



# **Optima Health**

## **Plan Information**

**Medical Loss Ratio Information--The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference. A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011. You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit [www.HealthCare.gov](http://www.HealthCare.gov)."**

Optima Vantage

Effective Date: April 1, 2013

# Evidence of Coverage

## **INTRODUCTION AND IMPORTANT INFORMATION ABOUT YOUR OPTIMA HEALTH PLAN**

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

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

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

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

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

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

### **Office of the Managed Care Ombudsman.**

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

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

# **INTRODUCTION AND IMPORTANT INFORMATION ABOUT YOUR OPTIMA HEALTH PLAN**

Welcome to the Plan. We look forward to providing your health care coverage. If you have any questions about your benefits, or any other information in this document please call Member Services at the number on your Plan insurance card.

In this document you will find information on how to use the benefits and health care services to which members are entitled under this Plan, as well as what services are excluded from coverage. You will also find information on the Plan's Pre-Authorization and Utilization Management Procedures. On the Face Sheet of the document you will find specific information about the Copayments, Coinsurances, and/or Deductibles for which you are responsible when receiving Covered Services.

Please take the time to read this Evidence of Coverage carefully so that you will understand the terms and conditions of coverage under the Plan.

## **ERISA NOTICE**

As a participant in the Plan you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA does not apply to you if your insurance is through a government, county, church, or school employer. Under ERISA, you are entitled to:

### **Receive Information about Your Plan and Benefits**

You may examine, without charge, at the plan administrator's office and at other specified locations, the plan administrator's documents, including insurance contracts, and a copy of the latest annual report filed by the plan administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. You may obtain, upon written request to the plan administrator, copies of all the plan administrator's documents and other plan information. The plan administrator may make a reasonable charge for the copies.

### **Continue Group Health Plan Coverage**

You may continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your spouse or your dependents may have to pay for such coverage. Please Review the Continuation of Coverage section in this document for the rules governing your COBRA continuation coverage rights.

You have a right to reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. Your group health plan or health insurance issuer must provide you with a certificate of creditable coverage, free of charge, when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in your interest and in the interest of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a group health plan benefit or exercising your rights under ERISA.

# **INTRODUCTION AND IMPORTANT INFORMATION ABOUT YOUR OPTIMA HEALTH PLAN**

## **Enforce Your Rights**

If your claim for a group health plan benefit is denied or ignored, in whole or in part, you have a right within certain time schedules to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan administrator's office and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if for example, it finds your claim is frivolous.

## **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

## **PROVIDER NETWORK**

### **Composition of Provider Network.**

A list of Plan Providers and their locations is available to each Member without charge upon enrollment or upon request. Such list shall be revised from time to time as necessary. It is possible that a Plan Participating Provider's contract may end. In that event, Members may be required to use another Plan Provider. Members may also call Member Services to find out if a provider participates with the Plan.

### **Use of Network or Plan Providers.**

Within the Service Area, the Member will be entitled to receive Covered Services from Plan Providers. All services must be deemed to be or have been Medically Necessary and all benefits are subject to the exclusions, limitations, and conditions, including Copayments, Coinsurances, and/or Deductibles set forth herein.

Plan Provider means a Physician, Hospital, Skilled Nursing Facility, urgent care center, laboratory, or any other duly licensed institution or health professional under contract to provide professional and Hospital services to Members. It is the Member's responsibility to know which providers are Plan Providers. Unless approved by the Plan Members will be responsible for all charges for services received from Non Plan Providers even if the Member has been referred to the Non Plan Provider by a Plan Provider. The member will be responsible for all charges for all laboratory services received from Non Plan laboratories even if a Plan Provider sends the Member's lab work to a non plan lab.

## **INTRODUCTION AND IMPORTANT INFORMATION ABOUT YOUR OPTIMA HEALTH PLAN**

### **Coverage for Services from Out-of-Network or Non-Plan Providers.**

Except in cases of Emergency, the Plan will have no liability or obligation whatsoever for any service or benefit sought or received by Covered Persons from any out-of-network provider or Non-Plan Provider, including any physician, Hospital, or other health care provider unless prior special arrangements are made by the Plan. Members who receive services from Non-Plan Providers may be responsible for charges in excess of what would have been paid had the services been received from Plan Providers. All services must be deemed to be or have been Medically Necessary, and all benefits are subject to the exclusions, limitations, and conditions including Copayments, Coinsurances, and Deductibles set forth herein.

### **Primary Care Providers.**

Each Member must designate a Primary Care Physician (PCP) from the list of Plan Providers. Primary Care Physicians include Internists, Pediatricians, Family Practitioners, and other physician specialties as the Plan may designate. If You do not select a PCP one will be assigned to You by the Plan.

At the time of enrollment each Member shall have the right to select a Primary Care Physician from among the Plan's affiliated Primary Care Physicians, subject to availability. Any Member who is dissatisfied with his Primary Care Physician shall have the right to select another Primary Care Physician from among the Plan's affiliated Primary Care Physicians, subject to availability. The Plan may impose a reasonable waiting period for this transfer.

### **Specialty Care Providers.**

All specialist care must be received from Plan Providers in order to be Covered by the Plan.

You will be responsible for all applicable Copayments or Coinsurance, and any applicable Deductibles depending on the type and place of service (e.g., Physician's office, Urgent Care Center, Hospital inpatient or Hospital outpatient setting.) Covered Services may require Pre-Authorization by the Plan as described in Pre-Authorization, and Utilization Management Procedures for Claims for Covered Services Section III of this Evidence of Coverage.

## **MATERNITY BENEFITS**

Under Federal and state law you have certain rights and protections regarding your maternity benefits under the Plan.

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

Under Virginia State law, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and Copayments that are no less favorable than for physical illness generally.

# **INTRODUCTION AND IMPORTANT INFORMATION ABOUT YOUR OPTIMA HEALTH PLAN**

## **CERTIFICATES OF CREDITABLE COVERAGE**

A certificate of creditable coverage is intended to help you and your dependents in case you lose or change health plan coverage. Under a federal law known as HIPAA, you or your dependents may need evidence of coverage to reduce a pre-existing condition exclusion period under another plan, to help get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems. When you change health care coverage, or if you or your dependents lose coverage under a health plan, the plan sponsor is usually required to provide written certification of how long you and your dependents were covered under that plan. You or your dependents can also request a certificate of creditable coverage if one is not automatically provided to you. When you enroll in an Optima Health plan we ask that you include a copy of certificates of creditable coverage for you and your dependents so that we may insure you receive credit for your prior coverage against any pre-existing condition exclusion periods under your Optima Health plan. Please call member services if you have any questions about obtaining a certificate of creditable coverage.

## **CORPORATE OFFICE**

The Corporate Office of Optima Health Plan is located at:

4417 Corporation Lane  
Virginia Beach, Virginia 23462  
757-552-7401 or 1-877-552-7401

## **REGULATION OF OPTIMA HEALTH**

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

## **SENTARA HEALTHCARE INTEGRATED NOTICE OF PRIVACY PRACTICES**

Optima Health Plan is part of the Sentara Healthcare integrated health care system. This system is made up of companies owned by Sentara Healthcare. In order to ensure uniformity throughout the system, every member of the Sentara Healthcare family, including this Plan, must comply with the basic privacy principles found in the "Sentara Healthcare Integrated Notice of Privacy Practices." A copy of the "Sentara Healthcare Integrated Notice of Privacy Practices" is included with this evidence of coverage.

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

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

## **RECONSTRUCTIVE BREAST SURGERY BENEFITS**

For information on a Member's rights to benefits for the treatment of mastectomy related services, including reconstructive surgery, prostheses, and physical complications, including lymphedemas please refer to the Important Coverage Notices section of this document.

## **Stop Health Care Fraud!**

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



## INTRODUCTION AND IMPORTANT INFORMATION ABOUT YOUR OPTIMA HEALTH PLAN

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

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

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



## OPTIMA HEALTH PLAN AMENDMENT FOR COVERAGE

### PATIENT PROTECTION AND AFFORDABLE CARE ACT

#### FOR PLANS NEW AND RENEWING ON OR AFTER 9/23/2010 AND PRIOR TO 1/1/2014

As of the Plan or Policy effective date or renewal date of coverage, regardless of anything different stated in the Plan, Agreement, Evidence of Coverage, or Face Sheet or Schedule of Benefits, the following provisions are added to comply with provisions found in the Patient Protection and Affordable Care Act (the Affordable Care Act or PPACA), and any applicable federal or state regulations issued pursuant to the Affordable Care Act.

#### **Statement on Grandfather Status**

Optima Health believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Optima Health at the number on your member ID Card. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

#### **Extension of Coverage for Adult Children**

Plans that include coverage of children will make such coverage available for children until attainment of 26 years of age. The Plan will not deny or restrict eligibility for a child who has not attained age 26 based on any of the following:

- a. financial dependency on the Subscriber or any other person;
- b. residency with the Subscriber or any other person;
- c. student status;
- d. employment status; or
- e. marital status.

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

for grandfathered plan years beginning before January 1, 2014 plans may exclude a child from coverage if the child is eligible to enroll in an employer sponsored health plan other than a group health plan of a parent.

Eligibility to age 26 does not extend to a spouse of a child receiving dependent coverage.

Eligibility to age 26 does not extend to a child of a child receiving dependent coverage unless grandchildren are eligible under the terms of the Plan.

**Special Enrollment Opportunity for Children under Age 26.**

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

**Lifetime Limits and Opportunity to Enroll**

Plan or Policy lifetime limits on the dollar amount of benefits for any individual will not apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan will have an opportunity to enroll in the Plan. Individuals have 30 days from the date of notice of special enrollment to request enrollment. For individuals who enroll under this opportunity, coverage will take effect not later than the first day of the Plan effective date.

**Pre-existing Conditions for Children under Age 19**

Pre-existing condition exclusions will not apply to children under age 19.

Preexisting condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

## **Rescission of Coverage**

Coverage under the Plan can only be rescinded for fraud or intentional misrepresentation of material fact as prohibited by the terms of coverage. Rescission means a cancellation or discontinuation of coverage that is retroactive. Rescission does not mean cancellation or discontinuance of coverage in accordance with the Plan's grace period for non-payment of premium.

## **Emergency Services**

Coverage of emergency services does not require pre-authorization. Coverage for emergency services is provided whether or not services are received from Plan Providers or Non-Plan Providers.

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)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

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

## **Preventive Care Services**

Preventive Care Services listed below are covered with no member cost sharing when received from In-Network Plan Providers including copayments, coinsurance, and deductible.

- (1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; and
- (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
- (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- (4) with respect to women, such additional preventive care and screenings not described in item

(1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph; and

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

The Plan is changed only as stated in this amendment. All other Plan terms and conditions of coverage, and Plan definitions remain the same. All definitions found in the Patient Protection and Affordable Care Act, and any applicable federal or state regulations issued pursuant to the Affordable Care Act will apply.

**OPTIMA HEALTH PLAN**

A handwritten signature in black ink, appearing to read "Michael M. Dudley". The signature is written in a cursive, flowing style.

**President**

**Optima Vantage 10/25  
Evidence of Coverage Face Sheet**

Group Name: SURA/Jefferson Science Associates  
Group Number: 2704, 2704\*SURA  
Effective Date: April 1, 2013

This Face Sheet lists Your Deductible and Your Copayments, or the percent Coinsurance the Plan will pay, when you use benefits. Please also read Section IV Covered Services and Section V Exclusions and Limitations. Some benefits require Pre-Authorization before You receive them. Please read Section III to learn about Pre-Authorization. **Except for covered Emergency Services the Plan will not pay for treatment or services You receive from Non-Plan Providers.**

**Deductible**

Your Plan Does not have a Deductible

**Maximum Out-of-Pocket Amount**

\$2,000 per Member Per Calendar Year<sup>1</sup>  
\$4,000 per Family Per Calendar Year<sup>1</sup>

**Physician Services**

**Pre-Authorization is required for in-office surgery.** Copayment or Coinsurance applies to Covered Services done in the Physician's office. An additional Copayment or Coinsurance may apply to outpatient therapy, rehabilitative services, and injectable and infused medications, and outpatient advanced imaging procedures done in the Physician's office.

<b>Physician Office Visits</b>	<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Primary Care Physician (PCP) Office Visit</b>	\$10 Copayment	
<b>Specialist Office Visit</b>	\$25 Copayment	
<b>Vaccines and Immunotherapeutic Agents</b>	Covered at 50% <sup>3</sup> Member is responsible for Coinsurance amount up to a maximum Copayment amount of \$250 per dose.	
<b>Preventive Care Visits</b>	<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Routine Annual Physical Exams</b> <b>Well Baby Exams</b> <b>Annual Gyn Exams and Pap Smears</b> <b>PSA Tests</b> <b>Colorectal Cancer Tests</b> <b>Routine Adult and Childhood Immunizations</b>	Covered at 100%	
<b>Screening Colonoscopy</b> <b>Screening Mammograms</b>	Covered at 100%	

**Outpatient Therapy and Rehabilitation Services**

Copayment or Coinsurance applies to Covered Services provided in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or in a Member's home as part of Skilled Home Health Care Services benefit. Short-term therapy and rehabilitation means services that can be expected to result in the significant improvement of a member's condition within a period of 90 days.

<b>Short Term Therapy Services</b>	<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Physical Therapy</b> <b>Occupational Therapy</b> <b>Speech Therapy</b>	\$10 Copayment per PCP office visit. \$25 Copayment per Specialist office visit. \$25 Copayment per outpatient facility visit/treatment.	Pre-Authorization is required.
<b>Short Term Rehabilitation Services</b>	<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Cardiac Rehabilitation</b> <b>Pulmonary Rehabilitation</b> <b>Vascular Rehabilitation</b> <b>Vestibular Rehabilitation</b>	\$10 Copayment per PCP office visit. \$25 Copayment per Specialist office visit. \$25 Copayment per outpatient facility visit/treatment.	Pre-Authorization is required.
<b>Other Outpatient Treatments</b>	<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Chemotherapy</b> <b>Radiation Therapy</b> <b>IV Therapy</b> <b>Inhalation Therapy</b>	\$10 Copayment per PCP office visit. \$25 Copayment per Specialist office visit. \$25 Copayment per outpatient facility visit/treatment.	Pre-Authorization is required for IV Therapy with medications and Inhalation therapy.

<p><b>Pre-Authorized Injectable and Infused Medications</b> Includes injectable and infused medications, biologics, and IV therapy medications that require prior-authorization. <i>(This does not include chemotherapy medications, allergy injections or serum.)</i> 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.</p>	Covered at 80% <sup>3</sup>		
<b>Outpatient Dialysis Services</b>			
		<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Dialysis Services</b>	\$10 Copayment  Copayment or Coinsurance applies regardless of place of service.		
<b>Outpatient Surgery</b>			
		<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Outpatient Surgery</b> Copayment or Coinsurance applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	\$100 Copayment per Admission		Pre-Authorization is required.
<b>Outpatient Diagnostic Procedures</b>			
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.			
		<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Diagnostic Procedures</b>	\$25 Copayment		Pre-Authorization is required.
<b>X-Ray</b> <b>Ultrasound</b> <b>Doppler Studies</b>	\$25 Copayment		
<b>Lab Work</b>	\$25 Copayment		
<b>Outpatient Advanced Imaging Procedures</b>			
		<b>Copayments/Coinsurance</b>	<b>Comments</b>
<p><b>Magnetic Resonance Imaging (MRI)</b> <b>Magnetic Resonance Angiography (MRA)</b> <b>Positron Emission Tomography (PET Scans)</b> <b>Computerized Axial Tomography (CT Scans)</b> <b>Computerized Axial Tomography Angiogram (CTA Scans)</b></p> <p>Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.</p>	\$150 Copayment		Pre-Authorization is required.
<b>Maternity Care<sup>2</sup></b>			
		<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Maternity Care</b> Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	\$100 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services		Pre-Authorization is required for prenatal services.
<b>Inpatient Services</b>			
		<b>Copayments/Coinsurance</b>	<b>Comments</b>
<b>Inpatient Hospital Services</b> Transplants are covered at contracted facilities only.	\$100 Copayment per day up to a \$500 maximum Copayment per inpatient Admission		Pre-Authorization is required.



<p><b>Skilled Nursing Facilities/Services</b> Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days per calendar year per illness or condition that in the Plan's judgment requires Skilled Nursing Services<sup>4</sup></p>	<p>Covered at 100%<sup>3</sup> after inpatient hospital Copayment has been met.</p>	<p>Pre authorization is required.</p>
<b>Ambulance Services</b>		
<b>Copayments/Coinsurance</b>		
<b>Comments</b>		
<p><b>Ambulance Services</b> For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan</p>	<p>\$25 Copayment per transport each way<sup>5</sup></p>	<p>Pre-Authorization is required for non-emergent transportation only.</p>
<b>Emergency Department Services</b>		
<b>Copayments/Coinsurance</b>		
<b>Comments</b>		
<p><b>Emergency Department Services</b> Includes emergency department facility, Physician, and ancillary services provided during an emergency department visit.</p>	<p>\$200 Copayment per visit. If the Member is admitted the Copayment will be waived, and the Member will pay the Inpatient Hospital Services Copayment or Coinsurance.<sup>5</sup></p>	<p>Pre-Authorization is <u>not</u> required.</p>
<b>Urgent Care Center Services</b>		
<b>Copayments/Coinsurance</b>		
<b>Comments</b>		
<p><b>Urgent Care Services</b> Includes urgent care center 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 be responsible for any applicable emergency department Copayment or Coinsurance.</p>	<p>\$25 Copayment</p>	<p>Pre-Authorization is <u>not</u> required.</p>
<b>Behavioral Health Care</b>		
<p>Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental illnesses.</p>		
<b>Copayments/Coinsurance</b>		
<b>Comments</b>		
<p><b>Inpatient Services</b></p>	<p>\$100 Copayment per day up to a \$500 maximum Copayment per inpatient Admission</p>	<p>Pre-Authorization is required for all inpatient services, and partial hospitalization services.</p>
<p><b>Outpatient Services</b></p>	<p>\$10 Copayment per outpatient visit/hour</p>	<p>Pre-Authorization is required for intensive outpatient Program (IOP), psychological and neuro-psychological testing, and electro-convulsive therapy.</p>
<b>Other Covered Services</b>		
<b>Copayments/Coinsurance</b>		
<b>Comments</b>		
<p><b>Artificial Limb Services<sup>4</sup></b> For adults 18 and over, artificial limbs, including repair and replacement, will be covered up to a \$10,000 lifetime maximum per limb, per occurrence. For children under age 18, artificial limbs, including repair and replacement, will be covered up to \$10,000 per limb for a maximum of two occurrences.</p>	<p>Covered at 100%<sup>3</sup></p>	<p>Pre-Authorization is required.</p>

<p><b>Diabetic Supplies and Equipment</b> Includes FDA approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment per 31-day supply.</p>	<p>Covered at 80%<sup>3</sup> for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. No Copayment or Coinsurance for insulin pumps. No Copayment or Coinsurance for outpatient self-management training and education, including medical nutritional therapy.</p>	
<p><b>Durable Medical Equipment (DME) and Supplies<sup>4</sup></b> <b>Orthopedic Devices and Prosthetic Appliances<sup>4</sup></b>  Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.</p>	<p>Covered at 100%<sup>3</sup></p>	<p>Pre-Authorization is required for single items over \$750. Pre-Authorization is required for all rental items. Pre-Authorization is required for repair and replacement.</p>
<p><b>Early Intervention Services.<sup>4</sup></b> Covered for Dependents from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.</p>	<p>Pre-authorization is required.</p>
<p><b>Home Health Care Skilled Services</b> A member must be homebound and unable to receive services outside the home to receive care. An outpatient therapy Copayment or Coinsurance will also apply to physical, occupational, and speech therapy received in the home.</p>	<p>Covered at 100%<sup>3</sup></p>	<p>Pre-Authorization is required.</p>
<p><b>Hospice Care</b></p>	<p>Covered at 100%<sup>3</sup></p>	<p>Pre-Authorization is required.</p>
<p><b>Reduction Mammoplasty</b> Coinsurance will apply to all applicable services associated with Reduction Mammoplasty including but not limited to Physician, facility, surgical, and/or diagnostic services. This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy.</p>	<p>Covered at 50%<sup>3</sup></p>	<p>Pre-Authorization is required.</p>

**Dependent Children**

- Dependent children are eligible to age 26 end of the month.

