Non-Plan Providers

6. This benefit requires Pre Authorization before You receive services. We have instructions and procedures in place for providers to obtain Pre-Authorization through Case Management/Clinical Care Services. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.

7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. Unless otherwise noted benefit limits are combined for services received both In-Network and Out-of-Network and for all places of service. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your In-Network or Out-of-Network Maximum Out of Pocket Maximum Limit.

8. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.

9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had You received care from a Plan Provider

10. Preventive Care includes the services listed below. You may be responsible for an office visit Copayment or Coinsurance when You receive preventive care. Some services may be administered under Your prescription drug benefit under the Plan. Where no frequency or limits are indicated the Plan will use it's normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Services covered under the Plan's outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

    1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;

    2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

    3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

    4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:

- **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
- **Contraceptive Methods and Counseling including:** Food and Drug Administration-approved 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.

11. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your SPD in the Utilization Management Section for more information on Pre-Authorization.

OPTIMA EQUITY 3000 (POS NETWORK)		
POINT OF SERVICE PLAN SUMMARY OF BENEFITS		

Newport News Public Schools
Effective January 1, 2020

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Summary plan document, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. There are two benefit columns. One column lists Your Copayment or the percent Coinsurance You will pay for In Network benefits from Plan Providers. The other column lists Your Copayment or the percent Coinsurance You will pay for Out of Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Summary plan document carefully.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT		
	In-Network Benefits	**Out-of-Network Benefits**
Deductibles per Calendar Year[3]	$3,000 per Person $6,000 per Family	$3,000 per Person $6,000 per Family
Maximum Out-of-Pocket Limit per Calendar Year	$4,000 per Person[4] $8,000 per Family[4]	$6,000 per Person[5] $12,000 per Family[5]

PHYSICIAN SERVICES

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery**[6].

Physician Office Visits	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Primary Care Physician (PCP) Office Visit	After Deductible Covered at 100%	After Deductible You Pay 30%
Virtual Consults Must be furnished by approved Optima Health providers.	After Deductible Covered at 100%	Virtual Consults are not Covered Out-of-Network
Specialist Office Visit	After Deductible Covered at 100%	After Deductible You Pay 30%
Vaccines and Immunotherapeutic Agents This does not include routine immunizations covered under Preventive Care.	After Deductible Covered at 100%	After Deductible You Pay 30%
Preventive Care [10,11]	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Routine Annual Physical Exams **Well Baby Exams** **Annual GYN Exams and Pap Smears** [11] **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** **Women's Preventive Services**	Covered at 100%	After Deductible You Pay 30%

OUTPUT THERAPY AND REHABILITATION SERVICES		
You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit.		
Short Term Therapy Services[7]	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Physical Therapy **Occupational Therapy** **Pre-Authorization is required.[6]** Physical and Occupational Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible Covered at 100%	After Deductible You Pay 30% per visit
Speech Therapy **Pre-Authorization is required.[6]** Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible Covered at 100%	After Deductible You Pay 30% per visit
Short Term Rehabilitation Services[7]	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.[6]** Copayment or Coinsurance applies at any place of service.	After Deductible Covered at 100%	After Deductible You Pay 30% per visit
Other Outpatient Treatments	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	After Deductible Covered at 100%	After Deductible You Pay 30% per visit
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.	After Deductible Covered at 100%	After Deductible You Pay 30%

OUTPATIENT DIALYSIS SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Dialysis Services Copayment or Coinsurance applies at any place of service.	After Deductible Covered at 100%	After Deductible You Pay 30% per visit

OUTPATIENT SURGERY		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Outpatient Surgery **Pre-Authorization is required.[6]** Coinsurance or Copayment applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible Covered at 100%	After Deductible You Pay 30%

OUTPATIENT DIAGNOSTIC PROCEDURES		
Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Diagnostic Procedures	After Deductible Covered at 100%	After Deductible You Pay 30%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible Covered at 100%	After Deductible You Pay 30%
Lab Work	After Deductible Covered at 100%	After Deductible You Pay 30%

OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Magnetic Resonance Imaging (MRI) **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)** **Sleep Studies** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Pre-Authorization is required for all procedures except MRS, SPECT and Nuclear Cardiology.[6]** Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	After Deductible Covered at 100%	After Deductible You Pay 30%

Maternity Care		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Maternity Care [8, 10,11] **Pre-Authorization is required for prenatal services.[6]** Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	After Deductible Covered at 100%	After Deductible You Pay 30%
Inpatient Services		
Inpatient Services	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Hospital Services **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 30%
Transplants **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 30%
Skilled Nursing Facilities/Services[7] **Pre-Authorization is required.[6]** Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined with In-Network and Out-of-Network benefits per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services.[7]	After Deductible Covered at 100%	After Deductible You Pay 30%
Ambulance Services		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Ambulance Services[9] **Pre-Authorization is required for non-emergent transportation only.[6]** Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	After Deductible Covered at 100%	After Deductible You Pay 30%
Emergency Services		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Emergency Services [2, 9] **Pre-Authorization is not required.** Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.	After Deductible Covered at 100%	After Deductible Covered at 100%
Urgent Care Center Services		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Urgent Care Services[9] **Pre-Authorization is not required.** Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay an Emergency Services Copayment or Coinsurance.	After Deductible Covered at 100%	After Deductible You Pay 30%

MENTAL/BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. **Pre-Authorization is required for Inpatient Services**, **partial hospitalization services, intensive outpatient program (IOP), electro-convulsive therapy, and Transcranial Magnetic Stimulation (TMS).[6]**		
Mental/Behavioral Health/Substance Use Disorder	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Services **Pre-Authorization is required[6]**	After Deductible Covered at 100%	After Deductible You Pay 30%
Outpatient Office Visits	After Deductible Covered at 100%	After Deductible You Pay 30%
Virtual Consults Must be furnished by approved Optima Health providers.	After Deductible Covered at 100%	Virtual Consults are not Covered Out-of-Network
Other Outpatient Visits **(Includes Hospital Outpatient and Freestanding Outpatient Centers)**	After Deductible Covered at 100%	After Deductible You Pay 30%

DIABETES TREATMENT		
Coverage includes benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating EyeMed Provider at the applicable office visit Copayment or Coinsurance amount.		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Insulin Pumps **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 30%
Pump Infusion Sets and Supplies **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 30%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution.	After Deductible Covered at 100%	After Deductible You Pay 30%
Insulin, Needles, and Syringes	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit
Outpatient Self-Management Training and Education and Nutritional Therapy	After Deductible Covered at 100%	After Deductible You Pay 30%

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Prosthetics and Components **Pre-Authorization is required.[6]** Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components. "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	After Deductible Covered at 100%	After Deductible You Pay 30%

mean or include prosthetic devices designed primarily for an athletic purpose.		
Autism Spectrum Disorder **Pre-Authorization is required.**[6] Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder. "Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of Autism Spectrum Disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder. "Treatment for Autism Spectrum Disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) **Applied Behavioral Analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.** "Applied Behavioral Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. **Coverage for Applied Behavioral Analysis under this benefit is limited to an annual maximum benefit of $35,000.**[6]	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.
Clinical Trials **Pre-Authorization is required.**[6] Coverage of routine patient costs for phase I, II and III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Durable Medical Equipment (DME) and Supplies **Orthopedic Devices and Prosthetic Appliances** **Pre-Authorization is required for single items over $750.[6]** **Pre-Authorization is required for all rental items.[6]** **Pre-Authorization is required for repair and replacement.[6]** Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.	After Deductible Covered at 100%	After Deductible You Pay 30%
Early Intervention Services **Pre-Authorization is required.[6]** Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.
Home Health Care Skilled Services **Pre-Authorization is required.[6]** You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.	After Deductible Covered at 100%	After Deductible You Pay 30%
Hospice Care **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 30%
Preventive Vision Services[7] Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 12 months when done by a participating EyeMed Provider. To contact EyeMed about participating Providers call 1-888-610-2268.	Covered at 100% Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.	For eye examinations from Out-of-Network Non-Plan Providers, Members will be reimbursed up to $30 for an eye examination only. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit unless services are considered an Essential Health Benefit (EHB) for children.
Telemedicine Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount

	Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.	You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.
Chiropractic Care Rider [7] Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit. To use this benefit call ASH's Member Services at 1-800-678-9133. Representatives are available 8:00 AM to 9:00 PM Monday-Friday. Coverage is limited to a combined maximum benefit with In-and Out-of-Network benefits of 30 visits per calendar year. This benefit also includes coverage of Chiropractic appliances up to a combined maximum benefit with In-and Out-of-Network benefits of 1 appliance per Person per calendar year when medically necessary. For providers not in the ASH network the Member will be responsible for payment of all charges in excess of ASH's allowable charge in addition to any Coinsurance amount. Allowable charge is the lesser of the provider's actual charge or ASH's In-Network fee schedule for the same services.	After Deductible You Pay 0% of ASH's fee schedule	After Deductible You Pay 30% of ASH's fee schedule

NOTES

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

Children are covered up to the end of the year in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your benefits. This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

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

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

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

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.

2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

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

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

   - If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits.

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

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

3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. If You have individual coverage You must satisfy the individual member Deductible before Coverage begins. If You have family coverage You must satisfy the family coverage Deductible. Your Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. A Plan may have separate individual and family Deductibles for In-Network Covered Services and for Out-of-Network Services. Deductibles will not be reimbursed under the Plan. The Deductible does not apply to Preventive Care Visits and Screenings from In-Network Plan Providers. Amounts applied to Your In-Network Deductible will apply toward Your Plan's In-Network Maximum Out of Pocket Limit. Amounts applied to Your Out-of-Network Deductible will apply toward Your Out-of-Network Maximum Out of Pocket Limit. Should the Federal Government adjust the

Deductible for high Deductible health plans as defined by the Internal Revenue Service, the Deductible amount in the Policy will be adjusted accordingly.

4. **Maximum Out of Pocket Limit for In-Network Benefits** means the total dollar amount You and Your family pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's Out-of-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out of Pocket Amount Optima Health will cover most In-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Plan In-Network benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out of Pocket Amount Optima Health will cover most In-Network benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayments or Coinsurances or any other charges for the following will not count toward Your In-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Balance billing amounts from Non-Plan Providers;
    4. Premium amounts;
    5. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available;
    6. Except for Emergency Services, amounts You pay for Out-of-Network Services

5. **Maximum Out of Pocket Limit for Out-of-Network Benefits** means the total dollar amount You and Your family will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's In-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out-of-Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Deductibles, Copayments, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Amounts You pay for In- Network Benefits;
    4. Amounts You pay for Vision care;
    5. Amounts You pay for any benefits covered under a plan rider including riders for Infertility Treatment, Vision Care and Materials, Hearing Aids, Chiropractic Care, Oral Surgery/Wisdom Teeth Extraction
    6. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available. Ancillary charges are not Covered Services;
    7. Amounts applied to Your In-Network Deductible;
    8. Balance billing amounts that exceed the Plan's Allowable Charge for a Covered Service from a Non-Plan Provider;
    9. Premium amounts;
    10. Amounts You pay for transplant services from Non-Plan Providers

6. This benefit requires Pre-Authorization before You receive services. We have instructions and procedures in place for providers to obtain Pre-Authorization through Case Management/Clinical Care Services. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.

7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. Unless otherwise noted benefit limits are combined for services received both In-Network and Out-of-Network and for all places of service. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your In-Network or Out-of-Network Maximum Out of Pocket Maximum Limit.

8. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.

9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had You received care from a Plan Provider

10. Preventive Care includes the services listed below. You may be responsible for an office visit Copayment or Coinsurance when You receive preventive care. Some services may be administered under Your prescription drug benefit under the Plan. Where no frequency or limits are indicated the Plan will use it's normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Services covered under the Plan's outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

   1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;

   2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

   3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

   4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:

      - **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
      - **Contraceptive Methods and Counseling including:** Food and Drug Administration-approved 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.

11. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your SPD in the Utilization Management Section for more information on Pre-Authorization.

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

ACCIDENT/INJURY means physical damage to a Covered Person's body caused by an unexpected event or trauma, independent of all other causes. Only a non-occupational Injury (i.e., one which does not arise out of or in the course of any work for pay or profit) is considered for benefits under the Plan. However, if proof, acceptable to the Plan, is furnished to the Plan that a Covered Person covered under a Workers' Compensation law, or similar law, is not covered for a particular accident or injury under such law, then such accident or injury shall be considered "non-occupational," regardless of its cause.

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

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

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

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

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 Covered Services received from Non-Plan Providers will be Covered under Out of Network benefits.

When a Covered Person uses Out-of-Network benefits from Non-Plan Providers the Allowable Charge may be a negotiated rate; or if there is no negotiated rate the Allowable Charge is the Plan's In-Network contracted rate for the same service performed by the same type of Provider

or the Provider's actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full. Except during an Emergency, if Covered Persons use a Non-Plan Provider who charges more than our allowable amount the Provider may balance bill the Covered Person for the difference. Covered Persons will have to pay the difference to the Provider in addition to their Copayment or Coinsurance amount. Charges from Non-Plan Providers will be higher than the Plan's Allowable Charge so Covered Persons will usually pay more out of pocket when using Out of Network benefits.

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

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

CLAIM means a request for a Plan benefit or benefits made by a claimant in accordance with the Plan's reasonable procedure for filing claims.

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

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law No. 99-272, and any subsequent amendments thereto. COBRA provisions apply to groups of more than 20 employees.

COINSURANCE means amounts required to be paid by the Covered Person for certain services covered under this Plan. Coinsurance amounts are expressed as a percentage of the Plan's fee schedule or of an allowable charge for a specific health care service. Coinsurance may be required to be paid to the provider of the service at the time service is received.

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

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

COORDINATION OF BENEFITS means those provisions by which the Plan Provider or the Plan either together or separately seek to recover costs of health care services provided to a Covered Person in connection with an incident of sickness or Accident, which may be covered by another group insurer, group service plan, or group health care plan including coverage provided under governmental programs subject to any limitations imposed by this Summary Plan Description.

COPAYMENT means a specific dollar amount which may be collected directly from a Covered Person as payment for Covered Services covered under this Plan. Copayment may be required to be paid to the provider of the service at the time service is received.

COVERAGE means the right of the Covered Person to receive those health care benefits of the Plan he or she has chosen, as set forth herein.

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

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

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

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

"Custodial Care" includes the following care: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, per the attending Physician, has reached the maximum level of recovery; and (2) in the case of institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and (3) rest cures, respite care and home care provided by family members. The Plan or its designee will determine if a service or treatment is Custodial Care.

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

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

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

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

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

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

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

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

1. The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
2. The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies; or
3. The research regarding this drug, device, medical treatment or procedure may be so limited than an evaluation of safety and efficacy cannot be made; or
4. The drug or device is not approved for marketing by the 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.

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

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

HOME HEALTH CARE PLAN means a program:
1. For the care and treatment of the Covered Person in his or her home;
2. Established and approved in writing by his or her attending Physician;
3. Certified, by the attending Physician, as required for the proper treatment of the injury or illness, and
4. In place of inpatient treatment in a Hospital or in a Skilled Nursing Facility.

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

HOSPICE SERVICES means a coordinated program of home and inpatient care including palliative and supportive physical, psychological, psychosocial and other Covered Services to individuals with a terminal illness, whose medical prognosis is death within six months.