**CONTRIBUTORY**

**NONCONTRIBUTORY**

## Notes

All benefits are subject to the terms and conditions in the *Evidence of Coverage* OHP.HMO.EOC.09

- 1 Maximum Out of Pocket Amount means the total amount a Member pays during a calendar year. Applicable Copayments or Coinsurances for, vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, any covered medical expenses paid at a rate of 50% or less, except vaccines do not count toward the Maximum Out of Pocket Amount and must continue to be paid after the Maximum Out of Pocket Amount has been met.
- 2 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 the Member is 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 the Member would have paid on a per visit or per procedure basis.
- 3 Benefits are payable at the percent specified of the Plan's fee schedule.
- 4 Amounts in excess of a benefit dollar limit and/or visit limit as stated in the Face Sheet or added by a Plan rider are excluded from Coverage.
- 5 All Emergency, Urgent Care, Ambulance and Emergency Mental Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an emergency, the Plan will have no responsibility for the cost of the treatment and the Member will be solely responsible for payment. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the Member received care from a Plan Provider.

**Optima Plus \$10/20/40/40  
Outpatient Prescription Drug Rider  
Schedule of Benefits**

Effective Date: April 1, 2013

This schedule of benefits describes Your outpatient prescription drug coverage. All drugs must be FDA approved and you must have a prescription. You will need to pay Your Copayment or Coinsurance when you fill your prescription at the pharmacy. If Your Plan has a Deductible you must meet that amount before your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. Your drug coverage has specific Exclusions and Limitations so please read the next few pages carefully. Optima's Pharmacy and Therapeutics Committee places covered drugs into the following Tiers.

- **Selected Generic (Tier 1):** includes commonly prescribed generic drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.
- **Selected Brand & Other Generic (Tier 2)** includes brand-name drugs, and some generic drugs with higher costs that Tier 1 generics, that are considered by the Plan to be standard therapy.
- **Non-Selected Brand (Tier 3)** includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a generic equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers.
- **All Other (Tier 4)** includes those drugs not classified by the Plan as Tier 1, Tier 2, or Tier 3; those drugs not excluded from Coverage; and those drugs that are not recognized by the Plan to be any more effective than other drugs available at Tier 1, Tier 2, or Tier 3 or over the counter.

Your Copayment, Coinsurance, and Deductible amounts for each Tier are listed below. If You need help please call Member Services or log on to [www.optimahealth.com](http://www.optimahealth.com) to find out which of the following Tiers Your drug is in.

<b>Copayments and Coinsurances.</b>	
<b>For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge.</b> Certain prescription drugs will be covered at a generic product level established by the Plan. If a generic product level has been established for a drug and You or Your prescribing Physician requests the brand-name drug or a higher costing generic, You must pay the difference between the cost of the dispensed drug and the generic product level in addition to the Copayment charge.	
<b>Selected Generic (Tier 1)</b>	\$10 Copayment
<b>Selected Brand &amp; Other Generic (Tier 2)</b>	\$20 Copayment
<b>Non-Selected Brand (Tier 3)</b>	\$40 Copayment
<b>All Other (Tier 4)</b>	\$40 Copayment
<b>Mail Order Pharmacy Benefit Copayments and Coinsurances</b>	
<b>Some Outpatient prescription drugs are available through the Plan's Mail Order Provider. You may call Caremark 1-888-766-5495 to find out if a drug is available. If Your drug is available You may purchase up to a 90-day supply for two Copayments or the applicable Coinsurance amount. Specialty drugs are not available under the Plan's Mail Order Benefit.</b>	
<b>Selected Generic (Tier 1)</b>	\$20 Copayment
<b>Selected Brand &amp; Other Generic (Tier 2)</b>	\$40 Copayment
<b>Non-Selected Brand (Tier 3)</b>	\$80 Copayment
<b>All Other (Tier 4)</b>	\$80 Copayment

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**Optima Plus \$10/20/40/40  
Outpatient Prescription Drug Rider  
Schedule of Benefits**

**EXCLUSIONS AND LIMITATIONS AND OTHER COVERAGE TERMS.**

The following is a list of exclusions, Limitations and other conditions that apply to Your drug benefit.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.
3. Copayment and Coinsurance are out of pocket amounts You pay directly to the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge.
4. Deductible means the dollar amount You must pay out of pocket each year for Covered Services before the Plan begins to pay for Your benefits.
5. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out of Pocket Limit.
6. The Plan will not cover any additional benefits after benefit Limits have been reached. You will be responsible for payment for all outpatient prescription drugs after a benefit Limit has been reached.
7. Amounts You pay for any outpatient prescription drug after a benefit Limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out of Pocket Amount.
8. Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan at the same level as the Plan gives to participating pharmacies.
9. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law. Medications with no approved FDA indications are excluded from Coverage.
10. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage.
11. The Plan may approve Coverage of Limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs
12. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. Benefits for Covered Services may be reduced or denied for not complying with the Plan's Pre-Authorization requirements.
13. At its sole discretions Optima's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
14. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
15. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
16. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
17. Insulin, syringes, and needles are covered under the prescription drug rider. Diabetic supplies and equipment, in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, other than those listed as covered under this prescription drug rider are covered under the Plan's medical benefit. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under this rider or the Plan's medical benefit.
18. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
19. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
20. Injectables (other than those self-administered and insulin) are excluded from Coverage under this rider.
21. Medication taken or administered to the Member in the Physician's office is excluded from Coverage under this rider.
22. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage under this rider.

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**Optima Plus \$10/20/40/40  
Outpatient Prescription Drug Rider  
Schedule of Benefits**

23. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
24. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
25. Replacement prescriptions resulting from loss, theft, or breakage are excluded from Coverage.
26. Therapeutic devices or appliances, including but not Limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
27. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
28. Infertility drugs are excluded from Coverage.
29. Medications for smoking cessation, including but not Limited to Nicorette gum, nicotine patches, nicotine spray are excluded from Coverage.
30. Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
31. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
32. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

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# OPTIMA HEALTH

## Vision Care and Materials Rider

Includes Covered Services for expanded vision care services in lieu of those Preventive Vision Care Benefits described in Section IV of this document.

EyeMed Vision Services administers this benefit for vision care services and materials. Each Covered Person is eligible to receive a routine eye examination, refraction, and lenses, frames, and contact lenses from an EyeMed network provider as specified and at the Copayment or coinsurance indicated on the Face Sheet.

To receive Covered Services:

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

Vision Materials Rider	Copayments/Comments
Each Covered Person is eligible to receive a routine eye examination, refraction; lenses and frames; or contact lenses once every 12 months from a Participating EyeMed provider.	\$0 Copayment per eye examination and materials.  Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost.  Lenses (single, vision, bifocal, trifocal) covered in full.  Frames covered in full up to \$100 retail.  Contact lenses (in lieu of glasses) covered in full up to \$100 retail.  For eye examinations from Out-of-Network providers Member's will be reimbursed \$30 for an eye examination only.  Copayments or coinsurance for covered services under this rider are not applied toward any Plan maximum out of pocket and must continue to be paid after the maximum is met.

Underwritten by Optima Health Plan



## OPTIMA HEALTH PLAN AMENDMENT

**Notwithstanding anything in the Group Agreement or Evidence of Coverage to the contrary, the following is added as a Covered Service to Section 6 “What is Covered”:**

### **Autism Spectrum Disorder**

Coverage includes the “Diagnosis” and “Treatment” of “Autism spectrum disorder” in individuals from age two through age six.

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.

"Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

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

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

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

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



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

Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, We have the right to request a review of that treatment, including an independent review, not more than once every 12 months unless We 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.

We 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 we apply them to all other Covered Services under the Plan.

Coverage for "autism spectrum disorder" is in addition to coverage provided under the Plan for Early Intervention Services and Biologically Based Mental Health Illness.

## **OPTIMA HEALTH PLAN**

A handwritten signature in black ink, reading "Michael M. Dudley". The signature is written in a cursive style with a large, prominent initial "M".

**President**



## OPTIMA HEALTH PLAN AMENDMENT

As of the Effective Date, and not withstanding anything in the Group Agreement or Evidence of Coverage to the contrary, the following sections are amended as follows:

### **The Definition of eVisit in Section I is amended to read:**

**1.24 eVisit** means an email exchange between a primary care or specialty physician and his/her established patient that substitutes for a standard office visit for the purpose of providing substantive advice or intervention for a non-urgent problem. Lesser services usually provided by phone or mail that would not qualify as an eVisit include reporting normal lab results, making appointments, or prescription refills.

### **Section, 2.3 HIPAA Special Enrollment Provisions, is amended to read:**

**2.3 HIPAA SPECIAL ENROLLMENT PROVISIONS.** The Plan provides special late enrollment periods for eligible Subscribers and Dependents that fall into the following categories:

**A. Late enrollees with other coverage.** Employees or Dependents who initially decline Coverage because they have other group health coverage or other health insurance will be allowed to enroll late without evidence of insurability if the following conditions are met:

1. The employee and/or Dependent is eligible under the Plan's terms; and
2. When the employee declined enrollment for the employee or Dependent, either the employee or Dependent had COBRA continuation coverage under another Plan and that coverage has since run out; or if the other Coverage was not under COBRA, either the other coverage has ended because of loss of eligibility, or the employer has stopped contributions toward the other coverage; and
3. An individual must request enrollment no more than 31 days from the time that he or she knew or should have known that his or her other Coverage had ended.
4. Late enrollment is effective no later than the first day of the first calendar month after the date the Plan receives a completed request for enrollment.

**B. Late enrollees due to marriage, birth, adoption, or placement for adoption.**

If a Dependent is added through marriage, birth, adoption, or placement for adoption, the employee and Dependents may apply for Coverage through special late enrollment. Individuals in this category do not have to have previously declined Coverage because of other Coverage. Individuals must request Coverage within 31 days of marriage, birth, adoption, or placement for adoption. For special enrollment due to birth or adoption late enrollment is effective on the date of the birth, adoption or placement for adoption. For special enrollment due to marriage late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.

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

Employees or Dependents who are eligible for group coverage will be permitted to enroll late if they (1) lose eligibility for Medicaid or CHIP coverage or (2) they become eligible to participate in a premium assistance program under Medicaid or CHIP. In both cases the employee must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. Special enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.

**The description of covered Physician Services listed in Section 4.2 V is amended to read:**

**4.2.V PHYSICIAN SERVICES.**

All Pre-Authorization requirements as outlined in Section III of the evidence of coverage apply.

Covered Physician Services include:

1. Surgical, home, Hospital, and office visits, for diagnosis and treatment of an injury or Illness or preventive care covered under this Plan.
2. Professional services received in conjunction with inpatient Hospital services, skilled nursing services, Emergency Department services, ambulatory surgery, or outpatient services.
3. Specialist care and consultations.
4. A second opinion from a Non-Plan Provider requires approval by the Plan.

Covered Physician Services do not include eVisits.

**The following is added to Section V Exclusions and Limitations under letter “E”:**

eVisits are excluded from Coverage.

**OPTIMA HEALTH PLAN**

A handwritten signature in black ink, appearing to read "Michael M. Dudley". The signature is written in a cursive, flowing style.

**President**

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## SECTION I DEFINITIONS

For purposes of the Group Agreement and the Evidence of Coverage and any Enrollment Application, questionnaire, form or other document provided or executed in connection with the Group Agreement, the following terms shall have the meanings given in this section unless the context requires otherwise:

- [1.1] **ACCIDENT/INJURY** means physical damage to a Member's body caused by an unexpected event or trauma independent of all other causes. Only a non-occupational injury (i.e., one which does not arise out of or in the course of any work for pay or profit) is considered for benefits under the Plan.
- [1.2] **ADMISSION** means registration as a patient under the patient's own name at a Hospital for purposes of determining the applicability of Copayments, Coinsurances, and Deductibles. A newborn that remains in the Hospital after the mother is discharged will be registered as a patient under the newborn's own name, and a separate Copayment, Coinsurance, and Deductible may be applied.
- [1.3] **ADVERSE BENEFIT DETERMINATION** means a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for, a benefit based on a Member'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.
- [1.4] **CASE MANAGEMENT/CLINICAL CARE SERVICES** means individual review and follow-up for ongoing services.
- [1.5] **CLAIM** means a request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's reasonable procedure for filing claims.
- [1.6] **CLAIMANT** means a Member or person authorized to act on their behalf in filing a request for Plan benefits.
- [1.7] **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law No. 99-272. COBRA provisions apply to groups of more than 20 employees.
- [1.8] **COINSURANCE** are charges required to be paid by the member for certain services covered under this Plan or in conjunction with any applicable rider hereto. Coinsurance amounts are expressed as a percentage of the Plan's fee schedule or of an allowable charge for a specific health care service. Coinsurance may be required to be paid to the provider of the service at the time service is received.
- [1.9] **CONCURRENT CARE CLAIM/DECISION** means a Claim regarding a decision by the Plan to terminate or reduce benefits that it previously approved. Concurrent Claim also may be a request to extend the course of treatment already approved by the Plan.
- [1.10] **CONCURRENT REVIEW** means ongoing medical review of the Member's care while hospitalized.
- [1.11] **CONVERSION** is the process of changing a member's status from group to individual membership when he or she is no longer eligible for membership under the Group Agreement.
- [1.12] **COORDINATION OF BENEFITS** means those provisions by which the Plan physician or the Plan either together or separately seek to recover costs of an incident of sickness or accident on the part of the member, which may be covered by another group insurer, group service plan, or group health care plan including coverage provided under governmental programs subject to any limitations imposed by a Group Agreement preventing such recovery.
- [1.13] **COPAYMENT** means a specific dollar amount which may be collected directly from a Member as payment for Covered Services covered under this Evidence of Coverage. The schedule of Copayments is contained in the Face Sheet to this Evidence of Coverage. Copayment may be required to be paid to the provider of the service at the time service is received.

## SECTION I DEFINITIONS

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

**[1.15] COVERED SERVICES** means those health services and benefits to which Members are entitled under the terms of this Evidence of Coverage which are rendered while the Member is under the direct care of a physician.

**[1.16] CREDITABLE COVERAGE** means coverage which may be applied for credit to reduce the length of a pre-existing condition exclusion period and shall include any of the following:

1. Group health plans, including COBRA continuation coverage;
2. Health insurance coverage (care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurer;)
3. Individual coverage;
4. Medicare Part A, or B;
5. Medicaid;
6. Military service related care such as CHAMPUS;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. A state health benefits risk pool;
9. A health program offered under the Federal Employees Health Benefits Program;
10. A public health plan. (Any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;)
11. A health plan offered under the Peace Corps Act;
12. A State Children's Health Insurance Program under Title XXI of the Social Security Act.

Creditable Coverage does not include accident or disability insurance, liability insurance and related supplements, worker's compensation, automobile medical, coverage for on-site medical clinics, credit only insurance, limited scope dental or vision and long-term care related benefits when offered separately from the medical plan, and specific disease, hospital indemnity, and Medicare supplement insurance which functions separately from the medical plan.

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

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

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

**[1.18] DEDUCTIBLE** means the dollar amount of covered medical expenses for which a Member is responsible to pay before benefits are payable under the Plan. Such amount will not be reimbursed under the Plan.

## SECTION I DEFINITIONS

- [1.19] **DEPENDENT** is any person who is a member of a subscriber's family and who meets all applicable eligibility requirements of this Evidence of Coverage and is enrolled pursuant to the Group Agreement, and for whom the required fees have been received by the Plan.
- [1.20] **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. Examples of Emergency Services include, but are not limited to, heart attacks, severe chest pain, cardiovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, and other acute conditions as the Plan shall determine. All Emergency Services are subject to Retrospective Review.
- [1.21] **EMERGENCY SERVICES** means those health care services that are rendered by Plan or non-Plan providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (a) serious jeopardy to the mental or physical health of the individual, or (b) danger of serious impairment of the individual's bodily functions, or (c) serious dysfunction of any of the individual's bodily organs, or (d) in the case of a pregnant woman, serious jeopardy to the health of the fetus.
- [1.22] **ENROLLMENT APPLICATION** means an application furnished or approved by the Plan, executed by a person meeting the eligibility requirements of a Subscriber, pursuant to which such person applies on his or her own behalf and/or on behalf of eligible members of his or her family for Coverage for Health Services in connection with the Group Agreement.
- [1.23] **EVIDENCE OF COVERAGE** means this document evidencing covered health care services which is issued to each subscriber.
- [1.24] **eVisit** means an email exchange between a Primary Care Physician and his/her established patient that substitutes for a standard office visit for the purpose of providing substantive advice or intervention for a non-urgent problem. Lesser services usually provided by phone or mail that would not qualify as an eVisit include reporting normal lab results, making appointments, or prescription refills.
- [1.25] **EXPERIMENTAL/INVESTIGATIONAL:** A drug, device, medical treatment or procedure may be considered experimental/investigational if:
1. the majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
  2. the use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies; or
  3. the research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy can not 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.



## SECTION I DEFINITIONS

[1.26] **GROUP AGREEMENT** means the contract executed between the Plan and the respective group which expresses the agreed upon contractual rights and obligations of the parties thereto, and which describes the costs, procedures, benefits, conditions, limitations, exclusions, and other obligations to which members are subject under the Plan's prepaid health services plan(s).

[1.27] **GROUP/SUBSCRIBING GROUP** means the organization or firm contracting with the Plan to provide and/or arrange health care services for its employees and their eligible Dependents.

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

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

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

[1.31] **HOSPITAL** means an institution which:

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

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

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

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

[1.34] **MAXIMUM OUT OF POCKET AMOUNT** means the total amount a Member and/or eligible Dependents pay during a year as specified on the Face Sheet or Schedule of Benefits.

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

## SECTION I DEFINITIONS

- [1.36] **MEDICALLY NECESSARY** services and/or supplies means the use of services or supplies as provided by a Hospital, Skilled Nursing Facility, Physician or other provider required to identify or treat a Member's Illness or injury and which, as determined by the Member's primary care Physician and the Plan, are:
1. consistent with the symptoms, diagnosis and treatment of the Member's condition, disease, ailment or injury;
  2. in accordance with recognized standards of care for the Member's disease, ailment or injury;
  3. appropriate with regard to standards of good medical practice;
  4. not solely for the convenience of the Member, his or her primary care Physician, participating Physician, Hospital, or other health care provider; and
  5. the most appropriate supply or level of service which can be safely provided to the Member. When specifically applied to an inpatient, it further means that the Member's medical symptoms or condition requires that the diagnosis, treatment or service cannot be safely provided to the Member as an outpatient.
- [1.37] **MEMBER** means a Subscriber as described herein and the enrolled eligible Dependent(s) as defined in the section entitled "Eligibility."
- [1.38] **NON-PLAN PROVIDER** means any provider that is not a Plan Provider.
- [1.39] **OPEN ENROLLMENT PERIOD** means a period of time no longer than thirty (30) days occurring at least once annually during which time any eligible employee of a Subscribing Group may join or transfer from one type of health care plan (e.g. indemnity or Health Maintenance Organization) to another.
- [1.40] **PARTICIPANT EMPLOYER** means any employer, sole proprietorship, partnership, corporation or firm which:
1. Is a subsidiary of or affiliated with the group;
  2. By written mutual agreement between the group and Plan, has been included under the Agreement; and
  3. Has not been removed in accordance with any of the Agreement terms.
- [1.41] **PHYSICIAN** means, with respect to any medical care and service, a person:
1. Certified or licensed, under the laws of the state where treatment is rendered, as qualified to perform the particular medical or surgical service for which claim is made and who is practicing within the scope of such certification or licensure; and
  2. Any other health care provider or allied practitioner if, and as, mandated by state law.
  3. This term does not include: (1) an intern; or (2) a person in training.
- [1.42] **PLAN** means Optima Health Plan which is licensed to conduct business in the Commonwealth of Virginia as a Health Maintenance Organization (HMO), which arranges to provide to Members health care services that are set forth herein.
- [1.43] **PLAN PHARMACY** means a duly licensed pharmacy which has a contract with the Plan.
- [1.44] **PLAN PROVIDER** means a Physician, Hospital, Skilled Nursing Facility, urgent care center, laboratory or any other duly licensed institution or health professional under contract to provide professional and Hospital services to Members. A list of Plan Providers and their locations is available to each Subscriber upon enrollment. Such list shall be revised from time to time as necessary and is available upon request. A Plan Provider's contract may terminate, and a Subscriber may be required to use another Plan Provider.
- [1.45] **POST-SERVICE CLAIM** means any Claim for a benefit under the Plan that is not a Pre-Service claim.
- [1.46] **PRE-AUTHORIZATION** means an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care.

## SECTION I DEFINITIONS

- [1.47] **PREMIUM** means the amount of money prepaid to the Plan by the Group, including Subscriber contributions, if any, on behalf of enrolled Subscribers and Dependents enrolled through that Group.
- [1.48] **PRE-EXISTING CONDITION** means a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the Member's enrollment date. The enrollment date is the first day of coverage under the Plan or if there is a waiting period the first day of the waiting period.
- [1.49] **PRE-SERVICE CLAIM** means any claim for a benefit under the Plan for which the Plan requires approval before the Member obtains medical care.
- [1.50] **PRIMARY CARE PHYSICIAN (PCP)** means the participating Physician selected by a Member to provide and/or coordinate medical care, which includes internists, pediatricians, and family practitioners. At the time of enrollment each Member shall have the right to select a Primary Care Physician from among the Plan's affiliated Primary Care Physicians, subject to availability. Any Member who is dissatisfied with his Primary Care Physician shall have the right to select another Primary Care Physician from among the Plan's affiliated Primary Care Physicians, subject to availability. The Plan may impose a reasonable waiting period for this transfer.
- [1.51] **RETROSPECTIVE REVIEW** means the review of the Member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment.
- [1.52] **SERVICE AREA** means the geographic area in which the Plan has directly or indirectly arranged for the provision Covered Services to be generally available to Members. The Plan's service area includes the following cities and counties:
- Accomack Co, Amelia Co, Brunswick Co, Caroline Co, Charles City Co, Charlotte Co, Chesapeake City, Chesterfield Co, Colonial Heights City, Cumberland Co, Dinwiddie Co, Emporia City, Essex Co, Fluvanna Co, Franklin City, Fredericksburg City, Gloucester Co, Goochland Co, Greensville Co, Hampton City, Hanover Co, Henrico Co, Hopewell City, Isle of Wight Co, James City Co, King George Co, King and Queen Co, King William Co, Lancaster Co, Louisa Co, Mathews Co, Middlesex Co, New Kent Co, Newport News City, Norfolk City, Northampton Co, Northumberland Co, Nottoway Co, Petersburg City, Poquoson City, Portsmouth City, Powhatan Co, Prince Edward Co, Prince George Co, Richmond City, Richmond County, Southampton Co, Spotsylvania Co, Stafford Co, Suffolk City, Surry Co, Sussex Co, Virginia Beach City, Westmoreland Co, Williamsburg City, York Co.
- Albemarle Co, Buckingham Co, Charlottesville City, Culpepper Co, Greene Co, Lunenburg Co, Madison Co, Mecklenburg Co, Nelson Co, Orange Co, Petersburg City.
- [1.53] **SKILLED NURSING FACILITY** means an institution which is licensed by the State and is accredited under one of the programs of the Joint Commission on Accreditation of Health care Organizations as a Skilled Nursing Facility or is recognized by Medicare as an extended care facility; and furnishes room and board and 24-hour-a-day skilled nursing care by, or under the supervision of, a registered graduate nurse (RN); and other than incidentally is not a clinic, a rest facility, a home for the aged, a place for drug addicts or alcoholics, or a place for Custodial Care.
- [1.54] **SPECIALIST** means any Physician who is not a Primary Care Physician. A Plan Specialist shall mean a Specialist who is a Plan Provider.
- [1.55] **SUBSCRIBER** means the individual, employee, or Member who meets the eligibility requirements of the group, who has made an application, and whose premiums have been paid.
- [1.56] **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

## SECTION I DEFINITIONS

maximum function; or (2) in the opinion of a physician with knowledge of the Member's medical condition, following the Plan's normal appeal procedure would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A prudent layperson standard applies when determining what is an urgent care claim, except where a physician with knowledge of the Member's medical condition determines that the claim is urgent.

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

## SECTION II ELIGIBILITY

### [2.1] ELIGIBILITY FOR COVERAGE

- A. Subscribers.** An employee is eligible for Coverage if he/she:
1. is employed by the group; and
  2. resides or works in the Service Area; and
  3. is actively at work; and
  4. within 31 days of the effective date of coverage files a complete enrollment application, including any applicable premium or fees, with the Plan ; and
  5. does not knowingly give incorrect, incomplete, or deceptive information regarding his/her eligibility for coverage to the Plan or to the Employer Group; and
  6. does not knowingly give incorrect, incomplete or deceptive information regarding his/her dependents eligibility for coverage to the Plan or to the Employer Group; and
  7. meets any other requirements as specified herein, or as specified by the Plan or by the Employer Group.

**Independent contractors, agents or consultants who do not receive W-2 forms are not eligible.**

- B. Actively At Work.** Employees must be “actively at work” to receive covered benefits and services. An employee is considered actively at work on any day he or she is employed by the group, meets all the eligibility requirements of the group, and premiums are being paid to the Plan on behalf of the eligible employee. Employees who, for any reason, are not actively at work on the group’s effective date of Coverage must wait until they return to being actively at work to receive Covered Services. Absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the Plan as being actively at work. Retired employees, COBRA beneficiary, or employees receiving Workers’ Compensation will be considered actively at work on any day that all of the group’s eligibility requirements are met and premiums are being paid to the Plan.

If an eligible employee is no longer actively at work because of one of the following circumstances, and the group’s Coverage remains in effect, Coverage may continue if premiums are being paid on the employee’s behalf:

1. For an approved short term leave of absence Coverage will continue for not longer than three months.
2. For an employee who is totally disabled, Coverage will continue for a period of not longer than six months or until the date the employee is covered under Medicare or Medicaid, whichever shall occur first. The Plan may require certification of disability from the employee.

- C. Dependents.** Dependents must be chiefly dependent upon the Subscriber for support. Eligible Dependents include:

1. A Subscriber’s lawful spouse.
2. A Subscriber’s unmarried natural or step child to the age specified on the Face Sheet. Children must be chiefly dependent upon the Subscriber for support.
3. A Subscriber’s unmarried legally adopted child or a child placed for adoption, to the age specified on the Face Sheet. Children must be chiefly dependent upon the Subscriber for support.

## SECTION II ELIGIBILITY

4. A Subscriber's unmarried dependent child who is a full-time student as specified on the Face Sheet. Students must be enrolled in an accredited educational institution, and must be chiefly dependent upon the Subscriber for support.
5. A child for whom the Subscriber is a court appointed legal guardian, and who is chiefly dependent upon the Subscriber for support. Foster children are not eligible. Grandchildren are only eligible with proof of legal guardianship.
6. Dependent children who are both (i) incapable of self-sustaining employment by reason of mental or physical disability and (ii) chiefly dependent upon the Subscriber for support and maintenance will continue to be eligible for coverage beyond the age listed on the Face Sheet.

The Plan will require acceptable proof of incapacity and dependency within 31 days of the child's reaching the specified age. Proof of incapacity consists of a statement by a licensed psychologist, psychiatrist, or other Physician stating the Dependent is incapable of self-sustaining employment by reason of disability from mental or physical disability. The Plan may require subsequent statements not more than once a year.

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

- D. Ineligible Individuals.** A person who would otherwise be eligible for Coverage may nonetheless be ineligible if that person or someone else in his or her family unit has been terminated for specific reasons as defined in Section X Termination of Coverage 10.3 A-G.

A person who would otherwise be eligible for Coverage may nonetheless be ineligible if that person would cause Optima Health to violate any of its policies for doing business with or providing services to a person who appears on any official sanction list maintained by local, state or federal government agencies.

- E. Changes in Eligibility.** The Plan must be notified of a change in the status of a Subscriber, spouse or other Dependent that would make them ineligible to remain covered under the Plan. Unless otherwise stated on Face Sheet or Schedule of Benefits coverage for a Dependent child ends the last day of the month in which the child reaches the Plan's limiting age as stated on the Face Sheet or Schedule of Benefits. Coverage for full-time students ends the last day of the month in which the student reaches the limiting age as specified on the Face Sheet or Schedule of Benefits, or the last day of the month in which they fail to satisfy the Plan's criteria for being eligible for Coverage as a full time student whichever occurs first.

When the Plan provides coverage for a dependent child enrolled as a full-time student and that child is unable due to a medical condition to continue as a full-time student, coverage under the policy for that child will continue in force (i) for a period of not more than 12 months from the date the child ceases to be a full-time student or (ii) until such child reaches the Plan's limiting age, as stated on the Plans Face Sheet or Schedule of Benefits, for full time students, whichever first occurs, provided the child's treating physician certifies to the Plan at the time the child withdraws as a full-time student that the child's absence is medically necessary. A child's status as a full-time student shall be determined in accordance with the criteria specified by the institution in which the child is enrolled.

Dependent children who are both (i) incapable of self-sustaining employment by reason of mental or physical disability and (ii) chiefly dependent upon the Subscriber for support and maintenance will continue to be eligible for coverage beyond the age listed on the Face Sheet. Acceptable proof of incapacity and dependency must be provided to the Plan within 31 days of the child's reaching the specified age. Proof of incapacity consists of a statement by a licensed psychologist, psychiatrist, or other Physician stating the Dependent is incapable of self-sustaining employment by reason of disability from mental or physical disability. The Plan may require subsequent statements not more than once a year.



## SECTION II ELIGIBILITY

- F. Verification of Eligibility.** The Plan reserves the right to request or review at any time, at its sole and absolute discretion, proof of eligibility of any Subscriber or Dependent.
- G. Disenrollment of Ineligible Subscribers and Dependents.** Should the Plan discover at any time that any Subscriber or Dependent is not eligible for Coverage, was never eligible to be enrolled for Coverage, and/or submitted false proof of eligibility for Coverage, then the Plan may, at its sole discretion either:
1. Retain the premium paid on behalf of the ineligible Subscriber/Dependent up until the date the Plan became aware of the ineligibility and cancel the Subscriber's/Dependent's coverage after the date through which premiums were paid; or
  2. Refund the premium payment made on behalf of the Subscriber/Dependent during the period of ineligibility to the Group, disenroll the Subscriber/Dependent, and retract all or part of any claims paid from the provider(s) during the period of ineligibility. Disenrollment of a Subscriber or Dependent due to ineligibility for coverage may result in the reversal and/or denial of claims during the period of ineligibility. The Subscriber/Dependent may be held responsible by the provider(s) for any charges for claims for services received during the period of ineligibility; or
  3. Refund the premium payment made on behalf of the Subscriber/Dependent during the period of ineligibility to the Group, and disenroll the Subscriber and/or Dependent. The Subscriber/Dependent will be held responsible for any charges for claims for services received during the period they were not eligible to receive services. The Plan may seek to recover from the Member Usual and Customary Charges for any claims paid by the Plan for services received during the period of ineligibility.

### [2.2] ENROLLMENT

- A. Plan Open Enrollment.** A Plan Open Enrollment Period shall be held annually. During the Plan Open Enrollment Period, each eligible employee may apply for Coverage as a Subscriber for himself or herself and for eligible Dependents. The Subscriber must complete an Enrollment Application provided by the Plan. The Enrollment Application must include all eligible Dependents.

**If an Enrollment Application is not completed and signed by the Subscriber during the Plan Open Enrollment period the Subscriber and Dependents will not be eligible for enrollment until the Plan's next Open Enrollment Period.** The Plan will may not recognize retroactive adjustments of Members enrollment due to the group's inability to furnish the Enrollment Application or fees within 31 days of the Coverage effective date. The Plan provides special late enrollment periods for eligible Subscribers and Dependents that satisfy requirements under HIPAA Special Enrollment provisions.

- B. Newly Eligible Subscriber.** Each new Subscriber entering employment after the Plan's initial effective date shall be permitted to apply for Coverage for himself or herself and eligible Dependents, within 31 days of becoming eligible.
- C. Newly Eligible Dependents.** A Subscriber may enroll or disenroll an eligible Dependent by notifying the Plan within 31 days of the occurrence of one of the following qualifying events:
1. Change in legal marital status including marriage, death of a spouse, divorce, legal separation, and annulment;
  2. Change in number of Subscriber's Dependents including birth, death, adoption, placement for adoption or court appointed legal guardianship;
  3. Change in employment status, including a change in work site, a switch between hourly and salaried status, and any other employment status change resulting in a gain or loss of eligibility of the employee, spouse, or Dependent;
  4. Change in Dependent's eligibility for Coverage;

## SECTION II ELIGIBILITY

5. Change in residence of employee, spouse, or Dependent that affects eligibility.

- D. Consistency Rule.** In order for one of these events to qualify as an occasion for changing coverage under the Plan, it must have a direct effect on the Subscriber's present coverage. For example, marriage is a permissible reason to change from Subscriber only coverage to family coverage. However, the death of a child has no effect on the Subscriber's coverage if he/she has a spouse and another child, and is carrying family coverage.

**If an Enrollment Application is not completed and signed by the Subscriber within 31 days of a qualifying event or family status change, the Subscriber and Dependents will not be eligible for enrollment until the Plan's next Open Enrollment Period.** The Plan provides special late enrollment periods for eligible Subscribers and Dependents that satisfy requirements under HIPAA Special Enrollment provisions.

**[2.3] HIPAA SPECIAL ENROLLMENT PROVISIONS.** The Plan provides special late enrollment periods for eligible Subscribers and Dependents that fall into the following categories:

- A. Late enrollees with other coverage.** Employees or Dependents who initially decline Coverage because they have other group health coverage or other health insurance will be allowed to enroll late without evidence of insurability if the following conditions are met:

5. The employee and/or Dependent is eligible under the Plan's terms; and
6. When the employee declined enrollment for the employee or Dependent, either the employee or Dependent had COBRA continuation coverage under another Plan and that coverage has since run out; or if the other Coverage was not under COBRA, either the other coverage has ended because of loss of eligibility, or the employer has stopped contributions toward the other coverage; and
7. An individual must request enrollment no more than 31 days from the time that he or she knew or should have known that his or her other Coverage had ended.
8. Late enrollment is effective no later than the first day of the first calendar month after the date the Plan receives a completed request for enrollment.

**B. Late enrollees due to marriage, birth, adoption, or placement for adoption.**

If a Dependent is added through marriage, birth, adoption, or placement for adoption, the employee and Dependents may apply for Coverage through special late enrollment. Individuals in this category do not have to have previously declined Coverage because of other Coverage. Individuals must request Coverage within 31 days of marriage, birth, adoption, or placement for adoption. For special enrollment due to birth or adoption late enrollment is effective on the date of the birth, adoption or placement for adoption. For special enrollment due to marriage late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.

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

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

**[2.4] EFFECTIVE DATE OF COVERAGE.** Subject to the Plan's receipt of an Enrollment Application and any applicable premium from or on behalf of each prospective Member, and to the



## SECTION II ELIGIBILITY

Plan's eligibility requirements, Coverage will become effective on the earliest of the following dates, unless otherwise specified by the group:

- A. Subscriber Coverage.**
1. When a person applies in writing for Coverage on or prior to the date he or she satisfies the eligibility requirements above, Coverage will start on the date of eligibility.
  2. When a person applies in writing for Coverage after the date he or she satisfies the eligibility requirements above, Coverage will start the first day of the calendar month following the month in which the Plan receives the application.
- B. Effective Date of Coverage.** Coverage under this Agreement for an eligible Subscriber becomes effective on the effective date of the Group Agreement.
- C. Multiple Coverage.** A Subscriber is not eligible for multiple Coverage even if he or she is connected with more than one employer. Such a Subscriber will be considered an employee of one employer. Lifetime maximums and limitations are based on each person's lifetime regardless of the number of policies under which the Member is or has been covered.
- D. Effective Date of Dependent Coverage.** A Subscriber must enroll Dependents, as defined, to be eligible for Coverage. Coverage for eligible Dependents will become effective on the latter of:
1. the date the Subscriber's Coverage becomes effective; or
  2. on the date the Subscriber acquires eligible Dependents.
- E. Newborn Children.** A newborn child will be covered from the moment of birth if the Subscriber's Coverage under this Plan is in effect, and if the Subscriber adds the newborn to his or her Coverage within 31 days of birth. An adopted child whose placement has occurred within thirty-one days of birth will be considered a newborn child of the Subscriber as of the date of adoptive or parental placement. The newborn child's Coverage will be identical to Coverage provided to the Subscriber. It also will provide 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. If the newborn is not added to the Plan within 31 days of birth the newborn may not be eligible to enroll until the next Plan Open Enrollment Period.
- F. Adopted Children.** An adopted child will be eligible for Coverage from the date of placement with an eligible Subscriber for the purpose of adoption. A child whose placement has occurred within thirty-one days of birth will be considered a newborn child of the Subscriber as of the date of adoptive or parental placement. Evidence of placement and any applicable Premiums must be submitted to the Plan within 31 days from the date of placement. If the adopted child is not added to the Plan within 31 days of placement the child may not be eligible to enroll until the next Open Enrollment Period.
- G. Coverage Mandated by Court Order.** Coverage mandated by court order issues, including Qualified Medical Child Support Orders (QMCSOs), will begin on the date of the court order if the request is made and an Enrollment Application is submitted within 31 days of the order. Coverage mandated by the Child Support Act will begin on the first of the month following the Group's notification to the Plan. Subject to the eligibility requirements of the Plan and/or the Group in order to provide Coverage to a Dependent child, both the child and the parent ordered to provide support may be required to enroll in the Plan.
- H. Medicare.** A Covered Person who is eligible to be covered under Medicare (Title XVIII of the Social Security Act of 1965, as amended), is encouraged to enroll in Parts A and B coverage on the date they are eligible. If you are under age 65, entitled to Medicare because of End Stage Renal Disease (ESRD), and have employer group health coverage, please contact the Plan regarding your participation with Medicare Part B or assistance in obtaining Part B.