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

"Hospital" does not include a facility, or part thereof, which is principally used as: a rest or custodial care facility, nursing facility, convalescent facility, extended care facility, or facility for the aged or for the care and treatment of drug addicts or alcoholics, unless specifically provided in the Summary Plan Description and/or as mandated by state or Federal law. It does not mean any institution in which the Covered Person receives treatment for which he or she is not required to pay.

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

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

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

MEDICAL DIRECTOR means a duly licensed Physician or his/her designee who has been appointed by the Plan to monitor the quality and delivery of health care to Covered Persons in accordance with the Summary Plan Description and the accepted medical standards of the community.

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

1. Required to identify, evaluate or treat the Member's condition, disease, ailment or injury, including pregnancy related conditions;
2. In accordance with recognized standards of care for the Member's condition, disease, ailment or injury;
3. Appropriate with regard to standards of good medical practice;
4. Not solely for the convenience of the Member or participating Physician, Hospital, or other health care provider; and
5. The most appropriate supply or level of service which can be safely provided to the Member as substantiated by the records and documentation maintained by the provider of the services or supplies.

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

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

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

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

PHYSICIAN means a doctor of medicine or osteopathy who is duly licensed under the laws of the state where the health care service is rendered, as qualified to perform the particular medical or surgical service for which claim is made and who is practicing within the scope of such certification or licensure. "Physician" does not include (1) an intern; or (2) a person in training.

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

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

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

PLAN PROVIDER means a Physician, Hospital, Skilled Nursing Facility, urgent care center, laboratory, or any other duly licensed institution or health professional under contract to provide professional and hospital services to Covered Persons.

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

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

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

PRE-AUTHORIZATION means an evaluation process which assesses the Medical Necessity of proposed treatment to determine that the treatment is being provided at the appropriate level of care.

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

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

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

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

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

SERVICE AREA means the geographic area within which the Plan shall arrange for the provision of Covered Services through Plan Providers.

Services from Plan Providers are available only through the Optima Health defined service area and PHCS.

SKILLED NURSING FACILITY means an institution which is licensed by the State and is accredited under one of the programs of the Joint Commission on Accreditation of Healthcare

Organizations as a Skilled Nursing Facility; or is recognized by Medicare as an extended care facility; and furnishes room and board and 24 hour a day skilled nursing care by, or under the supervision of, an R.N. ; and, other than incidentally, is not a clinic, a rest facility, a home for the aged, a place for drug addicts or alcoholics, or a place for custodial care.

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

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

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

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

USUAL AND CUSTOMARY CHARGES means the lower of the rate which a Provider usually charges for furnishing a treatment, service or supply; or the charge determined to be the general rate charged by others who render or furnish such treatments, services or supplies to persons: (1) who reside in the same area; and (2) whose injury or illness is comparable in nature and severity. When applied to a Plan Provider, "Usual and Customary Charges" means the compensation agreed to by the Plan Provider in its contract with respect to Covered Persons. Usual and Customary Charges shall be determined by the Plan.

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

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

YOU/YOUR means the Covered Person.

HOW BENEFITS ARE PAYABLE

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

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

Covered Persons may choose to receive most Covered Services from:

- The Plan's In-Network Level from Plan Providers;

  or

- The Plan's Out-of-Network Level from Non-Plan Providers.

IN-NETWORK COVERAGE -

Services obtained by a participating Optima Health and PHCS providers are covered as In-Network. PHCS providers are covered when the member is outside of the Optima Health Plan service area.

Except for Emergency Services, all Covered Services must be received from Plan Providers in order to be covered at the In-Network level of benefits. The Covered Person will be responsible for all applicable Copayments, Coinsurance and/or Deductibles specified on the Plan's Schedule of Benefits.

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 Covered Services must be Medically Necessary and are subject to the Plan's Pre-authorization procedures, exclusions, limitations, and conditions including Copayments, Coinsurance and/or Deductibles set forth herein.

Composition of Provider Network

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

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

Primary Care Providers

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

Specialty Care Providers

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

OUT-OF-NETWORK COVERAGE

Covered Persons may receive Covered Services directly, without a referral from a PCP, from Non-Plan Providers at the Out-of-Network level of benefits subject to the exclusions, limitations, and conditions including Copayments and Coinsurance set forth herein. All services must be deemed to be or have been Medically Necessary.

Covered medical expenses are the Usual and Customary Charges for Medically Necessary treatment, services and supplies as follows:

Benefits will be payable at the coinsurance rate of the Usual and Customary and/or Allowable Charge as defined herein, after any applicable deductible, as shown in the Schedule of Benefits. All benefits are subject to the Definitions, Benefit Limitations and Exclusions in this document. Covered Services are subject to all applicable Utilization Management requirements. In the absence of due proof to the contrary, when a single charge is made for a series of services, each service will be considered to bear a pro rata share of the charge.

Please Refer To Your Schedule Of Benefits For Applicable Copayments, Coinsurance or Deductibles applicable to Out-of-Network Coverage.

Accessing Care Outside of the Plan's Service Area:

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

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. Amounts You pay as a result of balance billing will not accumulate toward Deductible and Maximum Out-of-Pocket amounts.

All non-emergency care outside the Service Area must be received from Plan Providers to be covered at the In-Network level of benefits.

PRE EXISTING CONDITIONS WAITING PERIODS

There are no preexisting condition waiting periods.

DEDUCTIBLES

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

The Deductibles under this Plan are found in the Schedule of Benefits.

MAXIMUM BENEFIT

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

MAXIMUM OUT OF POCKET AMOUNT

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

This section explains the internal Claim decision processes and how the Plan will determine Medical Necessity for payment of a Claim. The Plan uses the following review processes to make coverage decisions on Pre-Service, Post-Service, Concurrent, and Urgent Care Claims:

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

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

Pre-Authorization

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

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

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

- Inpatient hospitalization services;
- Partial hospitalization services;
- 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;
- Hospice services;

- Oral surgery;
- TMJ services;
- Tubal ligation;
- Hospitalization and anesthesia for dental procedures;
- Treatment of lymphedema;
- Magnetic resonance imaging (MRI);
- Magnetic resonance angiography (MRA);
- Positron emission tomography (PET) scans;
- Computerized axial tomography (CT) scans;
- Computerized axial tomography angiogram (CTA) scans;
- Transplant services;
- Injectable and infused medications, biologics, and IV therapy medications defined by our Pharmacy Committee;
- Intensive outpatient programs (IOP);
- Electro-convulsive therapy;
- Transcranial magnetic stimulation;
- Chemotherapy and Chemotherapy Drugs;
- Radiation Therapy;
- Insulin pumps and pump supplies.

Pre-Service Claims Decisions

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

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

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

Expedited Decisions For Urgent Care Claims

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

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

The Plan will notify the Covered Person/Provider of our decision not later than 72 hours from receipt of the request for service. If additional information is required to make a decision the Plan will notify the Covered Person/Physician within 24 hours of receipt of the request. The

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

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

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

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

Post Service Claims

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

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

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

Adverse Benefit Determinations

You have certain rights if the Plan denies a request for Pre-Authorization or make other Adverse Benefit Determinations. The Plan will provide written notice of Adverse Benefit Determinations. For Urgent Claims notification may be provided orally and then confirmed in writing up to three days after the oral notice.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, experimental treatment, or similar exclusion or limit, You are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances. Please also read Section 13 Adverse Benefit Determination Internal and External Appeal Process.

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

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

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

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 Covered Services You receive from Non-Plan Providers will be Covered under Out of Network Benefits.

ACCIDENTAL DENTAL SERVICES –

Pre-Authorization is required.