# **SECTION III, PRE-AUTHORIZATION AND UTILIZATION MANAGEMENT PROCEDURES FOR CLAIMS FOR COVERED SERVICES**

**Pre-Authorizations are approved or denied based on current medical practice and guidelines and not on incentives or bonus structures.**

## **[3.1] UTILIZATION MANAGEMENT.**

The Plan's Medical Care Services/Clinical Care Services Department uses Pre-Authorization, Concurrent Review, Retrospective Review, and Case Management to manage utilization of Covered Services and to make coverage determinations on Pre-Service, Post-Service, Concurrent, and Urgent Care claims.

**Compliance with any of the review processes under the Plan's Utilization Management Program is not a guarantee of benefits or payment under the Plan.**

### **A. Pre-Authorization.**

Pre-Authorization is an evaluation process which assesses the Medical Necessity and coverage of proposed treatment, and checks to see that the treatment is being provided at the appropriate level of care.

Pre-Authorization is certification by the Plan of Medical Necessity and not a guarantee of payment by the Plan. Payment by the Plan for Covered Services is contingent on the Member's eligibility status on the date the Covered Service is received by the Member. The Member will be responsible for any applicable Copayment, Coinsurance, or Deductible as specified on the Face Sheet. Covered Services are subject to all exclusions and limitations under the Plan.

The Plan has policies and procedures in place that tell Physicians which Covered Services require Pre-Authorization. The Plan informs your Physician of the proper procedures for obtaining Pre-Authorization through the Physician's contract, provider manual, and newsletters.

1. **Your Primary Care Physician (PCP) or other Plan Provider must obtain Pre-Authorization from the Plan for the following treatment, services, and supplies:** Scheduled Ambulance Transport, Outpatient Surgery/Services, Surgery done in the Physician's Office, Inpatient Hospitalization, Inpatient Surgery/Services, Single items of Durable Medical Equipment and Orthopedic and Prosthetic Appliances over \$750, all rental items of Durable Medical Equipment and Orthopedic and Prosthetic Appliances, and all repair and replacement items of Durable Medical Equipment and Orthopedic and Prosthetic Appliances, Artificial Limbs, Prenatal Maternity Services, Prosthetic/Orthopedic Appliances, Home Health Care, Skilled Nursing Facility Care, Services for Short Term Therapy (physical, occupational, and speech therapy, and cardiac, pulmonary, and vascular rehabilitation), IV therapy with medications, Inhalation therapy, Early Intervention Services, Clinical Trials for Treatment Studies on Cancer, Hospice Services, Oral Surgery, TMJ Services, Tubal Ligation, Hospitalization and Anesthesia for Dental Procedures, Treatment of Lymphedema, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET) Scans, Computerized Axial Tomography (CT) Scans, Computerized Axial Tomography Angiogram (CTA) Scans; and Transplant Services.
2. **Mental Health and Substance Abuse Services.** Pre-Authorization is required for all inpatient services, and partial hospitalization services. Pre-Authorization is required for intensive outpatient Program (IOP), psychological and neuro-psychological testing, and electro-convulsive therapy.
3. **Pre-Authorization for other ridered services.**
  - a. **Hearing Aid Services.** If your plan includes a Rider for Coverage for Hearing Aids all services under the rider require Pre-authorization by the Plan.

## **SECTION III, PRE-AUTHORIZATION AND UTILIZATION MANAGEMENT PROCEDURES FOR CLAIMS FOR COVERED SERVICES**

b. **Chiropractic Care and Services.** If your Plan includes a Rider for Chiropractic Care all services are administered by American Specialty Health Networks (ASHN). All covered chiropractic services must be Pre-authorized by ASHN.

c. **Oral Surgery Wisdom Teeth Extraction Rider.** If your Plan includes a rider for extraction of wisdom teeth all services must be Pre-Authorized by the Plan.

d. **Morbid Obesity Rider.** If your Plan includes a rider for services related to treatment of Morbid Obesity all services must be Pre-Authorized by the Plan.

e. **Prosthetics Rider.** If your Plan includes a rider for coverage of medically necessary Prosthetics all prosthetic devices, their repair, fitting, replacement, and components must be Pre-Authorized by the Plan.

#### **4. Pre-Service Claims Coverage Decisions.**

The Plan will make coverage 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 we determine it to be necessary because of matters beyond our control. If an extension is necessary, the Member will be notified prior to the end of the initial 15 day period. If the extension is necessary due to the Plan not having enough information to make the initial coverage decision the Member/Provider will be notified of the specific information missing and the timeframe within which the information must be provided. The Plan will make its decision within 2 business days of receiving all the required medical information needed to process the Claim. When the Plan has made a decision on services requiring Pre-Authorization, the Plan will send the Member and treating Physician written notice of the Plan's decision.

#### **B. Expedited Approval for Urgent Care Claims.**

Urgent Care Claim means any request or claim for medical care or treatment that, if the Plan's normal Pre-Authorization standards are applied, would seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

For Urgent Care Claims, the Plan will notify the Member of the Plan's decision not later than 72 hours from receipt of the claim. If the Plan requires additional information, the Member/Physician will be notified within 24 hours of receipt of the claim of the specific information that is missing and the applicable timeframes within which to respond to the Plan.

For review determination relating to prescriptions for the alleviation of cancer pain, the Plan will notify the Member/Physician of its decision within 24 hours of receipt of the claim.

#### **C. Approval of care involving ongoing course of treatment.**

Concurrent Review means ongoing medical review of the Member's care during Hospital and Skilled Nursing Facility confinements. Concurrent Review may also be performed for Home Health Care Treatment Plans, and therapy and rehabilitative treatment plans. For Concurrent Claims the Plan will notify the Claimant prior to the benefit being reduced or terminated and early enough to allow for an appeal of the decision.

Plan Providers must follow certain procedures to ensure 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 Member of its 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

## **SECTION III, PRE-AUTHORIZATION AND UTILIZATION MANAGEMENT PROCEDURES FOR CLAIMS FOR COVERED SERVICES**

rehabilitative treatment plans must be made 7 days prior to the end of the authorized timeframe to avoid disruption of care or services.

### **D. Retrospective Review of Post-Service Claims.**

Retrospective Review means the review by the Plan of the Member's medical records and other supporting documentation after services have been rendered to determine if the services were Medically Necessary and the Plan's liability for payment.

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 we determine it to be necessary because of matters beyond our control. If an extension is necessary, the Member will be notified prior to the end of the initial 30 day period. If the extension is necessary due to the Plan not having enough information to make the initial coverage decision, the Member/Provider will be notified of the specific information missing and the timeframe within which the information must be provided.

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

### **E. Adverse Benefit Determinations.**

An Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit based on a Member'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.

The Plan will provide written notice of an Adverse Benefit Determination within the determination timeframe depending upon the type of Claim under review. Urgent claim notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notification will include the following:

1. The specific reason or reason for the adverse benefit determination;
2. Reference to the specific Plan provisions on which the determination is based;
3. A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.
4. The Member is 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, the Member is entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgement for the determination applying the terms of the Plan to the Member's medical circumstances.

You may be entitled to appeal an adverse benefit determination made by the Plan. Please refer to the Plan's Appeal Procedures in this document.

## SECTION IV COVERED SERVICES

### [4.1] OVERVIEW OF PROFESSIONAL SERVICES AND BENEFITS.

The Plan includes benefits for Medically Necessary Covered Services received from Plan Providers. The Plan, along with your Physician, will decide if a covered benefit is Medically Necessary. Medical necessity is determined in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment and in conformity with the professional and technical standards adopted by the Plan.

Services may require Pre-Authorization as described in Section III.

The Member will be responsible for all applicable Copayment or Coinsurance, and any applicable Deductibles depending on the type and place of service (e.g., Physician's office, Urgent Care Center, Hospital inpatient or Hospital outpatient setting).

Except for covered Emergency Services the Plan shall have no responsibility to pay for Covered Services rendered by Non-Plan Providers unless Pre-authorized by the Plan. Copayments, Coinsurances, any applicable Deductibles, and any applicable visit or dollar limits are listed on the Face Sheet of this Evidence of Coverage.

Plan Provider means a Physician, Hospital, Skilled Nursing Facility, urgent care center, laboratory, or any other duly licensed institution or health professional under contract to provide professional and Hospital services to Members. It is the Member's responsibility to know which providers are Plan Providers. The Member will be responsible for all charges for services received from Non Plan Providers even if the Member has been sent to the Non Plan Provider by a Plan Provider unless Pre-Authorized by the Plan. The member will be responsible for all charges for all laboratory services received from Non Plan laboratories even if a Plan Provider sends the Member's lab work to a non plan lab. The Member will be responsible for all charges for services received from Non-Plan Providers while receiving care at plan facilities unless Pre-Authorized by the Plan.

**Benefit Reductions.** The Plan shall provide to the Group written notice of any benefit reductions during the contract period at least 60 days before such benefit reductions become effective. The Group shall, in turn, provide to their Members written notice of any benefit reductions during the contract period at least 30 days before such benefit reductions become effective.

Detailed information about each of the Plan's Covered Services can be found in Section 4.2 Covered Services in the following sections:

- [A.] Accidental Dental Services.
- [B.] Allergy Care.
- [C.] Ambulance Service.
- [D.] Anesthesia Services.
- [E.] Artificial Limb Services.
- [F.] Clinical Trials for Treatment Studies on Cancer.
- [G.] Diabetic Equipment and Supplies.
- [H.] Durable Medical Equipment and Orthopedic and Prosthetic Appliances.
- [I.] Early Intervention Services.
- [J.] Emergency Services.
- [K.] Family Planning.
- [L.] Hemophilia and Congenital Bleeding Disorders.
- [M.] Home Health Care Skilled Services.
- [N.] Hospice Care.
- [O.] Hospital Services.
- [P.] Hospitalization and Anesthesia for Dental Procedures.
- [Q.] Infant Hearing Screenings.
- [R.] Maternity Services.

**PLEASE REFER TO YOUR FACE SHEET OF THIS EVIDENCE OF COVERAGE FOR APPLICABLE DEDUCTIBLES, COPAYMENTS AND/OR COINSURANCES.**

## SECTION IV COVERED SERVICES

- [S.] Mental Health Services.
- [T.] Biologically Based Mental Health Illnesses.
- [U.] Oral Surgery.
- [V.] Physician Services.
- [W.] Preventive Care Services.
- [X.] Preventive Vision Services.
- [Y.] Reconstructive Breast Surgery.
- [Z.] Short Term Therapy and Rehabilitation Services.
- [AA.] Skilled Nursing Services.
- [BB.] TMJ Syndrome.
- [CC.] Transplant Services.
- [DD.] Reduction Mammoplasty.
- [EE.] Lymphedema.
- [FF.] Diagnostic, X-ray, and Laboratory Services.

### [4.2] COVERED SERVICES

#### [A.] ACCIDENTAL DENTAL SERVICES.

##### **Pre-Authorization is required.**

Medically necessary dental services as a result of accidental injury, regardless of the date of such injury, are Covered Services under the Plan. For injuries occurring on or after the effective date of coverage, treatment must be sought within 60 days of the accident.

A health care professional (nurse, Physician, dentist, etc.) must document treatment.

Members may obtain services from any licensed dentist subject to the following:

1. Members are responsible for a specialist Copayment, or Coinsurance for each visit to a dentist or oral surgeon.
2. Members who choose to receive care from non-participating dentists or oral surgeons may be billed by the non-participating provider for charges in excess of the Plan's fee schedule.
3. The Plan covers dental services performed during an Emergency Department visit immediately after the Accident/Injury and in conjunction with the initial stabilization of the injury. The Plan will retrospectively review Emergency Department services. All Emergency Department Copayments, Coinsurances, and or Deductibles will apply.

#### [B.] ALLERGY CARE.

The Plan provides the following allergy care services:

1. Allergy Testing - Performance and evaluation of scratch puncture or prick allergy tests.
2. Allergy Serum - Professional services for supervising and providing antigens for allergy injections.
3. Allergy Administration - Coverage is limited to professional services related to allergy injections. The provision of allergenic extracts with injections depends upon serum Coverage.

#### [C.] AMBULANCE/STRETCHER/WHEELCHAIR SERVICE.

**Pre-Authorization is required for non-emergency transportation.**

**PLEASE REFER TO YOUR FACE SHEET OF THIS EVIDENCE OF COVERAGE FOR APPLICABLE DEDUCTIBLES, COPAYMENTS AND/OR COINSURANCES.**



## SECTION IV COVERED SERVICES

Covered for emergency transportation only when provided by an agency authorized to provide such service to transport a Member and is a vehicle staffed by medically trained personnel and equipped to handle a medical emergency. Ambulance/Wheelchair service is covered from the place where the Member was injured to the nearest Hospital where treatment can be furnished. Not included are any charges made to transport the person: a) if ambulance/wheelchair service is not required by the person's physical or mental condition; b) in any other vehicle; or c) to any other place. Ambulance/Wheelchair transportation from Hospital to Hospital may be covered if Medically Necessary and pre-authorized by the Plan.

### **[D.] ANESTHESIA SERVICES.**

Inpatient Hospital or outpatient facility Anesthesia Services include but are not limited to general, regional, 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. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids, and/or blood and the usual monitoring services.

### **[E.] ARTIFICIAL LIMB SERVICES.**

#### **Pre-Authorization is required.**

Artificial limbs, including repair and replacement, will be covered as indicated on the Face Sheet of this Evidence of Coverage.

### **[F.] COVERAGE FOR CLINICAL TRIALS FOR TREATMENT STUDIES ON CANCER.**

#### **Pre-Authorization is required.**

1. Coverage includes patient costs incurred during participation in clinical trials for treatment studies on cancer. This includes ovarian cancer trials.
2. The Plan determines reimbursement for patient costs incurred during participation in cancer treatment clinical trials as it would determine reimbursement for 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.
3. Definitions. For purposes of this section:

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

**“FDA”** means the Federal Food and Drug Administration.

**“Member”** means a policyholder, Subscriber, insured, or certificate holder or a covered Dependent of a policyholder, Subscriber, insured or certificate holder.

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

**“NCI”** means the National Cancer Institute.

**“NIH”** means the National Institutes of Health.

**PLEASE REFER TO YOUR FACE SHEET OF THIS EVIDENCE OF COVERAGE FOR APPLICABLE DEDUCTIBLES, COPAYMENTS AND/OR COINSURANCES.**

## SECTION IV COVERED SERVICES

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

4. The Plan covers patient costs incurred during cancer treatment clinical trials if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. It may, however, decide to provide Coverage on a case-by-case basis for Phase I clinical trials.
5. The treatment described in subsection F must be provided by a clinical trial approved by:
  - a) The National Cancer Institute;
  - b) An NCI cooperative group or an NCI center;
  - c) The FDA in the form of an investigational new drug application;
  - d) The Federal Department of Veterans Affairs; or
  - e) An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.
6. The facility and personnel providing the treatment must be capable of doing so by virtue of their experience, training and expertise.
7. Coverage under this section applies only if:
  - a) There is no clearly superior, non-investigational treatment alternative;
  - b) The available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and
  - c) The Member and the Physician or health care provider who provides services to the Member conclude that the Member’s participation in the clinical trial would be appropriate, pursuant to procedures established by the Plan and as disclosed in the policy and Evidence of Coverage.

### **[G.] DIABETIC EQUIPMENT AND SUPPLIES.**

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, gestational diabetes, insulin using diabetes and non-insulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. “Equipment” and “supplies” shall not be considered durable medical equipment. This benefit is not subject to any Policy or calendar year dollar or durational benefit limitations or maximums for benefits or services.

**The Member will be responsible for any applicable Copayment, Coinsurance, or Deductible as specified on the Face Sheet depending upon the type service received. Diabetic equipment and supplies are covered when received from Plan Providers only.**

To qualify for Coverage under this section, diabetes in-person outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional. Members may call 1-800-SENTARA for information on educational classes. Members may call Liberty Medical Supplies at 1-866-846-9361 to arrange for prescribed supplies to be delivered to them at home. Members will be responsible for the Copayment or Coinsurance as specified on the Face Sheet.

### **[H.] DURABLE MEDICAL EQUIPMENT (DME) AND ORTHOPEDIC AND PROSTHETIC APPLIANCES.**

**Pre-Authorization is required for items over \$750.**

**PLEASE REFER TO YOUR FACE SHEET OF THIS EVIDENCE OF COVERAGE FOR APPLICABLE DEDUCTIBLES, COPAYMENTS AND/OR COINSURANCES.**



## **SECTION IV COVERED SERVICES**

**Pre-Authorization is required for all rental items.**

**Pre-Authorization is required for all repair and replacement.**

**The rental, purchase, repair and replacement of durable medical equipment and orthopedic and prosthetic appliances is covered at the level indicated on the Face Sheet of this Evidence of Coverage. Members may contact Member Services to verify Coverage of specific DME items.**

The Plan covers DME that has been prescribed as necessary by an appropriate Physician in the care and treatment of disease and injury and is not used primarily for the comfort and well being of the affected person. Covered Services also include colostomy, ileostomy, and tracheostomy supplies, and suction and urinary Catheters. Any item of durable medical equipment, even if prescribed by a Physician, will not be covered if deemed to be useful, but not absolutely necessary, to the care and treatment of the patient or 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:**

- a) The initial appliance
- b) Medically Necessary customized splints and customized braces when pre-authorized by the Plan.

**Coverage for Prosthetic appliances includes:**

- a) Medically Necessary surgically implanted prosthetic devices.
- b) The replacement of prosthetic devices for infants/children up to age 18 due to growth are covered when Medically Necessary. This applies even if the infant's/child's condition resulted from an injury or illness which happened before the child became a Member under this Plan.

### **[I.] EARLY INTERVENTION SERVICES.**

**Pre-Authorization is required.**

Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices. The Plan covers Early Intervention Services for Dependents from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services. The Subscriber must give the Plan a copy of the certification. 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.