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

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

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

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

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

ALLERGY CARE

The Plan will cover the following allergy care services:

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

AMBULANCE, STRETCHER, & WHEELCHAIR SERVICES

Pre-Authorization is required for non-emergency transportation.

In an Emergency the Plan will cover ambulance services from the place of Accident/Injury to the nearest Hospital where treatment can be provided. Transportation must be provided by a professional agency authorized to provide service in a vehicle staffed by medically trained personnel equipped to handle a medical Emergency. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life or loss of limb.

Non-emergent transportation must be pre-authorized by the plan. The Plan will not cover transportation that is not required by the person's physical or mental condition. Transportation from Hospital to Hospital may be covered if Medically Necessary and Pre-Authorized by the Plan.

The Plan will provide reimbursement directly to the professional agency for Covered Services provided by an emergency medical services vehicle when presented with an assignment of benefits.

ANESTHESIA SERVICES -

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

AUTISM SPECTRUM DISORDER

Coverage includes the Diagnosis and Treatment of Autism spectrum disorder.

Coverage for Applied behavior analysis under this benefit will be subject to an annual maximum benefit of $35,000.

The following definitions apply to all Covered Services provided under this benefit.

Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

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

Diagnosis of Autism spectrum disorder means Medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism spectrum disorder.

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

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

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

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

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

Treatment plan means a plan for the Treatment of Autism spectrum disorder developed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

Except for inpatient services, if an individual is receiving Treatment for an Autism spectrum disorder, the Plan will have the right to request a review of that Treatment, including an independent review, not more than once every 12 months unless the Plan and the individual's licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review, including an independent review, will be covered under the Plan.

Coverage under this section will not be subject to any visit limits, and will not be different or separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors.

The Plan may apply benefit management and Pre-authorization procedures to determine the appropriateness of, and Medical Necessity for, Treatment of Autism spectrum disorder in the same way that they apply them to all other Covered Services under the Plan.

Coverage for Autism spectrum disorder is in addition to coverage provided under the Plan for Early Intervention Services and Mental Health and Substance Use Disorder Covered Services.

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

Pre-Authorization is required.

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

Bone or Joint treatment involving a bone or joint of the head, neck, face or jaw is covered like any other bone or joint of the skeletal structure. Covered Persons who choose to receive care from Non-Plan dentists or oral surgeons may be billed by the Non-Plan Provider for charges in excess of the Plan's fee schedule.

CHEMOTHERAPY, RADIATION THERAPY, IV THERAPY, AND INHALATION THERAPY

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

CHIROPRACTIC SERVICES

This benefit is administered by American Specialty Health (ASH) to provide Chiropractic Services in the Plan's Service Area. If You have questions about what is covered or how to find an ASH provider please call ASH toll free at 1-800-678-9133 Monday through Friday 8 a.m. to 9 p.m.

To receive services call an ASH participating provider and schedule an appointment. You do not need a referral. The number of visits allowed per year, any benefit maximums, and Your out of pocket amounts are listed on the Schedule of Benefits.

Covered Services

Covered Services include examination, re-examination, manipulation, conjunctive therapy, radiology, chiropractic appliances, and laboratory tests related to the delivery of chiropractic services subject to the following:

- An initial examination is performed by the participating provider to determine the nature of the Member's problem and, if covered services appear warranted, a treatment plan of services to be furnished is prepared. One initial examination is provided for each new patient. A Copayment is required when services are rendered.

- A re-examination may be performed by the participating provider to assess the need to continue, extend, or change a treatment plan approved by ASH. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a co-payment is required.
- Subsequent office visits, as set forth in a treatment plan approved by ASH, may involve an adjustment, a brief re-examination and other services, in various combinations. A co-payment is required for each visit to the office.
- Adjunctive therapy, as set forth in a treatment plan approved by ASH, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.
- X-rays and clinical laboratory tests are payable in full when referred by a participating chiropractor and authorized by ASH. Radiological consultations are a covered benefit when authorized by ASH as Medically Necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital which has contracted with ASH to provide those services.
- Chiropractic appliances are covered up to the limit stated on the Schedule of Benefits.

Exclusions and Limitations

The following are excluded from Coverage:

- Any services or treatments not authorized by ASH, except for initial examination and Emergency Services.
- Any services or treatments not delivered by participating chiropractors for the delivery of chiropractic care to Members, except for Emergency Services.
- Services for examinations and/or treatments for conditions other than those related to neuromusculoskeletal disorders from participating chiropractors.
- Hypnotherapy, behavior training, sleep therapy, and weight programs.
- Thermograph.
- Services, lab tests, X-rays and other treatments not documented as clinically necessary as appropriate or classified as experimental or investigational and/or as being in the research stage.
- Services and/or treatments that are not documented as Medically Necessary services.
- Magnetic resonance imaging, CAT scans, bone scans, and nuclear radiology and any diagnostic radiology other than covered plain film studies.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help or any self-help physical exercise training or any related diagnostic testing.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Any services or treatments for pre-employment physicals or vocational rehabilitation.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment, except as described as covered in this section.
- Services provided by a chiropractor practicing outside the Service Area, except for Emergency Services.
- Hospitalization, anesthesia, manipulation under anesthesia and other related services.

- All auxiliary aids and services, including but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.

CLINICAL TRIALS

Pre-Authorization is required.

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

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

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

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

Definitions for this section include:

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

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

FDA means the Federal Food and Drug Administration.

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

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

NCI means the National Cancer Institute.

NIH means the National Institutes of Health.

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

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

DIABETIC EQUIPMENT AND SUPPLIES

The Plan covers equipment and supplies prescribed by a provider for the treatment of these types of conditions:
- Insulin dependent diabetes;
- Gestational diabetes;
- Insulin using diabetes; and
- Non-insulin using diabetes.

The Plan will also cover outpatient self-management training and education when provided in person. This training and education includes medical nutrition therapy. Training must be provided by a certified, registered or licensed health care professional.

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

An annual diabetic exam is covered from a Plan Provider at the applicable office visit Copayment or Coinsurance amount.

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

Health Savings Account (HSA) Plans - Members may call EdgePark Medical Supplies at 1-888-394-5375 or Home Care Delivered at 1-800-867-4412 to arrange for prescribed testing supplies to be delivered to them at home. Insulin, syringes and needles are covered under the Plan's prescription drug benefit.

Non-Health Savings Account (HSA) Plans - Insulin, syringes, needles, blood glucose meters, test strips, lancets, lancet devices and control solution are covered under the Plan's Prescription Drug Benefit.

DIAGNOSTIC, X-RAY, AND LABORATORY SERVICES

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

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

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

Pre-Authorization is required for items over $750.

Pre-Authorization is required for all rental items.

Pre-Authorization is required for all repair and replacement.

The Plan covers DME prescribed by an appropriate Physician for the care and treatment of disease and Accident/Injury. The Plan also covers colostomy, ileostomy, and tracheostomy supplies, and suction and urinary Catheters .The Plan will only cover DME that is Medically Necessary. The Plan does not cover DME used primarily for the comfort and well-being of a Member. The Plan does not cover DME if deemed useful, but not absolutely necessary for Your care. The Plan will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items.

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

Coverage for Prosthetic appliances includes Medically Necessary surgically implanted prosthetic devices. For Children up to age 18 The Plan will cover replacement of prosthetic devices for growth if Medically Necessary. This also applies if the Child's condition is from an Accident/Injury or Illness which happened before the Child became a Covered Person under this Plan.

EARLY INTERVENTION SERVICES

Pre-Authorization is required.

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

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

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

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

EMERGENCY SERVICES

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 medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

The Plan covers Emergency Services In-Network or Out-of-Network. Emergency Services do not require Pre-authorization In-Network or Out-of-Network. Your Copayment or Coinsurance amount will be determined by the type and place of service associated with the Emergency. Your Schedule of Benefits lists Your out of pocket Copayment or Coinsurance rate for Emergency Services, inpatient hospital Admissions, ambulance services and urgent care visits. If You receive Emergency Services Out-of-Network from a Non-Plan Provider 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 at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket amounts.

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:

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

You must notify the Plan within 48 hours or 2 business days when You receive Emergency Services and You are admitted to the hospital from the emergency department. If You can't notify the Plan because of Your medical condition, have a friend or relative call Us. You can use the number on the back of Your ID card.

Some examples of Emergency Medical Conditions include:

- Heart attacks;
- Severe chest pain;
- Strokes;
- Excessive bleeding;
- Poisoning;
- Major burns;
- Loss of consciousness;
- Serious breathing difficulties;
- Spinal injuries; and
- Shock.

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

Ambulance Services means transportation services from the place of injury to the nearest hospital where treatment can be provided. Transportation must be provided by a professional

agency authorized to provide service in a vehicle staffed by medically trained personnel equipped to handle a medical emergency. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life. Pre-authorization is required for non-emergent Transportation only. Copayment or Coinsurance is applied per transport each way.

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. If transferred to an Emergency Department from an urgent center, You will pay an Emergency Services Copayment or Coinsurance. Pre-authorization is not required.

Retrospective Review means Our review of Your medical records and any other supporting documentation after You have received emergency treatment or non-authorized services. Emergency, Urgent Care, Ambulance, and Emergency Mental Health Services may be subject to Retrospective Review to determine responsibility for payment.

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

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

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

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

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

FAMILY PLANNING SERVICES

The Plan covers the following services:

- Counseling and education for birth control options;
- Tubal ligation services (Pre-authorization is required);
- Vasectomy services;
- Depo-Provera, lunelle injections or other injections approved by the plan;
- Intrauterine devices (IUDs) and cervical caps and their insertion;

- All other Food and Drug Administration (FDA) approved contraceptive methods as required by Women's Preventive Services under ACA recommended preventive care guidelines.

HEMOPHILIA AND CONGENITAL BLEEDING DISORDERS

Pre-Authorization is required for home treatment.

The Plan covers the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits include the purchase of blood products and blood infusion equipment required for home treatment. The home treatment program must be under the supervision of the state-approved hemophilia treatment center.

HOME HEALTH CARE SKILLED SERVICES

Pre-Authorization is required.

The Plan covers Home Health Care Skilled Services for Covered Persons who are homebound for medical reasons, physically unable to seek care on an outpatient basis, or in place of inpatient hospitalization. You will pay a separate outpatient therapy Copayment or Coinsurance amount for Physical, Occupational and Speech Therapy. Therapy visits received at home will count toward your Plan's annual Outpatient Therapy Benefit Limits. See Your Schedule of Benefits for visit limits.

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

The Plan will not cover any services not in the approved Home Health Care Plan. If Your home care includes any therapy or rehabilitation benefits they will count toward Your total benefit limit for therapy services.

The following definitions apply to services under this section:

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

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

Home Health Care Plan" means a program:

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

- Certified, by the attending Physician, as required for the proper treatment of the injury or Illness, in place of inpatient treatment in a Hospital or in a Skilled Nursing Facility.

Home Health Care Skilled Services means:
- Part-time or intermittent nursing care by a nurse; or
- Part-time or intermittent home health aide services which consist primarily of medical or therapeutic caring for the patient; or
- Physical, speech, and occupational therapy, if provided by the home health care agency; or
- Surgical dressings, medical appliances, oxygen and supplies which are Medically Necessary for treatment of the Member at home, but only to the extent such items or services would have been covered under this Plan if the Covered Person had been confined in a Hospital or Skilled Nursing Facility.

Home Health Skilled Care Visit means:
- Each visit by an R.N. or by an L.P.N. to provide nursing care; or
- Each visit by a therapist to provide physical, occupational, or speech therapy.

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

HOSPICE CARE

Pre-Authorization is required.

The Plan will cover Hospice Services for Covered Persons whose condition has been diagnosed as terminal with a life expectancy of 6 months, and who elect to receive Palliative Care instead of curative care.

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

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

HOSPITAL SERVICES

Pre-Authorization is required.

Inpatient Room and Board

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

Other Hospital Services

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

- Physician, surgical and general nursing care;
- Use of operating and recovery room facilities;
- Use of intensive care or cardiac care units and services;
- Use of delivery room and care
- Laboratory services;
- Diagnostic tests;
- X-ray facilities (diagnosis and therapy);
- Medications;
- Anesthesia and oxygen services;
- Inhalation therapy;
- Physical and occupational therapy;
- Dialysis, hemodialysis, peritoneal;
- Blood and blood products and their administration;
- Surgically implanted prosthetic devices;
- Outpatient ambulatory surgical or other services (i.e., observation room);
- Medical detoxification;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Injectable medications
- Nuclear medicine services;
- Other services approved by the plan.

Inpatient Length of Stay Requirements

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

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

HOSPITALIZATION AND ANESTHESIA FOR DENTAL PROCEDURES

Pre-Authorization is required.

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

- Be under age 5; or
- Severely disabled; or

- Have a medical condition that requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment.

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

INFANT HEARING SCREENINGS

Pre-Authorization is required.

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

INTERRUPTION OF PREGNANCY SERVICES

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

LYMPHEDEMA

Pre-Authorization is required.

The Plan will cover the following services to treat lymphedema if they are prescribed by a health care professional legally authorized to prescribe or provide such items under law:
- Equipment;
- Supplies;
- Complex decongestive therapy;
- Outpatient self-management training and education;

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

MATERNITY SERVICES –

Pre-Authorization is required for prenatal services.

The Plan will cover the following maternity services:
- Obstetrical and prenatal care and all related inpatient hospital services;

- Postpartum inpatient care; and a home visit or visits in accordance with the plan's medical criteria;
- Lab work and genetic testing authorized by the Plan;
- All care and services related to a miscarriage;
- A minimum length of stay of 48 hours for a vaginal delivery, 96 hours following a cesarean section. The attending Physician and patient may decide that a shorter Hospital stay is appropriate. Pre-authorization is not required for delivery.

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

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

MEDICAL SUPPLIES AND MEDICATIONS

The Plan will cover medical supplies and prescription medications prescribed by Your Plan Provider. Some medications and supplies may be covered under the Plan's outpatient prescription drug benefit. Covered medications and supplies include:

- Hypodermic needles and syringes;
- Prescription medications and infused medications;
- Oxygen and equipment for administration of oxygen;
- Surgical supplies examples include ostomy, tracheostomy and ileostomy supplies;
- Cancer chemotherapy drugs administered orally and intravenously or by injection.

MENTAL HEALTH/BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

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

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

Emergency Mental Health and Substance use disorder Services are subject to the same requirements as Emergency Medical Conditions and do not require Pre-authorization. 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 Provider.

Inpatient Mental Health and Substance Use Disorder Services

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

Outpatient Mental Health and Substance Use Disorder Services

The Plan will cover Medically Necessary outpatient care.

Definitions

The following definitions will apply to this section:

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

Alcohol or drug rehabilitation facility means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health or by The Department of Behavioral Health and Developmental Services or (ii) a state agency or institution.

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

Inpatient treatment means mental health or substance use disorder services delivered on a twenty-four hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

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

Medication management visit means a visit no more than twenty minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance use disorder treatment.

Mental health services means treatment for mental, emotional or nervous disorders.

Mental health treatment center means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

Outpatient treatment means mental health or substance use disorder treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment also includes services delivered through a partial hospitalization or intensive outpatient program as defined herein.