Coverage is limited to \$5,000 per Member per calendar year. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the place of service as specified on the Face Sheet. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of Coverage paid by the insurer to or on behalf of the insured during the insured's or Member's lifetime.

### **[J.] EMERGENCY SERVICES**

An 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. Examples of Emergency Services include, but are not limited to, heart attacks, severe chest pain, cardiovascular

**PLEASE REFER TO YOUR FACE SHEET OF THIS EVIDENCE OF COVERAGE FOR APPLICABLE DEDUCTIBLES, COPAYMENTS AND/OR COINSURANCES.**

## SECTION IV COVERED SERVICES

accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, and other acute conditions as the Plan shall determine.

The Plan covers Emergency Services in or out of network at the level indicated on the Plan's Face Sheet or Schedule of Benefits. The Member's Copayment or Coinsurance amount will be determined by the type and place of service associated with the emergency treatment (e.g., Emergency Department visits, inpatient Admissions, and urgent care visits). The Member will be responsible for any applicable Deductible amount as specified on the Plan's Face Sheet or Schedule of Benefits.

1. **EMERGENCY DEPARTMENT SERVICES** means those Emergency Department facility, physician, and ancillary services that are rendered during an Emergency Department visit for the treatment of illness or injury resulting from an accident or onset of an emergency medical condition. Examples of emergency medical conditions include, but are not limited to, heart attacks, severe chest pain, cardiovascular Accidents, hemorrhaging, poisoning, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, and other acute conditions as the Plan shall determine.

If the Plan requires a Copayment for an Emergency Department visit, and the Member requires inpatient hospital admission the Emergency Department Copayment will be waived. The Member will be responsible for the applicable inpatient hospital admission Copayment or Coinsurance as specified on the face sheet or schedule of benefits.

2. **AMBULANCE SERVICES** are covered for Medically Necessary emergency transportation when provided by an agency authorized to provide such services to transport a Member; and the ambulance is a vehicle staffed by medically trained personnel and equipped to handle a medical emergency. Ambulance service is covered from the place where the Member was injured to the nearest Hospital where treatment can be furnished. The Member will be responsible for a Copayment or Coinsurance, and any applicable Deductible for transportation each way as specified on the face sheet or schedule of benefits.
3. **URGENT CARE CENTER SERVICES** means those urgent care facility, physician, and ancillary services rendered during an urgent care center visit for treatment of medical conditions which are non-life-threatening but Medically Necessary in order to prevent a serious deterioration of the Member's health that results from an unforeseen Illness or injury. Members are expected to seek care at the nearest Plan Provider (i.e., urgent care and/or medical center). The Member will be responsible for any applicable Deductible, Copayment or Coinsurance listed on the Plan's Face Sheet.
4. **EMERGENCY OR URGENT MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES.** The Psychiatric Emergency Response Service is available 24 hours a day, seven days per week to respond to clinical psychiatric and substance abuse emergencies. The Plan may be reached by calling 757-552-7174, or 1-800-648-8420.
5. **AFTER HOURS NURSE TRIAGE PROGRAM.** The After Hours Nurse Triage Program lets Members talk to a professional nurse who can help them find the most appropriate care in the most appropriate setting. Professional nurses listen to concerns, analyze the situation, and advise Members where to get medical care on evenings and weekends when the doctor's office is closed. If Medically Necessary, the nurse will send Members to Emergency Departments or urgent care centers where they can get appropriate treatment.

When the Member calls the After Hours nurse, the Member should have his/her Membership ID card ready. The Member should be prepared to describe the immediate medical situation in as much detail as possible. Members should make sure to include information about any other medical problem for which they are currently being treated. Members also should tell the nurse what prescriptions they take.

**PLEASE REFER TO YOUR FACE SHEET OF THIS EVIDENCE OF COVERAGE FOR APPLICABLE DEDUCTIBLES, COPAYMENTS AND/OR COINSURANCES.**

## SECTION IV COVERED SERVICES

**In a life-threatening situation, the Member should call 911 or proceed to the nearest Emergency Department.**

**The After Hours nurse cannot diagnose medical conditions or write prescriptions.**

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

- 6. PLAN NOTIFICATION FOLLOWING EMERGENCY TREATMENT.** The Member must notify the Plan of all Emergency Services (e.g., Emergency Department visits, inpatient Admissions, and urgent care visits) within 48 hours, or two business days, medical condition permitting. It is the ultimate responsibility of the Member, or the Member's representative, to notify the Plan of any services in order for such claims to be considered for payment.
- 7. FOLLOW UP CARE.** Routine follow up care after an emergency is not covered under Emergency Services benefits unless authorized by the Plan.
- 8. RETROSPECTIVE REVIEW OF EMERGENCY SERVICES.** All Emergency, Urgent Care, Ambulance and Emergency Mental Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an emergency, the Plan will have no responsibility for the cost of the treatment and the Member will be solely responsible for payment.

Retrospective Review means the review of the Member's medical records and other supporting documentation by the Plan after emergency services have been rendered. The cost of reproduction of medical records and other supporting documentation is the responsibility of the party seeking Retrospective Review. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the member received care from a Plan Provider.

### **[K.] FAMILY PLANNING SERVICES.**

The following family planning services are covered:

1. Gynecological examinations.
2. Counseling and education for birth control options.
3. Tubal Ligation services. **(Pre-authorization is required.)**
4. Vasectomy services.
5. Depo-Provera, Lunelle injections or other injections as approved by the Plan.
6. Intrauterine devices (IUDs) and cervical caps and their insertion.
7. Elective Abortion: Elective termination of pregnancy is covered during the first 12 weeks of pregnancy. The Plan covers abortions after the first 12 weeks only if the life of the mother would be endangered if the fetus were carried to full term; there is reasonable medical evidence of lethal fetal abnormalities, or in the case of rape or incest.

### **[L.] HEMOPHILIA AND CONGENITAL BLEEDING DISORDERS.**

**Pre-Authorization is required for home treatment.**

Benefits include Coverage for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits include Coverage for the purchase of blood products and blood infusion equipment required for home treatment of

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## SECTION IV COVERED SERVICES

routine bleeding disorders associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

### [M.] HOME HEALTH CARE SKILLED SERVICES.

#### **Pre-Authorization is required.**

Benefits are payable, as specifically shown on the Face Sheet, for the following home health care charges if made:

1. By a certified home health care agency; and
2. For home health care services furnished to a Member in his or her home, or in place of Hospitalization; and
3. In accordance with a home health care Plan, under which such home health care services are expected to result in significant improvement of the Member's condition within a period of 90 days; and
4. Member must be home bound and unable to receive services outside the home to qualify for care; and
5. Therapy benefits may be furnished to a Member who is home bound and will be subject to all applicable short term therapy benefit limits and specialist Copayments as specified on the Face Sheet.

The following definitions apply to this section:

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

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

**"Home Health Care Plan"** means a program:

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

**"Home Health Care Services"** means:

1. Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.), if the services of a registered nurse are not available; or
2. Part-time or intermittent home health aide services which consist primarily of medical or therapeutic caring for the patient; or
3. Physical, speech, and occupational therapy, if provided by the home health care agency, for conditions which are expected to result in significant improvement within the 90-day period noted above; or

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4. Surgical dressings, medical appliances, oxygen and supplies which are Medically Necessary for treatment of the Member at home, but only to the extent such items or services would have been covered under this Plan if the Member had been confined in a Hospital or Skilled Nursing Facility.

**“Home Health Skilled Care Visit”** means:

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

The maximum number of home health care visits for which benefits are payable under the Plan is shown on the Face Sheet of this Evidence of Coverage.

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

### **[N.] HOSPICE CARE.**

**Pre-Authorization is required.**

Coverage for Hospice Services means a coordinated program of home and inpatient care and shall include palliative and supportive physical, psychological, psychosocial and other Health Services to individuals with a terminal illness, whose medical prognosis is death within six months, and who elect to receive palliative care rather than curative care.

Palliative care shall mean 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.

### **[O.] HOSPITAL SERVICES**

**Pre-Authorization is required.**

Members must go to Plan Hospitals or diagnostic facilities for inpatient or outpatient services. Members will be responsible for a Copayment or Coinsurance as specified in the Face Sheet depending on place of service. The Member's authorized Primary Care Physician or specialist must order or approve services. Hospital services include:

1. Room and board in semiprivate room.
2. General nursing care.
3. Meals and special diets.
4. Use of operating room facilities.
5. Use of intensive care or cardiac care units and services.
6. Laboratory and other diagnostic tests.
7. X-ray facilities (diagnosis and therapy).
8. Medications.
9. Anesthesia and oxygen services.
10. Inhalation therapy.
11. Administration of whole blood and blood products.
12. Surgically implanted prosthetic devices.
13. Outpatient ambulatory surgical and/or other services (i.e., observation room).
14. Medical detoxification.
15. Minimum Length of Stay:

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- a. Not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. The attending Physician in consultation with the patient may decide that a shorter Hospital stay is appropriate.
- b. Not less than 48 hours for a patient following a radical or modified radical mastectomy, and 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. The attending Physician in consultation with the patient may determine that a shorter Hospital stay is appropriate.
- c. 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

### **[P.] HOSPITALIZATION AND ANESTHESIA FOR DENTAL PROCEDURES.**

#### **Pre-Authorization is required.**

Coverage for Medically Necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a covered person who is determined by a licensed dentist in consultation with the covered person's treating Physician to require general anesthesia and Admission to a Hospital or outpatient surgery facility to effectively and safely provide dental care and (i) is under the age of five, or (ii) is severely disabled, or (iii) has a medical condition and requires Admission to a Hospital or outpatient surgery facility and general anesthesia for dental care treatment. For purposes of 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.

### **[Q.] INFANT HEARING SCREENINGS**

#### **Pre-Authorization is required.**

Coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 of the Code of Virginia and as prescribed herein for newborn. Coverage shall provide coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 of the Code of Virginia 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. Such coverage shall include benefits for any 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.

### **[R.] MATERNITY SERVICES.**

#### **Pre-Authorization is required for pre-natal services.**

The Plan covers:

1. Obstetrical and prenatal care and all related inpatient Hospital services.
2. Postpartum inpatient care; and a home visit or visits in accordance with the Plan's medical criteria.
3. Genetic testing limited to Amniocentesis, HLAB 27, and infant chromosomal analysis.
4. All care and services related to a miscarriage.
5. A minimum length of stay of 48 hours for a vaginal delivery, 96 hours following a cesarean section. The attending Physician and patient may decide that a shorter Hospital stay is appropriate. Pre-authorization is not required for delivery.

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

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

### [S.] BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES.

Pre-Authorization is required for all inpatient services, and partial hospitalization services. Pre-Authorization is required for intensive outpatient Program (IOP), psychological and neuro-psychological testing, and electro-convulsive therapy. The Plan may be reached by calling 757-552-7174 or 1-800-648-8420. Benefits are payable, as specifically shown in the Face Sheet of this Evidence of Coverage. Please refer to the Face Sheet for applicable Copayments, Coinsurances, and Deductibles.

Emergency Mental Health Services are subject to the same rules established under Section 4.2.J.. The Plan determines what is a psychiatric emergency based on the medical community's accepted standards. The Member's medical benefit covers emergency medical care related to a psychiatric condition.

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 State Mental Health, Mental Retardation and Substance Abuse Services Board 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 abuse 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 abuse 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 abuse 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 abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

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

### **1. Inpatient Mental Health and Substance Abuse Services.**

Benefits are payable for Medically Necessary inpatient treatment. Benefits for inpatient and partial hospitalization, mental health and substance abuse services include, but are not limited to treatment at a general hospital, an inpatient unit of a mental health treatment center or an intermediate care facility. Mental health care is covered subject to benefit Copayments and Coinsurances specified on the Face Sheet or Schedule of Benefits.

### **2. Outpatient Mental Health and Substance Abuse Services.**

Medically Necessary outpatient mental health care is covered subject to Copayments and Coinsurances specified on the Face Sheet or Schedule of Benefits.

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### 4. Behavioral Health Exclusions and Limitations.

The following services are excluded from Coverage:

- Medically Necessary Treatments - Any services, supplies or treatments not specifically listed as Covered as well as services and any other procedures determined not to be Medically Necessary are excluded from Coverage.
- The Plan only covers psychiatric confinement in a Plan Hospital.
- All services, other than emergency services that have not been authorized by Optima Behavioral Health Services, Inc. are excluded from Coverage.
- Non-medical ancillary services are not covered including but not limited to vocational rehabilitation services, employment counseling, expressive therapies, and health education are excluded from Coverage.
- Psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings are excluded from Coverage.
- Court ordered examinations or care unless medically necessary is excluded from Coverage.
- Services delivered while detained under a Temporary Detention Order (TDO) are excluded from coverage.
- Psychiatric treatment for sexual dysfunction or sexual therapy, mental retardation or learning disabilities is excluded from Coverage.
- Psychoanalysis to complete degree or residency requirements is excluded from Coverage.
- Pastoral counseling, or relationship counseling is excluded from Coverage.
- Psychological testing for educational purposes is excluded from Coverage.
- Residential level of care or treatment is excluded from Coverage.
- Other non-covered services listed in this manual that could be deemed mental health services are excluded from Coverage.
- Sex Change Operations and any medical treatment of gender identity disorders are excluded from Coverage.
- Services not listed as covered even if a provider or clinician is licensed to provide such services.
- Services provided by behavioral health clinicians not licensed for independent practice in the Commonwealth of Virginia are excluded from Coverage. Services include, but are not limited to medication dispensing in methadone

### [T.] BIOLOGICALLY BASED MENTAL ILLNESS.

**Pre-Authorization is required. The Plan may be reached by calling 757-552-7174 or 1-800-648-8420.**

Covered Services includes inpatient and outpatient care and services for the following diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Benefits for biologically based mental Illnesses may be different from benefits for other Illnesses, conditions or disorders if such benefits meet the medical criteria necessary to achieve the same outcomes as are achieved by the benefits for any other Illness, condition or disorder that is covered by such policy or contract.

Coverage for biologically based mental Illnesses shall neither be different nor separate from Coverage for any other Illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime

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durational limits, benefit year of lifetime dollar limits, lifetime episodes or treatment limits, Copayment and coinsurance factors, and benefit year maximum for deductibles and Copayment and coinsurance factors.

Please refer to the face sheet or schedule of benefits in this document for applicable Copayments or Coinsurances.

### **[U.] ORAL SURGERY.**

**Pre-Authorization is required.**

Oral surgery is covered for:

1. Surgical procedures required to repair accidental injuries to the jaws, mouth, lips, tongue or hard and soft palates.
2. Treatment of fractures of the facial bones.
3. 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.
4. 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.
5. Coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Inpatient and outpatient dental, oral surgical, and orthodontic services which are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia will be covered.

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

### **[V.] PHYSICIAN SERVICES.**

**All Pre-Authorization and referral requirements as outlined in Section III of this document apply.**

Covered Services include:

1. Surgical, home, Hospital, and office visits, for diagnosis and treatment of an injury or illness or preventive care covered under this Plan.
2. Professional services received in conjunction with inpatient Hospital services, skilled nursing services, Emergency Department services, ambulatory surgery, or outpatient services.
3. Specialist care and consultations.
4. A second opinion from a Non-Plan Provider requires approval by the Plan.
5. eVisits from a Primary Care Physician if the PCP makes this service available to patients.

### **[W.] PREVENTIVE CARE SERVICES.**

The following preventive care services are covered in accordance with professional standards adopted by the Plan:

1. One routine physical exam each year.
2. For females 13 years or older one routine annual GYN exam every 12 months without a referral from the Member's PCP when performed by a Plan-participating OB/GYN. Coverage includes routine health care services incidental to and rendered during the annual visit. Services related to infertility are not considered routine. Services related to high risk OB are not considered routine. Health care services related to this benefit means Medically Necessary services provided by the OB/GYN in the

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care of or related to the female reproductive system and breasts. Additional health care services may be provided by the OB/GYN, subject to the following:

- a) consultation by the OB/ GYN with the PCP for follow-up care or subsequent visits;
  - b) the OB/GYN may refer directly to a Plan participating Specialist for services directly related to reproductive organs;
  - c) all inpatient hospitalizations and outpatient surgery/ services must be pre-authorized by the Plan.
3. Routine mammogram including one screening mammogram to persons age 35 to 39 and annually to persons age 40 and over.
  4. Pap smears including Coverage for annual testing performed by any FDA approved gynecologic cytology screening technologies.
  5. One PSA test in a 12-month period and digital rectal examinations for persons over age 50 and persons over age 40 who are at high risk for prostate cancer.
  6. All routine and necessary immunizations for each newborn child from birth to thirty-six months of age, including diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other immunizations as may be prescribed by the Commissioner of Health.
  7. Colorectal cancer screening including an annual occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, 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 such recommendations.
  8. One annual routine hearing test.
  9. Well-baby care including routine care and periodic review of a child's physical and emotional status subject to the following :
    - a) services include a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards;
    - b) 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;
    - c) 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.

### [X.] PREVENTIVE VISION CARE SERVICES.

#### **In-Network Coverage.**

EyeMed Vision Services administers this benefit for vision care services. Each Member is eligible to receive a routine eye examination, refraction, and prescription for eyeglass lenses from an EyeMed network provider as specified and at the Copayment indicated on the Face Sheet.

To receive Covered Services:

1. Select a participating EyeMed network provider from the Plan's provider directory or by calling 1-888-610-2268. Automated location information is available 24 hours a day. Customer service representatives are available Monday through Friday 9 a.m. - 9 p.m., and Saturdays 9 a.m. - 5 p.m.

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2. Visit or call the participating provider and identify yourself as a participant by providing your Member ID information. The provider will verify eligibility, your Plan's Covered Services and any applicable Copayment or Coinsurance. Payment is due when you receive services.
3. If the vision provider determines that you need additional medical care you should contact your PCP or other physician for treatment options.

### **Out of Network Coverage.**

If you use a provider that is not in the EyeMed network for an examination you will be responsible for paying the provider in full at the time services are rendered. For Covered Services Members will be reimbursed according to the out of network benefit on the Face Sheet. For reimbursement, call Customer Service at 1-888-610-2268 to verify eligibility and to receive 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

### **[Y.] RECONSTRUCTIVE BREAST SURGERY.**

#### **Pre-Authorization is required.**

For each Member who has had a mastectomy the Plan will cover the following in a manner determined in consultation with the attending Physician and the Member:

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

### **[Z.] SHORT TERM REHABILITATION AND THERAPY SERVICES.**

#### **Pre-Authorization is required.**

Benefits are payable for short-term physical, occupational, and speech therapy, and cardiac, pulmonary and vascular rehabilitation which, in the judgment of the Plan, is expected within a period of 90 days to result in the significant improvement of a specific body function lost or impaired due to an injury or illness.

Short term physical therapy will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness, or pre-condition level.

Short term occupational therapy services are limited to services which assist the Member to restore self-care and improve functionality in activities of daily living.

Short term speech therapy benefits are covered when judged Medically Necessary to correct an organic impairment of organic origin due to accident or illness, or following surgery to correct a congenital defect, and will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness, or pre-condition speech function.