Partial hospitalization means a licensed or approved outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence that require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment

over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

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

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

ORAL SURGERY

Pre-Authorization is required.

The Plan will cover the following:

- Surgical procedures required to repair Accident/Injury to the jaws, mouth, lips, tongue or hard and soft palates;
- Treatment of fractures of the facial bones;
- Excision including diagnostic biopsy of malignant and/or symptomatic tumors and cysts of the jaws, gums, cheeks, lips, tongue, hard and soft palates, and salivary glands;
- Orthognathic surgical procedures such as osteotomy or other reconstruction of the jaws and/or facial bones (when associated with severe malocclusion) that are necessary to restore and maintain function;
- Coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Inpatient and outpatient dental, oral surgical and orthodontic services which are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia will be covered.

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

PPACA RECOMMENDED PREVENTIVE CARE SERVICES

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

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

- Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; and
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph including:
    - **Breastfeeding support, supplies, and counseling in conjunction with each birth including**: comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
    - **Contraceptive Methods and Counseling including**: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
    - **Screening and Counseling for domestic and interpersonal violence** including annual screening and counseling for all women.
    - **Gestational diabetes screening** including screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
    - **Human Immunodeficiency Virus (HIV)** including annual screening and counseling for sexually active women.
    - **Human Papillomavirus (HPV) DNA Test** including: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
    - **Sexually Transmitted Infections (STI)** including annual counseling for sexually active women.
    - **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services
- Additional breast cancer screening, mammography, and prevention according to recommendations of the United States Preventive Service Task Force.

SMOKING AND TOBACCO CESSATION

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

PHYSICIAN SERVICES

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

The Plan will cover the following physician services:

- Surgical, home, Hospital, and office visits, for diagnosis and treatment of an Accident/Injury or Illness;
- Covered preventive care and preventive screenings;
- Professional services received while You are receiving covered services in an Inpatient Hospital, Skilled Nursing Facility, Emergency Department; ambulatory surgery, or other outpatient facility;
- Specialist care and consultations;
- A second opinion from a Non-Plan Provider will be covered only if a Plan Provider is unavailable;
- Virtual Consults when provided by an Optima Health approved provider;
- Annual school and sports physicals;
- Maternity care and related checkups.

PREVENTIVE CARE SERVICES AND SCREENINGS

Annual Physicals

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

Annual Gynecological (GYN) Exams

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

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

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

Screening Mammograms

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

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

Pap Smears

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

Prostate Screening Tests (PSA)

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

Colorectal Cancer Screening

The Plan will cover colorectal cancer screening. 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

The Plan will cover one annual routine hearing test.

Well Child Care

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

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

Immunizations for Newborn Children from Birth to Age 36 Months

The Plan will cover immunizations for each Child from birth to thirty-six months of age including:

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

Immunizations for older Children and Adolescents ages 7-18

The Plan will cover the following immunizations according to Center for Disease Control (CDC) recommendations:

- Tetanus;

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

PREVENTIVE VISION CARE SERVICES

In-Network Coverage.

We contract with EyeMed Vision Services to administer preventive vision benefits. We cover a routine eye examination, refraction, and prescription for eyeglass lenses from an EyeMed provider.

To receive Covered Services:
- 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.
- 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.
- 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 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

PROSTHETIC COMPONENTS AND DEVICES

Pre-Authorization is required for all services.

Covered Services include coverage for Medically Necessary Prosthetic devices. This also includes repair, fitting, replacement, and Components.

Definitions:

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

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

Prosthetic 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.

RECONSTRUCTIVE BREAST SURGERY

Pre-Authorization is required.

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

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

SKILLED NURSING SERVICES

Pre-Authorization is required.

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

TELEMEDICINE SERVICES

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, or the provision of remote patient monitoring services. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission. The Plan will not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

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

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

THERAPY AND REHABILITATION SERVICES

Pre-Authorization is required.

The Plan will cover the following therapy and rehabilitation services:
- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Cardiac rehabilitation;
- Pulmonary rehabilitation;
- Vascular rehabilitation;
- Vestibular rehabilitation.

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

The Plan will cover physical therapy only to the extent of restoration to the level of the pre-trauma, pre-Illness, or pre-condition level.

The Plan will cover occupational therapy services which assist the Covered Person to restore self-care and improve functionality in activities of daily living.

The Plan will cover speech therapy that is Medically Necessary to correct an organic impairment of organic origin due to accident or Illness. The Plan will cover speech therapy following surgery to correct a congenital defect. Speech therapy is covered only to the extent of restoration to the level of the pre-trauma, pre-Illness, or pre-condition speech function. The Plan does not cover any therapy services related to developmental delay except for covered Early Intervention services.

All therapy and rehabilitation services must be provided by a Physician, or by a licensed or certified physical, occupational or speech therapist. The Plan will cover therapy and rehabilitation services furnished to a Covered Person on an outpatient or inpatient basis according to a specific written treatment plan that:

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

TRANSPLANT SERVICES

Pre-Authorization is required.

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

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

Travel and Transportation

We may cover the cost of reasonable and necessary travel and lodging costs if We have Pre-Authorized the costs and You need to travel more than 50 miles from your home to reach the Hospital where the authorized transplant procedure will be done. For Members receiving a covered transplant, or for the donor when both the donor and recipient are Members, benefits are limited to travel costs to and from the facility and lodging for the patient and one companion or two companions if the patient is a minor. You must provide Us with itemized receipts for all travel and lodging costs and We will determine if your expenses are covered. Covered Services will not include Child care, rental cars, buses, taxis or other transportation not approved by Us, frequent flyer miles, or any other travel services not related to the transplant.

VIRTUAL CONSULTS

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

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

EXCLUSIONS AND LIMITATIONS

Vantage/POS Products

The following is a list of Exclusions and Limitations that generally apply to all Optima Health plans. Once you are an enrolled member please refer to your Plan documents for the Exclusions and Limitations specific to your plan.

Administered by Sentara Health Plans, Inc.

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

A

Abortion is covered in the first 12 weeks of pregnancy. After 12 weeks abortion is covered if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.
Acupuncture is not a Covered Service**.**
Adaptations to Your Home, Vehicle or Office are not Covered Services. Handrails, ramps, escalators, elevators, or any other changes because of a medical condition or disability are not Covered Services.
Ambulance Service for non-emergency transportation is not a Covered Service unless We authorize the service.
Non-medical **Ancillary Services** You are referred to are not Covered Services. Vocational rehabilitation services, employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education, or other non-medical services are not Covered Services.
General **Anesthesia** in a Physician's office is not a Covered Service.
Aromatherapy is not a Covered Service.
Autopsies are not a Covered Service.

B

Batteries are not Covered Services except for motorized wheelchairs, left ventricular assist device (LVAD) and cochlear implants when authorized.
Blood Donors. Costs for finding blood donors are not Covered Services. Costs for transportation and storage of blood in or outside the Plan's Service Area is not a Covered Service.
Bone Densitometry Studies more than once every two years are not Covered Services unless We authorize them.
Bone or Joint treatment involving a bone or joint of the head, neck, face or jaw is covered like any other bone or joint of the skeletal structure. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone.
Botox injections are not Covered Services unless We have approved them.
Breast Augmentation or Mastopexy is not a Covered Service unless We have authorized them. Cosmetic procedures or surgery for breast enlargement or reduction are not Covered Services. Procedures for correction of cosmetic physical imperfections are not Covered Services. Breast implants are not covered. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.
Breast Ductal Lavage is not a Covered Service.
Breast Milk from a donor is not a Covered Service.

C

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

Contact Lenses are not Covered Services. Fitting of lenses or eyeglasses is not a Covered Service. However, the first pair of lenses following cataract surgery including contact lens, or placement of intraocular lens or eyeglass lens only are Covered Services.
Cosmetic Surgery and Cosmetic Procedures are not Covered Services. Medical, surgical, and mental health services for, or related to, cosmetic surgery or cosmetic procedures are not Covered Services. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **The following are also not Covered Services:**

- Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Non-medically necessary treatment or services resulting from complications due to cosmetic experimental procedures;
- Breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following mastectomy;
- Tattoo removal;
- Keloid treatment as a result of the piercing of any body part;
- Consultations or office visits for obtaining cosmetic or experimental procedures;
- Penile implants; or
- Vitiligo **or other cosmetic skin condition** treatments by laser, light or other methods.

Costs of Services paid for by Another Payor are not Covered Services. We do not cover the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of covered services in those cases where You received services in accordance with the Plan's authorization procedures. We will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.
Court ordered examinations or treatments are not Covered Services unless they are determined to be Medically Necessary and are listed as a Covered Service under the Plan.
Custodial Care is not a Covered Service including, but not limited to the following:

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

D
Dentistry/Oral Surgery/Dental Care.

Dentistry.

- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are not Covered Services.
- Cosmetic services to restore appearance are not Covered Services.
- Dental implants or dentures and any preparation work for them are not Covered Services.

- Dental services performed in a hospital or any outpatient facility are not Covered Services except for those services listed under "Hospitalization and Anesthesia for Dental procedures."

Oral Surgery.

- Oral surgery which is part of an orthodontic treatment program is not a Covered Service.
- Orthodontic treatment prior to orthognathic surgery is not a Covered Service.
- Dental implants or dentures and any preparation work for them are not a Covered Service.
- Extraction of wisdom teeth is not a Covered Service unless Your plan includes a rider.

Dental Care.

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

Diagnostic tests or Surgical Procedures are not Covered Services where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes**.**
Disposable Medical Supplies are not Covered Services unless ordered as part of wound care and authorized by the Plan. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide and other disposable supplies are not Covered Services.
Driver Training is not a Covered Service.
Durable Medical Equipment (DME) is a Covered Service up to the limits stated on Your Plan's Face Sheet or Schedule of Benefits. Covered Services may be limited to an amount, supply, or type of DME that We determine will safely and adequately treat Your condition. **The following are not Covered Services:**

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

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

E

Electron Beam Computer Tomography (EBCT) is not a Covered Service. Other diagnostic imaging tests where there is insufficient scientific evidence of the test's safety or efficacy in improving clinical outcomes are not Covered Services.

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

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

Enteral or Parenteral Feeding supplements are not Covered Services unless they are used as the sole **or major** source of nutrition. Over the counter infant formulas or medical foods are not Covered Services.

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

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

Experimental or Investigative drugs, devices, treatments, or services are not Covered Services. **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, medical treatment or procedure is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment or procedure.

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

Eye Glasses and contact lenses are not Covered Services unless the plan includes a rider for vision materials. Fitting of lenses or eyeglasses is not a Covered Service except for the first pair of lenses following cataract surgery including contact lenses, or placement of intraocular lenses or eyeglass lenses only.

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

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

F

The following **Foot Care Services are not Covered Services** except for Members with Diabetes or severe vascular problems:

- Removal of corns or calluses;
- Nail trimming;
- Treatment and services for or from flat-feet, fallen arches, weak feet, or chronic foot strain;
- Foot Orthotics of any kind;
- Customized or non-customized shoes, boots, and inserts.

G

Genetic Testing and Counseling are not Covered Services unless We have authorized the services. Counseling is a Covered Service only as part of the approved genetic test unless considered preventive care.
GIFT programs (Gamete Intrafallopian Transfer) are not Covered Services.
Growth Hormones are only Covered Services under the Plan's Outpatient Prescription Drug Rider. Growth hormones for the treatment of idiopathic short stature are not Covered Services**.**

H

Hearing Aids are not Covered Services unless Your plan has a rider. Fittings, molds, batteries or other supplies are not Covered Services unless Your plan has a rider.
Home Births are not a Covered Service.
Home Health Care Skilled Services are not Covered Services unless You are homebound, physically unable to seek care on an outpatient basis, or service is provided in lieu of inpatient hospitalization. Services or visits 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. Custodial Care is not a Covered Service.
Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not Covered Services.
Implants for cosmetic breast enlargement are not Covered Services. Cosmetic procedures or cosmetic surgery for breast enlargement or reduction are not Covered Services. Procedures for correction of cosmetic physical imperfections are not Covered Services. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.
Incarceration - Services and treatments done during **Incarceration** in a Local, State, Federal or Community Correctional Facility or prison are not Covered Services.
Unless listed as a Covered Service in this EOC, or under a Rider, **Infertility Services** listed below are not Covered Services:

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as a Covered Service;
- Services, tests, medications, and treatments for the enhancement of conception;
- In-vitro Fertilization programs;
- Artificial insemination or any other types of artificial or surgical means of conception;
- Drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- Reproductive material storage;

- Treatment or testing related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage,
- Sperm washing;
- Services to reverse voluntary sterilization;
- Infertility Treatment or services from reversal of sterilization;
- Drugs used to treat infertility;
- Surrogate pregnancy services.

J

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

L

M
Massage Therapy is not a Covered Service unless provided as part of an approved medical therapy program.
Matristem Extracellular Wound Care System is not a Covered Service.
Maximum Benefit Amounts are stated on Your Plan's Face Sheet or Schedule of Benefits. Additional services or treatments after a benefit limit has been reached are not Covered Services.
Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not a Covered Service.
Medically Necessary Treatments - Any services, supplies, treatments, or procedures not specifically listed as a Covered Service, and any other services, supplies, or treatments or procedures determined not to be Medically Necessary are not Covered Services unless required under state or federal laws and regulations.
Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not Covered Services. **The following are not Covered Services:**

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

Medical Nutritional Therapy and nutrition counseling are not Covered Services except when provided as part of preventive care, diabetes education or when received as part of 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 Services.
Membership Fees to pools, gyms, health clubs, or athletic clubs are not Covered Services.
Mobile Cardiac Outpatient Telemetry (MCOT) is not a Covered Service.

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not Covered Services unless Your plan includes a rider, and services have been **authorized by the Plan for Members who meet established criteria.**
Motorized or Power Operated Vehicles or chair lifts are not Covered Services unless authorized by the Plan. This does not include wheelchairs or scooters.

N
Neuro-cognitive therapy is not a Covered Service.
Newborns or other children of a Covered Dependent Child are not Covered Persons under the Plan unless mutually agreed to by the Plan and the Group.

O
Oral Surgery services listed below **are not Covered Services**:

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

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

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

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

For Optima Health POS and Patient Optional Point of Service plans:
Services or treatment You receive from **Out-of-Network Non-Plan Providers** will be Covered Services only under Your Out-of-Network benefits except in the following situations:

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

P
PARS System (Physical Activity Reward System) is not a Covered Service.
Pass Devices (Patient Activated Serial Stretch) are not a Covered Service.
Paternity Testing is not a Covered Service.
Penile implants are not a Covered Service.

Personal comfort items such as, but not limited to, telephones, televisions, extra meal trays, personal hygiene items, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs and any other similar items for personal comfort are not Covered Services.
Physician Examinations <u>are limited as follows</u>:

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

Physician's Clerical Charges are not Covered Services. Charges for broken appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records or correspondence to other parties, and any other clerical services are not Covered Services.
Private Duty Nursing is not a Covered Service.
Pulsed Irrigation Evacuation System is not a Covered Service.

Q

R
Reconstructive surgery is not a Covered Service unless Medically Necessary and surgery follows 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 a Covered Service.
Remedial Education and Programs are not Covered Services. Services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities **are not Covered Services.**
Residential or Sub-Acute Level of Care or treatment is not a Covered Service.