Benefits are payable and Members are responsible for Copayments or coinsurance only as shown on the face sheet of this Evidence of Coverage, for charges made by a Physician, or by a licensed or certified physical, or speech therapist for the following:

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1. Therapy or rehabilitation services furnished to a Member, on an outpatient or inpatient basis, in a facility covered under this Plan;
2. Therapy or rehabilitation services provided to correct an impairment for which corrective surgery has been performed for such therapy;
3. Therapy or rehabilitation services provided in accordance with a specific written treatment Plan which:
  - a) details the treatment to be rendered, including its frequency, duration, and goals; and
  - b) provides for ongoing review; and
  - c) only allows renewal of the treatment plan if the therapy continues to be restorative and the Plan determined that continued therapy can be expected to result in the significant improvement of a Member's condition within a period of 90 days.

### **[AA.] SKILLED NURSING SERVICES.**

#### **Pre-Authorization is required.**

The Plan covers care given in a licensed Skilled Nursing Facility subject to the following:

1. When ordered by the Physician.
2. Covered Expenses Include:
  - a) Semi-private room and board charges
  - b) Other facility services and supply charges
3. Services are covered up to the maximum number of days per calendar or contract year as specified on the Face Sheet.
4. Custodial Care is not covered.

### **[BB.] TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME.**

#### **Pre-Authorization is required.**

Medically indicated services and supplies necessary for the treatment of temporomandibular joint (TMJ) syndrome. Treatment given by a Plan PCP, or by a Plan oral surgeon referred by a Plan PCP is covered in full, minus applicable Copayments or Coinsurance. Members who choose to receive care from Non-Plan dentists or oral surgeons may be billed by the Non-Plan Provider for charges in excess of the Plan's fee schedule.

### **[CC.] TRANSPLANT SERVICES.**

#### **Pre-Authorization is required.**

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

The Plan covers the following human organ transplants, provided they are Medically Necessary, non-experimental, and meet all Plan criteria:

1. Kidney;
2. Heart;
3. Cornea;
4. Liver;
5. Lung;
6. Heart-lung;

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7. Kidney-pancreas;
8. Bone marrow transplants for leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, severe combined immunodeficiency disease, aplastic anemia and Wiskott-Aldrich syndrome;
9. Dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for the treatment of breast cancer.
10. At the discretion of the Plan, this list may be amended in accordance with accepted medical and community standards.

### **[DD.] REDUCTION MAMMOPLASTY.**

Covered Services include all applicable services associated with Reduction Mammoplasty including but not limited to physician, facility, surgical, and/or diagnostic services. This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy covered under the Plan's benefits for Reconstructive Breast Surgery .

### **[EE.] LYMPHEDEMA.**

#### **Pre-Authorization is required.**

Coverage includes benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

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.

### **[FF.] DIAGNOSTIC, X-RAY, AND LABORATORY SERVICES.**

#### **Pre-authorization is required for diagnostic services.**

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

Covered Services include Medically Necessary diagnostic x-ray, and laboratory services. The Member will be responsible for all applicable Copayments, Coinsurances, and Deductibles

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## SECTION V EXCLUSIONS AND LIMITATIONS

The following is a list of services, supplies, equipment and benefits that are limited in or excluded from Coverage:

### A

**Abortion** - Elective termination of pregnancy is covered during the first 12 weeks of pregnancy. The Plan covers abortion after the first 12 weeks only if the life of the mother would be endangered if the fetus were carried to full term; or if there is reasonable medical evidence of lethal fetal abnormalities; or in the case of rape or incest.

**Acupuncture** - is excluded from Coverage.

**Adaptations to the Home** - are excluded from Coverage. Examples include, but are not limited to, handrails, ramps, escalators, elevators, or other disability modifications.

**Allergy Testing** - Food allergy ingestion testing, IGE immunoassays for quantitative In-vitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST is excluded from Coverage.

**AMA - Against Medical Advice** - A Member may opt not to comply with recommended treatment. In such cases, the Plan will not assume any further liability for the particular condition unless the Member later decides to follow prescribed treatment under the care of the ordering physician and subject to the terms of the Member's Coverage.

**Ambulance Services** – other than for emergency transportation are excluded from Coverage unless authorized by the Plan.

**Ancillary Services** - non-medical ancillary services for which the Member is referred are excluded from Coverage. These include, but are not limited to, vocational rehab services, employment counseling, marriage counseling, expressive therapies and health education.

**Anesthesia** – General anesthesia in a Physician's office is excluded from Coverage.

**Aromatherapy** - is excluded from Coverage.

**Autopsies** - are excluded from Coverage.

### B

**Batteries** - Batteries for repair or replacement is excluded from Coverage. This does not apply to batteries for motorized wheelchairs.

**Behavioral Health**– Optima Behavioral Health Services, Inc. administers mental health and substance abuse services for the Plan. The following services are excluded from Coverage:

- Medically Necessary Treatments - Any services, supplies or treatments not specifically listed as Covered as well as services and any other procedures determined not to be Medically Necessary are excluded from Coverage.
- The Plan only covers psychiatric confinement in a Plan Hospital.
- All services, other than emergency services that have not been authorized by Optima Behavioral Health Services, Inc. are excluded from Coverage.
- Non-medical ancillary services are not covered including but not limited to vocational rehabilitation services, employment counseling, expressive therapies, and health education are excluded from Coverage.

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## SECTION V EXCLUSIONS AND LIMITATIONS

- Psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings are excluded from Coverage.
- Court ordered examinations or care unless medically necessary is excluded from Coverage.
- Services delivered while detained under a Temporary Detention Order (TDO) are excluded from coverage.
- Psychiatric treatment for sexual dysfunction or sexual therapy, mental retardation or learning disabilities is excluded from Coverage.
- Psychoanalysis to complete degree or residency requirements is excluded from Coverage.
- Pastoral counseling, or relationship counseling is excluded from Coverage.
- Psychological testing for educational purposes is excluded from Coverage.
- Residential level of care or treatment is excluded from Coverage.
- Other non-covered services listed in this manual that could be deemed mental health services are excluded from Coverage.
- Sex Change Operations and any medical treatment of gender identity disorders are excluded from Coverage.
- Services not listed as covered even if a provider or clinician is licensed to provide such services.
- Services provided by behavioral health clinicians not licensed for independent practice in the Commonwealth of Virginia are excluded from Coverage. Services include, but are not limited to medication dispensing in methadone

**Biofeedback** - is excluded from Coverage except when authorized by the Plan.

**Blood Pressure Monitors** - are excluded from Coverage unless authorized by the Plan.

**Blood and Blood Products** - are excluded from Coverage. The costs of securing the services of blood donors are excluded from Coverage. The cost of transportation and storage of blood if used in or outside the Plan's Service Area is excluded from Coverage.

**Bone Densitometry** - studies done more frequently than once every two years are excluded from Coverage unless authorized by the Plan.

**Bone or Joint treatment** – The Plan does not exclude coverage for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw or impose limits that are more restrictive than limits on coverage applicable to such treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

**Botox injections** - are excluded from Coverage unless approved by the Plan. Botox injections for the following are excluded from Coverage: headaches, cosmetic procedures, bone and joint conditions, and writer's cramp.

**Breast Augmentation/Mastopexy** - Procedures requested for the purpose of correction of cosmetic physical imperfections, except as required by State or Federal law regarding breast reconstruction and symmetry following mastectomy are excluded from Coverage.

**Breast Ductal Lavage** - is excluded from Coverage.

**Breast Milk** – donor breast milk is excluded from Coverage.

### C

**Chelation Therapy** - is excluded from Coverage for other than arsenic, copper, iron, gold, mercury or lead poisoning.

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## SECTION V EXCLUSIONS AND LIMITATIONS

**Chiropractic Care** - which shall mean the detection, treatment and correction of structural imbalance, subluxation or misalignment of the vertebral column in the human body, for the purpose of alleviating pressure on the spinal nerves and its associated effects related to such structural imbalance, misalignment or distortion, by physical or mechanical means is excluded from Coverage unless covered under a Rider.

**Circumcision** - is excluded from Coverage for non-medically indicated reasons after six weeks of age.

**Cold Therapy Machine** - is excluded from Coverage.

**Contact Lenses** - or eyeglasses or the fitting thereof are excluded from Coverage, except for the first pair of lenses (this may include contact lens, or placement of intraocular lens or eyeglass lens only) following cataract surgery.

**Cosmetic Surgery** - Emotional conflict or distress does not constitute medical necessity. The following are excluded from Coverage:

- Any cosmetic surgery and any hospital, physician, or other health service related thereto, except to the extent Medically Necessary to restore function;
- Non-Medically Necessary treatment or services resulting from complications due to cosmetic and/or experimental procedures;
- Breast Augmentation/ /Mastopexy procedures requested for the purpose of 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 and/or office visits for the purpose of obtaining cosmetic and/or experimental procedures;
- Penile Implants;
- Vitiligo treatments by laser, light or other methods are excluded from Coverage.

**Covered Services by Another Payor** - 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, are excluded from Coverage. Should a Member 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 the Member received services in accordance with the Plan's referral procedures. The Plan will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

**Custodial Care** - or domiciliary care, rest cures, or any examination and/or care ordered by a court of law, which has not received prior authorization by the Plan and has been arranged through, or provided at, a Plan Provider is excluded from Coverage.

### D

**Dentistry/Oral Surgery** - the following is a listing of specific dental and oral surgery exclusions, including, but not limited to:

#### 1. Dentistry

- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are excluded from Coverage. Medically necessary dental services as a result of accidental injury, regardless of the date of such injury, are Covered Services under the Plan. For injuries occurring on or after the effective date of coverage treatment must be sought within 60 days of the accident.

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## SECTION V EXCLUSIONS AND LIMITATIONS

- Medically Necessary dental services performed during an emergency room visit immediately after a traumatic injury and in conjunction with the initial stabilization of the traumatic injury are covered subject to utilization review for Medical Necessity.
- Services to restore appearance or for cosmetic purposes are excluded from Coverage.
- Dental implants and any preparation work for implants or dentures are excluded from Coverage.
- Dental services performed in a hospital or any outpatient facility except as described in the Member's Covered Services under "Hospitalization and Anesthesia for Dental procedures" are excluded from Coverage.

### 2. Oral Surgery

- Oral surgery, which is part of an orthodontic treatment program, is excluded from Coverage.
- Orthodontic treatment prior to Orthognathic surgery is excluded from Coverage.
- Dental implants and any preparation work for implants or dentures are excluded from Coverage.
- Extraction of wisdom teeth is excluded from Coverage unless covered under a rider

### 3. Dental Care

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are excluded from Coverage.
- Dental implants and any preparation work for implants or dentures are excluded from Coverage.

**Disposable Medical Supplies** - are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

**Driver Training** - is excluded from Coverage.

**Durable Medical Equipment (DME)** - The rental, purchase, repair and replacement of durable medical equipment are limited to the level of Coverage indicated on the Face Sheet or Schedule of Benefits. DME and surgical equipment benefits are excluded for:

- More than one item of equipment for the same or similar purpose.
- An amount that exceeds the cost of a similar supply that would have been sufficient to safely and adequately treat the Member's physical condition.
- Equipment and appliances which are not uniquely relevant to the treatment of disease.
- Disposable medical supplies and medical equipment are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.
- DME for use in altering air quality or temperature or for exercise or training.
- DME primarily for the comfort and well being of the Member.
- Batteries for repair or replacement. This does not apply to batteries for motorized wheelchairs.
- Blood Pressure Monitors unless authorized by the Plan.

## E

**Electron Beam Computer Tomography (EBCT)** - is excluded from coverage.

**Educational/Teacher Services/Evaluations** - educational, tutorial, evaluation, testing, screening and any other services relating to school or classroom performance is excluded from Coverage. This exclusion does not apply to those services that qualify as, and are covered under the Plan's benefit for Early Intervention Services.

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## SECTION V EXCLUSIONS AND LIMITATIONS

**Enteral or Parenteral Feeding** - Supplements and/or supplies is excluded from Coverage unless they are used as the sole source of nutrition. Over the counter supplements are excluded from Coverage.

**Exercise Equipment** - is excluded from Coverage, including, but not limited to bicycles, treadmills, stair climbers, pool or health club memberships.

**Experimental Treatment and Procedures** - are excluded from Coverage. Any drug, device, medical treatment or procedure may be considered experimental or investigative if:

- 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 Food and Drug Administration (FDA); or
- The drug, device, medical treatment or procedure is currently under study in a Phase I, Phase II clinical trial, an experimental study/investigational arm of a Phase III clinical study, or otherwise under study to determine safety and efficacy or to compare its safety and efficacy to current standards of care; or
- The drug device or medical services is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment.

**Eye Examination** - or any corrective or protective eyewear required by an employer as a condition of employment is excluded from Coverage.

**Eye Glasses** - or contact lenses or the fitting thereof are excluded from Coverage, except for the first pair of lenses (including contact lens, or placement of intraocular lens or eyeglass lens only.) following cataract surgery.

**Eye Movement Desensitization and Reprocessing Therapy** - is excluded from Coverage.

**Eye Corrective Surgery** - is excluded from Coverage, including, but not limited to, Radial Keratotomy, PRK and LASIK.

### F

**Food Allergy Testing** - is excluded from Coverage.

**Foot Care** –

- The following foot care services are excluded from Coverage unless authorized by the Plan:
  - operations which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions.
  - Treatment and services related to plantar warts
- The following are excluded from Coverage except for those Members with Diabetes or severe vascular problems:
  - Foot care including, but not limited to, the removal of corns or calluses and the trimming of nails,
  - Treatment and services related to flat-feet, fallen arches, or chronic foot strain;
  - Foot Orthotics of any kind, including but not limited to, customized or non-customized shoes, boots, and inserts.

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## SECTION V EXCLUSIONS AND LIMITATIONS

### G

#### **Genetic Testing and Counseling –**

- Genetic testing and counseling are excluded from Coverage except for amniocentesis, HLAB 27, and infant chromosomal analysis.
- BRAC1 and BRAC2, and FAP or AFAP are covered for colorectal cancer or other testing when Pre-Authorized by the Plan.

**GIFT programs (Gamete Intrafallopian Transfer)** - are excluded from Coverage.

**Growth Hormones** – are covered only under the Plan’s Outpatient Prescription Drug Rider.

### H

**Hearing Aids** - are excluded from Coverage, including but not limited to, fittings, molds and/or supplies, such as batteries, unless covered under a Rider.

**Heart** - Artificial and/or mechanical heart devices, placement and other related expenses are excluded from Coverage.

**Home Births** – are excluded from Coverage.

**Home Health** - Home Health Care Skilled Services are limited or excluded as follows:

- Services or supplies which are not specified in Home Health Care Plans are excluded from Coverage;
- Services for any Member who is not home-bound as determined by the Plan are excluded from Coverage;
- Custodial Care is excluded from Coverage;
- Transportation services are excluded from Coverage.

**Hypnotherapy** - is excluded from Coverage.

### I

**IGE** - IGE immunoassays for quantitative In-vitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST is excluded from Coverage.

**Immunizations** - as related to foreign travel and/or employment are excluded from Coverage.

**Implants** - Breast implants, except after mastectomy to produce symmetry, and are excluded from Coverage.

**Incarceration** - Services and treatments required or performed while the Member is incarcerated in a Local, State, Federal or Community Correctional Facility are excluded from Coverage.

**Infertility** - All services, tests, medications, and treatments in connection with the diagnosis or treatment of Infertility, and all services, tests, medications, and treatments that aid in or diagnose potential problems with conception are excluded from Coverage unless covered under a Rider, including, but not limited to:

- In-Vitro Fertilization programs, Artificial insemination or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- GIFT/ZIFT programs;
- Reproductive material storage;

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## SECTION V EXCLUSIONS AND LIMITATIONS

- Treatment related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage, or sperm washing;
- Infertility Services needed due to a reversal of sterilization;
- Services to reverse voluntary sterilization;
- Semen analysis;
- Sims-Huhner test (smear);
- Drugs used to treat infertility.

### J

### K

**Keloids** – the treatment of keloids as a result of body piercing or pierced ears is excluded from Coverage.

### L

**Laboratory Services** - Laboratory services received from Non-Plan Providers or laboratories are excluded from Coverage.

**Laser Therapy** - for Vitiligo or psoriasis is excluded from Coverage.

**Lung Cancer Screening Helical CT Scans** - are excluded from Coverage.

### M

**Magnetic Resonance Spectroscopy** - is excluded from Coverage.

**Massage Therapy** - is excluded from Coverage.

**Maternity Services** - Home births are excluded from Coverage.

**Maximum Benefit** - Amounts in excess of a benefit limit as stated in the Face Sheet or Schedule of Benefits of this Evidence of Coverage are excluded from Coverage.

**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 excluded from Coverage.

#### **Medical Equipment and Supplies –**

- Any disposable or convenience medical equipment, appliances, devices, and/or supplies are excluded from Coverage, including but not limited to: exercise equipment, air conditioners, purifiers, humidifiers and dehumidifiers, whirlpool baths, hypoallergenic pillows or bed linens, telephones, handrails, ramps, elevators and stair glides, orthotics, changes made to vehicles, residences or places of business, adaptive feeding devices, adaptive bed devices, water filters or purification devices and other similar equipment and supplies.
- Disposable Medical Supplies are excluded from Coverage, including, but not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

**Membership Fees** - to health and/or athletic clubs are excluded from Coverage.

**Mobile Cardiac Outpatient Telemetry** - (MCOT) is excluded from coverage.

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## SECTION V EXCLUSIONS AND LIMITATIONS

**Morbid Obesity** - Coverage for the treatment of morbid obesity through gastric bypass surgery or other such methods, surgeries, services or drugs are excluded from Coverage unless covered under a Rider.

**Motorized or Power Operated Vehicles** - are excluded from Coverage, including, but not limited to, any adaptations to motorized or power operated vehicles and/or chair lifts.

### N

**Neuro-cognitive therapy** - Following a neurological event or to restore cognitive deficits neuro-cognitive therapy is excluded from Coverage.

**Neuropsychological Services** - including, but not limited to, psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings are excluded from Coverage unless approved by the Plan.

**Newborn Coverage** - for the newborn or other child of a Dependent child is excluded from Coverage.

### O

**Obstetrical Care** - Home births are excluded from Coverage.

#### **Oral Surgery**

- Dental implants, and any preparation work for implants or dentures are excluded from Coverage
- Extraction of wisdom teeth is excluded from Coverage unless covered under a rider.
- Oral surgery, which is part of an orthodontic treatment program, is excluded from Coverage.
- Orthodontic treatment prior to Orthognathic surgery is excluded from Coverage.

**Orthoptics** - or vision/visual training and any associated supplemental testing are excluded from Coverage.

**Out Of Network Medical and Laboratory Services** - any services other than Emergency Services received from Non-Plan Providers, whether referred or directed by a Plan Provider, are excluded from Coverage unless Pre-authorized by the Plan.

### P

**Pass Devices (Patient Activated Serial Stretch)** – are excluded from Coverage.

**Paternity Testing** – paternity testing is excluded from Coverage.

**Penile implants** - are excluded from Coverage.

**Personal comfort items** - are excluded from Coverage, which include, but are not limited to, telephones, televisions, extra meal trays and personal hygiene items including, but not limited to, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs.