S
Second Opinions from Plan providers do not require authorization. A second opinion from a Non-Plan provider is a Covered Service only when a Plan provider is not available and authorized by the Plan.
Services – <u>The following are not Covered Services:</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;
- Services not listed as a covered service under this plan; or
- Any service or supply that is a direct result of a non-covered service.

Spinal Manipulation is not a Covered Service unless covered under a Chiropractic Care Rider.
S**terilization**

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

T
Non-interactive **Telemedicine Services** such as fax, telephone only conversations, email, or online questionnaire are not Covered Services under the Plan's Telemedicine benefits.
Therapies. Physical, Speech, and Occupational **Therapies** are limited as stated on Your Face Sheet or schedule of benefits. Therapies will be Covered Services only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. **The following are not Covered Services except for those services that are listed under Early Intervention Services or under Autism Spectrum Disorder:**

- Therapies for developmental delay or abnormal speech pathology;
- Therapies which are primarily educational in nature;
- Special education services;
- Treatment of learning disabilities;
- Lessons for sign language;
- Therapies to correct an impairment resulting from a functional or developmental nervous disorder (i.e. stuttering, stammering);
- Therapies to maintain current status or level of care;
- Restorative therapies to maintain chronic level of care;
- Therapies available in a school program;
- Therapies available through state and local funding;
- Recreational or nature therapies;
- Art, craft, dance, or music therapies;
- Exercise, or equine therapies;
- Sleep therapies;
- Driver evaluations as part of occupational therapy;
- Driver training;
- Functional capacity testing needed to return to work;
- Work hardening programs;
- Gambling therapy; or
- Remedial education and programs.

Total Body Photography is not a Covered Service.
Transplant Services -The following are not Covered Services:

- Organ and tissue transplant services not listed as a Covered Service;
- 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; or
- Services related to donor complications following a transplant.

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

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

For Optima Health Vantage Plans:
Treatment and services, other than Emergency Services, received while **traveling outside of the United States of America** are not Covered Services.

For Optima Health POS and Patient Optional Point of Service Plans:
Treatment and services, other than Emergency Services, received while **traveling outside of the United States of America** are Covered Services only under Your Out-of-Network benefits.

U

V
Video Recording or Video Taping of any service or procedure is not a Covered Service.
Treatment of **varicose veins** or **telangiectatic dermal veins** (spider veins) for cosmetic purposes are not Covered Services.
Virtual Consults do not include the following:

- Electronic mail message;
- Facsimile transmission; or
- Online questionnaire.

W
Wisdom Teeth extraction is not a Covered Service unless under a rider**.**
Work-related injuries or diseases when the employer must provide benefits or when that person has been paid by the employer are not Covered Services.

X

Y

WORKERS' COMPENSATION

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

MEDICARE

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

OTHER GOVERNMENT PROGRAMS

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

COVERED PERSON'S COOPERATION

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

COORDINATION OF BENEFITS

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

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

Definitions

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

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

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

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

Primary Plan or **Secondary Plan** is determined by the order of benefit determination rules. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When This Plan is a Secondary Plan, its benefits may be reduced and it may recover from the Primary Plan the reasonable cash value of benefits provided by this Plan. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

Allowable Expense means the Usual and Customary Charge for an item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those relating to services provided without required pre-authorizations by the Plan or referrals from the Primary Care Physician.

Claim Determination Period means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date of this COB provision or a similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

2. Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph 3 below, when This Plan and another plan cover the same child as a Dependent of different persons, called “parents:”

   a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
   b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

   However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the plan of the parent with custody of the child;
   b. Then, the plan of the spouse of the parent with custody of the child; and
   c. Finally, the plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan which covers that person as a laid off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (4) is ignored.

5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee longer are

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

The start of a new plan does not include:

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

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

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

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

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Plan any facts it needs to pay the claim.

Facility of Payment

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

Right of Recovery

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

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

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

COPAYMENTS

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

COINSURANCE

Coinsurance amounts are charges required to be paid by the Covered Person for Covered Services. Coinsurance amounts are expressed as a percentage of an allowable charge for a specific health care service. Coinsurance may be required to be paid to the provider of the service at the time service is received.

DEDUCTIBLE

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

MAXIMUM OUT-OF-POCKET AMOUNT

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

EMERGENCY ROOM COPAYMENT

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

PLAN PROVIDERS

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

NON-PLAN PROVIDERS

Claims for Covered Services rendered by Non-Plan Providers should be sent to the Plan c/o Sentara Health Plan, 4417 Corporation Lane, Virginia Beach, VA 23462 for payment consideration. If a charge is made to a Covered Person for any service that is reimbursable under this Summary Plan Description, written proof of such charge shall include an itemized statement plus diagnosis and must be submitted to the Plan within ninety (90) days after the delivery of the service. Failure to furnish such documentation within the specified period shall not invalidate nor reduce any such claim if for good reason it was not possible to submit the claim within the specified period, provided such proof is produced on a timely basis.

PAYMENT BY PLAN

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Chard Snyder
6867 Cintas Blvd
Mason, OH 45040
833-212-1988

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

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

The Plan's Appeals Process

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

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

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

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

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

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

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

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

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

- For denials due to medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the Member's medical circumstances.

Types of Claims

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

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

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

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

Concurrent care decision/claim means a Claim regarding a decision by the Plan to terminate or reduce benefits that it previously approved. Concurrent Claim also may be a request to extend the course of treatment already approved by the Plan. An example is where the Plan reviews an inpatient hospital stay approved for five days on the third day to determine if the full five days is appropriate. To appeal a Concurrent Care Decision/Claim the Covered Person must follow the procedure for expedited appeals.

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

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

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

By Facsimile: 757-687-6232

By Mail: Send requests for an appeal to:

Sentara Health Plan

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

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

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

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

Requesting an Appeal

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

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

By Facsimile: 757-687-6232

By Mail: Send requests for an appeal to:

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

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

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

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

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

Sources for Additional Information

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

External Review of Adverse Benefit Determinations

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

Requesting a Standard External Review

You must file a request for an external appeal within four months after receiving notice of a final adverse benefit determination. To begin your external appeal please contact Member Services at the number on the back of the ID card.

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

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

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

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

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

Requesting an Expedited External Review

You can request and expedited external review of an adverse benefit determination that involves a medical condition for which the time frame for completion of an expedited internal appeal (or a standard external review in the case of a final internal adverse benefit

determination) would seriously jeopardize your life or health or your ability to regain maximum function.

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

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

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

Other Resources to Help You

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

MAJOR DISASTERS AND OTHER CIRCUMSTANCES BEYOND THE PLAN'S CONTROL

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

SEVERABILITY

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

POLICIES AND PROVISIONS

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

NAMED FIDUCIARY AUTHORITY

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

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

ASSIGNMENT

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

RELATIONSHIP OF PARTIES

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

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

IDENTIFICATION CARD

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

AUTHORIZATION TO EXAMINE HEALTH RECORDS

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

MODIFICATIONS OF BENEFITS AND RIGHT TO TERMINATE

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

LIMITATION ON BENEFITS OF THIS PLAN

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

GOVERNING LAWS

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

PLAN NOT A CONTRACT OF EMPLOYMENT

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

ENTIRE CONTRACT

The Purchaser Services Agreement and the Summary Plan Description together with all exhibits and amendments thereto, the individual Enrollment Applications of Members, Medical Care Management Policies, and any other questionnaire, form or other document provided in execution with the Purchaser Services Agreement shall constitute the entire agreement between the parties. No statements or representations may be used in any legal dispute regarding the terms of Coverage or any exclusions or limitations hereunder unless contained in such documents.