**PET Scans** - Positron Emission Tomography (PET) Scans are excluded from Coverage unless authorized by the Plan.

#### **Physician Examinations** -

- Physicals for employment, insurance or recreational activities are excluded from Coverage.

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## SECTION V EXCLUSIONS AND LIMITATIONS

- Executive physicals are excluded from Coverage.
- School physicals are excluded from Coverage, except when a Member has not had a health assessment with his or her physician during the calendar year.
- A second opinion from a Non-Plan Provider is covered only when authorized by the Plan.
- Services or supplies not prescribed, performed, or directed by a provider licensed to do so.

**Physician's clerical charges** - are excluded from Coverage. This includes, but is not limited to; charges for no show appointments, telephone calls, and completion of forms, transfer of medical records, the cost of copying medical records or the generation of correspondence to other parties.

**Prescription Drugs** - outpatient prescription drugs are excluded from Coverage unless covered under a Rider.

**Prescription Drug Rider Exclusions** - Any drugs not specifically listed as covered in the Prescription Drug Rider are excluded from Coverage. All other drugs and over-the-counter medications, even if written on a prescription blank, are excluded from Coverage unless they are listed on the Plan's list of covered Preferred and Standard drugs. For a full listing of excluded outpatient prescription drugs, please reference your Plan's Prescription Drug Rider exclusions.

**Private Duty Nursing** - is excluded from Coverage.

### Q

### R

**RAST Testing** -IGE immunoassays for quantitative In-vitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST are excluded from Coverage.

**Reconstructive surgery** - is excluded from Coverage unless such services follow trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. If the trauma occurred before the Member's effective date of Coverage, the reconstructive surgery is covered subject to the Plan's pre-existing condition exclusion provisions and Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is covered.

**Remedial Education and/or Programs** - are excluded from Coverage, including services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities or for mental retardation or for autism disabilities.

**Routine Disposable Medical Supplies** - are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

### S

**Saliva Tests** - are excluded from Coverage.

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

**Services** – the following services are excluded from Coverage:

- Services for which a charge is not normally made;

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## SECTION V EXCLUSIONS AND LIMITATIONS

- Services or supplies not prescribed, performed or directed by a provider licensed to do so;
- Services if they are for dates of service before the Member's effective date under the Plan or after the Member's Coverage under the Plan ends;
- Telephone consultations, charges for missed appointments, charges for completing forms or charges associated with copying medical records.
- Services not specifically listed or described as covered under this Plan.
- Non-medically necessary complications of non-covered services including medical, mental health and surgical services related to the complication.
- Treatment and services, other than Emergency Services, received outside of the United States of America.

**Sex Change Operations** - and any treatment of gender identity disorders are excluded from Coverage.

**Smoking Cessation** - including the drugs and treatment associated with smoking cessation are excluded from Coverage.

**Spinal Manipulation** - is excluded from Coverage, unless covered under a Chiropractic Care Rider.

**Sterilization** - Reversal of voluntary sterilization and infertility services required because of such reversal are excluded from Coverage.

**Supplies** - Disposable medical supplies are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diaper, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

### T

**Therapies** - Physical, speech and occupational therapies will be limited in Coverage and only covered to the extent of restoration to the pre-trauma or pre-illness level.

- Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status;
- Therapies for developmental delay or abnormal speech pathology are excluded from Coverage except as covered through Early Intervention Services;
- Therapies which are primarily educational in nature, including but not limited to, special education or lessons in sign language are excluded from Coverage;
- Therapies performed to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering) are excluded from Coverage;
- Therapies to maintain current status or level of care are excluded from Coverage;
- Restorative therapies to maintain chronic level of care are excluded from Coverage;
- Therapies which are available in a school program or similar programs available through state and local funding are excluded from Coverage;
- Recreation therapies including art, dance, music, exercise, equine, or sleep therapies are excluded from Coverage;
- Driver evaluations as part of occupational therapy are excluded from Coverage;
- Driver Training is excluded from Coverage;
- Functional capacity testing to return to work is excluded from Coverage;
- Work hardening programs are excluded from Coverage.

**Transplant Services** - Any organ or tissue transplant services not specifically listed as covered by the Plan are excluded from Coverage, including, but not limited to:

- Services received from Non-Contracted Providers unless Pre-authorized by the Plan;
- Services and supplies associated with screenings, searches and registries;

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## SECTION V EXCLUSIONS AND LIMITATIONS

- Organ and tissue transplants that are considered experimental or investigative are excluded from Coverage;
- Organ and tissue transplants that are not medically necessary are excluded from Coverage.

**Travel and Transportation** - expenses are excluded from Coverage except for Medically Necessary transport and ambulance services which must be approved and authorized by the Plan.

### U

**Urea Breath Testing** - is excluded from Coverage.

### V

**Vaccines** – are excluded from Coverage unless approved by the Plan.

**Video Recording or Video Taping** of procedures is excluded from Coverage.

**Virtual Colonoscopy** - is excluded from Coverage unless approved by the Plan.

**Vision Materials** - Any vision supplies or materials not specifically listed as covered are excluded from Coverage.

**Vitiligo** – treatments by laser, light or other methods is excluded from Coverage.

### W

**Wigs** - or cranial prostheses as a result of hair loss for any reason are excluded from Coverage.

**Wisdom Teeth** - extraction of wisdom teeth are excluded from Coverage unless covered under a rider.

### X

### Y

### Z

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## SECTION VI DOUBLE COVERAGE AND COORDINATION OF BENEFITS

### [6.1] DOUBLE COVERAGE

- A. Workers' Compensation.** The Plan does not cover benefits available under Worker's Compensation. If the Plan provides services covered under Worker's Compensation, Worker's Compensation will pay the provider of the services directly for those services. The Plan will coordinate benefits with the provider of the service. Money received by the Plan belongs to the Plan.
- B. Medicare.** The Plan does not cover benefits available under Medicare Parts A, B, or C unless required to do so by federal law. If the Plan provides services covered under Medicare, Medicare will pay the provider of the services directly for those services. The Plan will coordinate benefits with the provider of the services. Money received by the Plan belongs to the Plan.
- C. Other Government Programs.** The Plan does not cover benefits available under any other government program not listed above, unless required to do so by law. If the Plan provides services under a government program, the government program will pay the provider of the services directly for those services. The Plan will coordinate benefits with the provider. Money received by the Plan belongs to the Plan.
- D. Cooperation.** Each Member must submit to the Plan any completed consents, releases, assignments and/or other documents that are necessary for the Plan to coordinate benefits .

### [6.2] COORDINATION OF BENEFITS

#### **Applicability.**

1. Coordination of Benefits ("COB") applies when a Member has health Coverage under more than one Plan.
2. If COB applies, the Plan uses order of benefit rules to determine whether it is the primary or secondary Plan. The benefits of this Plan will not be affected when, under the order of benefit determination rules, this Plan is the Primary Plan. If the Plan is not the Primary Plan, the Plan will coordinate benefits with the Primary Plan.

#### **Definitions.**

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

1. Group insurance or group-type Coverage, whether insured or self-insured. This does not include Worker's Compensation.
2. A government health Plan, or Coverage required or provided by law. This does not include a state Plan under Medicaid.

Each contract or other arrangement for Coverage under (a) or (b) above is a separate Plan. If a Plan has more than one part and COB rules apply to less than all of the parts, each of the parts is a separate Plan.

**"This Plan"** is the part of this Evidence of Coverage that provides benefits for health care expenses.

**"Primary Plan/Secondary Plan"**. When this Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a secondary Plan, its benefits may be coordinated with any other health insurance or health care benefits or services that are provided by any other group policy, group contract, or group health care Plan so that no more than 100% of the eligible incurred expenses are paid. This Plan may recover from the primary Plan the reasonable cash value of services provided by this Plan.

**"Allowable Expense"** means an expense for which the Plan will pay. It is the usual and customary charge for an item or service covered at least in part by the Member's insurance. The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an allowable

## SECTION VI DOUBLE COVERAGE AND COORDINATION OF BENEFITS

expense unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an allowable expense. For example, services obtained without a required Pre-Authorization or referral are not allowable expenses.

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

### [6.3] ORDER OF BENEFIT DETERMINATION RULES

1. **General.** When a Member is covered under more than one insurance Plan, the Plan that covers the Member as the Subscriber (not a spouse or Dependent) is normally the primary Plan. If the Plan that covers the person as the Subscriber is a government Plan, the law may require the other Plan to pay first.
2. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:
  - a) **Subscriber/Dependent.** The Plan that covers the person as a Subscriber pays its covered benefits first. The Plan that covers the person as a Dependent then pays any of its covered benefits that the first Plan did not pay.
  - b) **Dependent Child.** Parents not Separated or Divorced. Except as stated in subparagraph 3 below, when both the mother's and the father's health Plans cover the same child:
    1. The Plan that covers the parent whose birthday falls earlier in a year pays its benefits first. The Plan who covers the other parent then pays any of its covered benefits that the first Plan did not pay. (If the other Plan has a rule based on the parent's sex instead of this rule, the other Plan's rule applies.)
    2. If both parents have the same birthday, the Plan that has covered one of the parents the longest pays its benefits first. The other Plan then pays any of its covered benefits that the first Plan did not pay.
3. **Dependent Child.** Parents Separated or Divorced. When the health Plans of both divorced or separated parents cover the same child, the Plans pay in the following order:
  - a) The Plan of the parent with custody of the child pays its benefits;
  - b) The Plan of the spouse of the parent with custody of the child, if any, pays its covered benefits not paid by the spouse's Plan;
  - c) Finally, the Plan of the parent not having custody of the child pays any of its covered benefits left over.

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

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

## **SECTION VI DOUBLE COVERAGE AND COORDINATION OF BENEFITS**

5. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee longer are determined first. Two consecutive Plans are treated as one Plan if the person starts the second Plan within 24 hours of the termination of the first Plan.

The start of a new Plan does not include:

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

**D. Effect on the Benefits of This Plan. The Plan as a Secondary Plan.**

If the Plan determines that it is a secondary Plan, the Plan will pay the difference between what the Primary Plan(s) pay the provider and what the Plan would pay if it were the primary Plan.

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

**E. Right to Receive and Release Needed Information.**

The Plan needs certain facts in order to apply these COB rules. The Plan decides which facts it needs. It may get needed facts from 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 all facts it needs to pay the claim. The Plan may release information to other persons and organizations in accordance with the Insurance Information and Privacy Protection regulations as set forth in the Code of Virginia 38.2-613.

**F. Facility of Payment.**

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

**G. Right of Recovery.**

If the Plan pays more than it should have paid under COB, it may recover the excess from one or more of:

1. the person(s) it paid; or
2. insurance companies; or
3. other organizations.

The Plan is not required to reimburse a Member in cash for the value of services provided.

## **SECTION VII COINSURANCE, COPAYMENTS, DEDUCTIBLES, AND PREMIUMS**

### **[7.1] COPAYMENTS.**

Copayments are specific dollar amounts the Member must pay for Covered Services. Copayments are listed on the Face Sheet of this Evidence of Coverage. Members must pay Copayments to the provider of the service at the time they receive service.

### **[7.2] COINSURANCE.**

Coinsurance amounts are charges required to be paid by the member for certain services covered under this Plan or in conjunction with any applicable rider. 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.

### **[7.3] DEDUCTIBLE.**

If Your Plan has a Deductible it will be specified on the Face Sheet or Schedule of Benefits of this Evidence of Coverage. The Deductible is the dollar amount of covered medical expenses for which a Member is responsible to pay before benefits are payable under the Plan. Such amount will not be reimbursed under the Plan. Please refer to Your Face Sheet or Schedule of Benefits for Your Plan's Deductible provisions.

### **[7.4] MAXIMUM OUT OF POCKET AMOUNT.**

Maximum Out of Pocket Amount means the total amount a Member and/or eligible Dependents pay during a year as specified on Your Plan's Face Sheet or Schedule of Benefits. Copayment and/or Coinsurance amounts for certain services will be accumulated and will apply toward the maximum dollar amount listed on the Face Sheet.

The Plan maintains a record of payments made by the Member. Once a Member has reached the maximum allowable amount for a calendar year, no further payments will be required for that year, except for those services listed on the Plan's Face Sheet or Schedule of Benefits that do not apply toward the maximum out of pocket amount. The Plan will notify the Member within 30 days after the out-of-pocket maximum is reached. The Plan will promptly refund any payments charged after the Member reaches the maximum out-of-pocket.

### **[7.5] EMERGENCY DEPARTMENT COPAYMENT.**

If the Plan requires a Copayment for an Emergency Department visit and the Member is hospitalized as a result of an emergency the Plan waives the Emergency Department Copayment. The Member will be responsible for all applicable Deductibles and inpatient hospital Copayments or Coinsurances as specified on the Face Sheet.

### **[7.6] INPATIENT HOSPITAL COPAYMENT.**

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

A newborn that remains in the Hospital after the mother is discharged will be admitted as a patient under the newborn's own name, and a separate Copayment, Coinsurance, and Deductible may be applied to the newborn's Covered Services.

### **[7.7] MONTHLY PREMIUM.**

The Application to the Group Agreement lists the monthly premium. If Members must contribute toward the cost of Coverage, the Application to the Group Agreement and the Face Sheet of the Evidence of Coverage will indicate so. If a Member fails to pay, or arrange for payment of, any amount due under the

## **SECTION VII COINSURANCE, COPAYMENTS, DEDUCTIBLES, AND PREMIUMS**

Plan, including failure to pay a premium required by the Plan, Coverage will terminate upon 31 days written notice.

### **[7.8] GRACE PERIOD.**

The Group contract holder is entitled to a grace period of 31 days for the payment of any premium due except the first premium. During the grace period coverage shall continue in force unless the contract holder has given the Plan written notice of discontinuance in accordance with the terms of the contract and in advance of the date of discontinuance. The contract holder shall be liable to the Plan for the payment of a pro rata premium for the time the contract was in force during the grace period.



## SECTION VIII CLAIMS FOR REIMBURSEMENT

### **[8.1] FILING A CLAIM FOR BENEFITS.**

If you go to a Plan-Provider the provider will usually file claims for you. A Plan-Provider means a Physician, Hospital, Skilled Nursing Facility, urgent care center, laboratory or any other duly licensed institution or health professional under contract to provide professional and Hospital services to Members. You may have to file a claim if your Provider is unable to file for you, or if you go to a Non-Plan Provider.

If you need to file a Claim for reimbursement of amounts you paid to a provider you must include complete written proof of loss. Complete written proof of loss means that the Plan has all the information needed to process the Claim. Written proof of loss must include an itemized statement or bill from the provider. The itemized bill must contain the name and address of the provider, the name of the Member receiving services, the date, diagnosis and type of services the Member received, and the charge for each type of service. The itemized statement, proof of loss or receipts showing payment must be in English.

**Send an itemized bill and any other information you have regarding your claim to:**

**MEDICAL CLAIMS  
Lason Systems  
P.O. Box 5028  
Troy, MI 48007-5028.**

### **[8.2] TIMELY FILING OF CLAIMS.**

#### **A. Member Reimbursement.**

In order for the Plan to reimburse a Member directly for a Claim the Member must submit written proof of loss to the Plan within 90 days after the date of service. Complete written proof of loss means that the Plan has been furnished all the information needed to process the Claim. Notwithstanding the foregoing, failure to furnish such documentation within 90 days will not invalidate or reduce any Claim if it was not reasonably possible to furnish the documentation within that time, and the documentation is furnished to the Plan as soon as is reasonably possible. In no event, except in the absence of legal capacity of the Claimant, shall such documentation be furnished to the Plan later than one year from the time documentation is otherwise required.

#### **B. Claims From Non-Plan Providers.**

Non-Plan Providers must submit claims for Covered Services rendered to Plan Members to:

**MEDICAL CLAIMS  
Lason Systems  
P.O. Box 5028  
Troy, MI 48007-5028.**

Claims must be received by the Plan within 365 days of the date the Member received the Covered Service.

In no event will the Plan be liable for or pay a claim it receives from a Non-Plan Provider more than 365 days from the date of service.

### **[8.3] PROCESSING THE CLAIM.**

When processing a Claim submitted by a Member or a Non-Plan Provider the Plan will follow the guidelines and procedures described in Section III of this document entitled "Referral, Pre-Authorization, and Utilization Management Procedures For Claims For Covered Services." The Member is responsible for compliance with all Plan requirements outlined in Section III. Plan benefits are subject to all exclusions and limitations as outlined in this document.

## **SECTION VIII CLAIMS FOR REIMBURSEMENT**

If a Claim for benefits is denied by the Plan the Member has the right to a full and fair review of the Plan's determination in accordance with the Plan's appeal procedures. The Plan's appeal procedures are found in Section XIII of this document entitled "Adverse Benefit Determination Appeal Procedure."

### **[8.4] PAYMENT BY THE PLAN.**

The Plan may make payment to the person or institution providing the services. However, if the Member furnished evidence satisfactory to the Plan that the Member paid the person or institution for the service covered, the Plan will reimburse the Member. The Plan will deduct from reimbursement to the Member any payment made by the Plan before receipt of such evidence.

### **[8.5] RIGHT OF EXAMINATION.**

While a claim is pending, the Plan has the right and opportunity to have any claimant examined, without expense to the claimant, when and as often as it may reasonably require. The Plan also has the right, at its own expense, to conduct or have conducted, appropriate investigations relative to a Member's death, or to request an autopsy to be done after death, where it is not prohibited by law.

### **[8.6] CLAIMS PAID DIRECTLY TO MEMBERS FOR SERVICES FROM NONPARTICIPATING PHYSICIANS.**

IF THE PLAN SENDS PAYMENT DIRECTLY TO THE MEMBER FOR A CLAIM FOR COVERED SERVICES FROM A NON-PLAN PHYSICIAN OR OSTEOPATH, THE MEMBER MUST APPLY THE PLAN PAYMENT TO THE CLAIM FROM THE NON-PLAN PROVIDER. THE PLAN WILL INCLUDE THE NAME AND ANY LAST KNOWN ADDRESS OF THE PHYSICIAN OR OSTEOPATH WITH ANY PAYMENT SENT DIRECTLY TO THE MEMBER.

## SECTION IX TERMINATION OF COVERAGE

### [9.1] TERMINATION OF SUBSCRIBER COVERAGE.

**Anything in this agreement to the contrary notwithstanding, no termination will be made on the basis of a Member's health.**

#### **A Subscriber's Coverage ends:**

- A. The date the Group Agreement ends, upon 31 days written notice.
- B. The date the Subscriber fails to meet the Plan's eligibility requirements;
- C. The date the grace period, as defined in Section VIII, for payment of premiums to the Plan expires;
- D. The date the Subscriber fails to pay, have paid on his or her account or for his or her benefit, or arrange to pay any amounts due under the Plan, including failure to pay a premium required under the Plan; or
- E. The date the Subscriber dies.

### [9.2] TERMINATION OF DEPENDENT COVERAGE.

**Anything in this agreement to the contrary notwithstanding, no termination will be made on the basis of a Member's health.**

#### **A Dependent's Coverage ends:**

- A. The date the Group Agreement ends, upon 31 days written notice.
- B. The date any Subscriber or his or her Dependent fails to pay, have paid on his or her account or for his or her benefit, or arrange to pay any amounts due under the Plan, including failure to pay a premium required under the Plan;
- C. The date the Subscriber's Coverage under the Plan ends unless otherwise agreed to by the Plan and the Employer Group;
- D. The date a Dependent ceases to satisfy the Plan's definition of an eligible Dependent;
- E. The date a Dependent spouse or child becomes covered as an employee under the Plan; or
- F. The date the Dependent dies.

### [9.3] REASONS FOR TERMINATION.

Coverage will not be terminated on the basis of the status of the Member's health or because the Member has exercised his rights under the Plan's grievance system by registering a complaint against the Plan. The Plan will not terminate a Member's coverage for services provided under the Group Agreement except for one or more of the following reasons:

- A. Failure to pay the amounts due under the Plan, including failure to pay a premium required by the Group Agreement as shown in the Group Agreement or Evidence of Coverage.
- B. Fraud or material misrepresentation in enrollment or in the use of services or facilities.

**Fraud or Misrepresentation.** The Plan may terminate the Coverage of any Member who knowingly gives incorrect, incomplete or deceptive information regarding themselves or their Dependents eligibility for coverage to the Plan or to the Group. This applies whether the Member gives the information or has others give it on their behalf. The incomplete, incorrect or deceptive information must be material. The Member is responsible for all costs incurred by the Plan because of the incorrect, incomplete, or deceptive information, including legal fees.

**Misuse of Plan Identification Card.** No one but the Member may use his or her Plan identification card. Use by anyone else is fraud. The Plan may prosecute the Member and the person using the card. Both the Subscriber and the person using the Subscriber's card are liable to the Plan for all costs resulting from the misuse of the identification card.

- C. Material violation of the terms of the Plan Group Agreement.

## SECTION IX TERMINATION OF COVERAGE

- D. Failure to meet the eligibility requirements under the Plan Group Agreement;
- E. Termination of the Group Agreement under which the Member was covered.
- F. Engaging in activities that endanger the safety and welfare of the Plan or its employees or providers;
- G. Failure of the Member and the Primary Care Physician to establish a satisfactory relationship provided the Plan has in good faith made an effort to provide the opportunity for the Member to establish a satisfactory patient-physician relationship, including assigning the enrollee to other Primary Care Physicians from among the Plan's participating providers.

### [9.4] NOTICE OF TERMINATION.

The Plan will not terminate Coverage for services provided under the Plan Group Agreement without giving the Subscriber written notice of termination, effective at least 31 days from the date of mailing or, if not mailed, from the date of delivery, except that:

- A. For termination due to nonpayment of premium, the provisions of the Plan's grace period shall apply. The contract holder is entitled to a grace period 31 days for the payment of any premium due except the first premium. During the grace period coverage shall continue in force unless the contract holder has given the Plan written notice of discontinuance in accordance with the terms of the contract and in advance of the date of discontinuance. The contract holder shall be liable to the Plan for the payment of a pro rata premium for the time the contract was in force during the grace period.
- B. For termination due to nonpayment of premium by an employer, the following additional provisions shall apply:
  - 1. Any employer who (i) assumes part or all of the cost of providing group accident and sickness insurance or a group health services plan or group health care plan for his employees under a group insurance policy or subscription contract or other evidence of coverage; (ii) provides a facility for deducting the full amount of the premium from employees' salaries and remitting such premium to the insurer, health services plan, or health maintenance organization; or (iii) provides for health and medical care or reimbursement of medical expenses for his employees as a self-insurer, shall give written notice to participating employees in the event of termination or upon the receipt of notice of termination of any such policy, contract, coverage, or self-insurance not later than fifteen days after the termination of a self-insured plan or receipt of the notice of termination.
  - 2. Any employer who collects from his employees or covers any part of the cost of any of the policies, contracts, or coverages specified in subsection B 1 above and who knowingly fails to remit to the insurer or plan such funds required to maintain coverage in accordance with the policy or contract provisions under which the employees are covered shall be guilty of a Class 1 misdemeanor and shall be subject to civil suit for any medical expenses the employee may become liable for as a result of the employer letting such coverage be terminated.
  - 3. In the event coverage under the Plan are terminated due to nonpayment of premium by the employer, no such coverages shall be terminated by the Plan with respect to a covered individual unless and until the employer has been provided with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least fifteen days after such notice has been mailed. The Plan shall make reimbursement on all valid claims for services incurred prior to the date coverage is terminated.

## **SECTION IX TERMINATION OF COVERAGE**

- C. For termination due to activities that endanger the safety and welfare of the Plan or its employees or providers, immediate notice of termination may be given.
  
- D. For termination due to change of eligibility status of a Member, immediate notice of termination may be given.

### **[9.5] CONTINUATION OF CARE EXTENSION OF BENEFITS FOR TOTAL DISABILITY**

If Coverage ends under the Group Agreement members who become totally disabled while enrolled under the Plan and who continue to be totally disabled when the Group Agreement ends are entitled to an extension of benefits for total disability. Upon payment of premium, coverage shall remain in full force and effect for a period of time not less than 180 days, or until the member is no longer totally disabled, or a succeeding carrier elects to provide replacement coverage to that member without limitation as to the disabling condition. Upon termination of the extension of benefits, the enrollee shall have the right to convert or continue coverage as provided herein.

### **[9.6] REINSTATEMENT OF COVERAGE FOLLOWING ABSENCE FROM EMPLOYMENT.**

An employee who is re-hired after 90 days will be considered a new employee and will be subject to all Plan eligibility requirements, including any pre-existing condition exclusions, waiting periods, and effective date of Coverage requirements, as described in Section II with the following exceptions:

- A. An employee who is rehired with no more than a 63-day break in Coverage will have the same employment and eligibility status as before.
- B. An employee who returns to work within 90 days after a layoff or an approved leave of absence will keep the same employment and eligibility status as before.

### **[9.7] TERM AND TERMINATION OF THE GROUP AGREEMENT.**

Unless otherwise stated, upon termination of the Group Agreement, and in accordance with all notice requirements, Coverage of Subscribers and Dependents will terminate immediately upon the effective date of termination. It is the Group's responsibility to notify Members promptly that the Plan is no longer required to provide any service in connection with the Group Agreement.

Upon termination of the Group Agreement, and in accordance with all notice requirements, all Covered Services under the Plan, including treatment for ongoing conditions and care for hospitalized Members may stop immediately. This does not include those Members who have become totally disabled while a Member of the Plan and remain totally disabled at the time of the termination of the Group Agreement. (Refer to the section entitled, "Extension of Benefits For Total Disability" for details).

If Membership terminates, the Plan will refund the difference between fees paid to the Plan after the termination date and amounts otherwise due to the Plan. Refunds will go to the Group unless the premiums are billed directly to and paid by the Member.

## **SECTION X CONVERSION OR CONTINUATION OF COVERAGE**

### **INDIVIDUAL CONVERSION**

**[10.1]** If Coverage ends under this group Plan Members may convert to Coverage under an individual Subscriber Plan.

- A.** Members must complete an application for the individual Subscriber Plan and make the first premium payment within 31 days after Coverage under the group Plan ends. Coverage under the individual Subscriber Plan will then be effective on the date Coverage ended under the group Plan.
- B.** Coverage will be provided without additional evidence of insurability. No preexisting condition limitations or exclusions will be imposed other than those that remain unexpired under the group Plan the Member converted from.
- C.** The Plan's Conversion Coverage may be different from Coverage under this Evidence of Coverage. The Member will be subject to the terms of the Conversion Plan in effect at the time application for Conversion is made.

**[10.2]** Members will not be eligible for Conversion if any conditions below are true.

- A.** The Member is covered by, or is eligible for benefits under Title XVIII, under the United States Social Security Act.
- B.** The Member is covered by, or is eligible for substantially the same level of Hospital, medical, and surgical benefits under state or federal law.
- C.** The Member is covered by substantially the same level of Hospital, medical, and surgical benefits under any policy, contract, or Plan for individuals in a group.
- D.** The Member has not been continuously covered during the three-month period immediately preceding the Member's termination of Coverage.
- E.** The Member was terminated by the Plan for any of the following reasons.
  - 1. Failure to pay the amounts due under the contract, including failure to pay a premium required by the contract as shown in the contract or evidence of coverage;
  - 2. Fraud or material misrepresentation in enrollment or in the use of services or facilities;
  - 3. Material violation of the terms of the contract;
  - 4. Engaging in activities that endanger the safety and welfare of the Plan or its employees or providers;
  - 5. Failure of the Member to establish a satisfactory relationship with the Primary Care Physician provided the Plan has made an effort to provide the opportunity for the Member to establish a satisfactory patient-Physician relationship, including assigning the Member to another Primary Care Physician from among the Plan's providers.

## **SECTION XI COMPLAINT AND GRIEVANCE PROCEDURES, AND ADVERSE BENEFIT DETERMINATION APPEAL PROCEDURES**

If you are dissatisfied with the care or service you received from one of our physicians or hospitals, or if you are dissatisfied with any of the services, policies or procedures of Optima Health you may file a grievance or complaint by following the “Grievance and Complaint Procedure” in this section.

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 Member'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. If you have received an Adverse Benefit Determination from the Plan, and you wish to appeal that determination you should follow “The Plan’s Appeals Procedures” in this section.

### **GRIEVANCE AND COMPLAINT PROCEDURE**

If you want to file a formal written complaint or grievance you should request a complaint form from Member Services. You may also download forms on [www.OptimaHealth.com](http://www.OptimaHealth.com). You may designate someone else, such as a physician or family member, to act on your behalf in filing a complaint. In order for the Plan to address your concerns, your complaint must be submitted within 180 days from the date of your concern with care, service and/or policies or procedures of the Plan. No member who exercises the right to file a complaint will be subject to disenrollment or otherwise penalized for filing a grievance or complaint.

Please send the completed complaint forms and any additional information related to your concern to:

Optima Health  
Appeals Department  
P.O. Box 62876  
Virginia Beach, VA 23466-2876

You can also fax your completed information to:

757-687-6232  
Toll Free: 866-472-3920.

You will be notified in writing that your complaint has been received and about how long it will take to investigate the issues presented. Time frames for resolving complaints vary by the type of complaint. Once we have concluded our investigation into your complaint we will notify you in writing how we have resolved your complaint.

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

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

You may also contact the Virginia Department of Health at:

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



# **SECTION XI COMPLAINT AND GRIEVANCE PROCEDURES, AND ADVERSE BENEFIT DETERMINATION APPEAL PROCEDURES**

The Managed Care Ombudsman is available to help Virginia consumers who experience problems with, or have questions about managed care. There are several ways to contact the Office of the Managed Care Ombudsman:

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

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

## **ADVERSE BENEFIT DETERMINATION APPEALS PROCEDURE**

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:

1. A Member's eligibility to participate in the Plan;
2. A Utilization Management decision; or
3. Failure to cover an item or service because the Plan considers it to be Experimental, Investigational, or not Medically Necessary.

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

The Member 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 Member's request.

The Member 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. A Designation Authorization Form must be completed and signed by the Member when designating a representative to act on his/her behalf.

The Member 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 Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Members 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 Member written notification of the outcome. If the Plan does not reverse its decision the written notice will include:

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

# **SECTION XI COMPLAINT AND GRIEVANCE PROCEDURES, AND ADVERSE BENEFIT DETERMINATION APPEAL PROCEDURES**

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

1. Reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
2. Copies of any internal rule, guideline, protocol, or other criteria relied upon in making the adverse decision;
3. For denials due to medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the Member's medical circumstances.

## **TYPES OF CLAIMS.**

The type of claim under review will determine what process the Member 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 Member 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 Member must follow the Appeal Procedure for Pre-Service, Post-Service, and Concurrent Care 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 Member or the ability of the Member to regain maximum function; or (2) in the opinion of a physician with knowledge of the Member's medical condition, following the Plan's normal appeal procedure would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A prudent layperson standard applies when determining what is an urgent care claim, except where a physician with knowledge of the Member's medical condition determines that the claim is urgent. To appeal any denial of an Urgent Care Claim the Member 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 Member must follow the Appeals procedure for Pre-Service, Post-Service, and Concurrent Care Claims explained below.

**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 Member must follow the procedure for Pre-Service, Post-Service, and Concurrent Care Claims explained below.

## **EXPEDITED APPEALS OF URGENT CARE CLAIMS .**

The Member or treating physician may request an expedited appeal by telephone, facsimile, or letter, and must explicitly state "expedited appeal" in the request to initiate this process.

To Contact the Plan with a request for an expedited appeal:

- By Phone: Call Member Services at the number on the ID card
- By Facsimile: at 757-687-6232
- By Mail: send requests for an appeal to:

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

## **SECTION XI COMPLAINT AND GRIEVANCE PROCEDURES, AND ADVERSE BENEFIT DETERMINATION APPEAL PROCEDURES**

The Plan will consider an expedited appeal and notify the Member 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, CONCURRENT, 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 to:  
Optima Health  
APPEALS DEPARTMENT  
P.O. Box 62876  
Virginia Beach, VA 23466-2876

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

- The Member's name, address, telephone number, Member number, and group number; and
- The date of service, place of service, provider and charge related to the service; and
- 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 Member 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 Member notified of the Plan's decision within 60 calendar days of the Plan's receipt of written request for the appeal.

For Concurrent Care Claims, the appeal decision will be completed and the Member notified of the Plan's decision as soon as possible and prior to the benefit being reduced or terminated.

#### **EXTERNAL REVIEW.**

For final Adverse Benefit Determination based on medical necessity determinations, the Member will be provided information and forms on the right to appeal final adverse decisions to the Bureau of Insurance, Office of the Managed Care Ombudsman. The Plan may reconsider any final Adverse Benefit Determination that is the subject of an external review at any time. Reconsideration by the Plan will not delay or terminate the external review.

The Office of the Managed Care Ombudsman is available to help Virginia consumers who experience problems with, or have questions about managed care. The Managed Care Ombudsman can assist Plan members in understanding and exercising their rights of appeal of Adverse Benefit Determinations. There are several ways to contact the Office of the Managed Care Ombudsman:

- Write: Office of the Managed Care Ombudsman

# **SECTION XI COMPLAINT AND GRIEVANCE PROCEDURES, AND ADVERSE BENEFIT DETERMINATION APPEAL PROCEDURES**

Bureau of Insurance  
P.O. Box 1157  
Richmond, Virginia 23218

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

## **SOURCES FOR ADDITIONAL INFORMATION.**

If you have been unable to contact or obtain satisfaction from the Plan or the agent, you may contact the Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection at 1-800-955-1819.

You may also contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration Toll-free at 1-866-275-7922 or visit their website at [www.dol.gov](http://www.dol.gov).

## **SECTION XII GENERAL PROVISIONS**

### **[12.1] Major Disasters and Other Circumstances Beyond the Plan's Control.**

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

### **[12.2] Incontestability.**

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

### **[12.3] Severability.**

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

### **[12.4] Policies and Provisions.**

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

### **[12.5] Modifications.**

Alterations to the Group Agreement and its attachments may be made, in accordance with the terms of the Group Agreement between the Plan and group. This may be done without the Subscriber's consent or concurrence.

### **[12.6] Entire Contract.**

The Group Agreement and this Evidence of Coverage together with all exhibits and amendments thereto, the individual Enrollment Applications of Members, and any other questionnaire, form or other document provided in execution with the Group 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. No alteration of the Group Agreement and no waiver of any of its provisions shall be valid unless evidenced by a written endorsement or amendment signed by a duly authorized officer of the Plan. Any insurance agent or broker licensed through the Plan who may have assisted in the contract for this Plan is not an authorized officer of the Plan for this or any other purpose.

**[12.7]** Neither the group nor any Member is an agent or representative of the Plan, and neither shall be liable for any acts or omissions of the Plan, its agents or employees, or of any provider, or any other person or organization with which the Plan, its agents or employees, has made or hereafter shall make arrangements for the performance of services under this agreement. Certain Members may, for reasons personal to themselves, refuse to accept procedures or courses of treatment recommended by a Plan provider. Providers shall use their best efforts to render all necessary and appropriate professional services in a manner compatible with the Member's wishes, insofar as this can be done consistently with the provider's judgment as to the requirements of proper medical practice. If a Member refuses to follow a recommended treatment or procedure, and a provider believes that no professionally acceptable alternative exists, such Member shall be so advised; and if upon being so advised the Member still refuses to follow the recommended treatment or procedure, then the Member shall be given no further treatment for the condition under treatment, and neither the Plan provider nor the Plan shall have any further responsibility to

## SECTION XII GENERAL PROVISIONS

provide care for such condition or related ailment nor financial responsibility for payment of such care or complications arising from failure to follow the medical advice of Plan providers. However, the Member shall have the right to a consultation (second opinion) regarding his/her medical condition. This second opinion must be pre-authorized by the Member's Primary Care Physician using participating Plan providers.

**[12.8]** The relationship between the Plan and Hospitals is that of an independent contractor. Hospitals are not agents or employees of the Plan nor is the Plan or any employee of the Plan an employee or agent of Hospitals. Hospitals shall maintain the Hospital-patient relationship with Members and are solely responsible to Members for all Hospital services.

**[12.9]** The relationship between the Plan and health professionals is that of an independent contractor except in such cases whereby the health professional is employed by the Plan. Independently contracted health professionals are not agents or employees of the Plan nor is the Plan, or any employee of the Plan, an employee or agent of its health professionals. Health professionals shall maintain professional patient relationships with Members in accordance with the terms hereof and applicable law, and are solely responsible to Members for all medical services.

**[12.10]** Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

**[12.11]** Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

**[12.12]** Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

**[12.13] Notice in writing.**

**From the Plan to you.** A notice sent to you by the Plan is considered "given" when received by the Subscriber's employer at the address listed in the Plan's records or, if sent directly to you, the notice is considered "given" when mailed to the subscriber's last known address as shown in the Plan's enrollment records. Notices include any information which the Plan may send you, including identification cards.

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

**[12.14] Limitations of damages.**

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

## SECTION XII GENERAL PROVISIONS

### **[12.15] Time limits on legal action.**

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

### **[12.16] The Plan's continuing rights.**

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

### **[12.17] Standing Referrals For Special Conditions.**

For those individuals with special conditions the Plan may, after consultation with the PCP, issue a standing referral to a Plan Specialist, (i) authorized to provide Covered Services and (ii) selected by the individual, to be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral.

Special condition means a condition or disease that is (i) life-threatening, degenerative or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, the specialist will be permitted to authorize referrals, procedures, tests, and other medical services related to the initial referral as the individual's PCP would be permitted to provide or authorize.

### **[12.18] Standing Referrals For Cancer Pain.**

Individuals who have been diagnosed with cancer may be issued a standing referral to a board-certified Physician in pain management or oncologist who is authorized to provide services under the Plan. Some services may require Pre-Authorization by the Plan.

### **[12.19] Continuity of Care.**

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

- A.** For a period of at least 90 days from the date of the notice of a provider's termination for Members who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider;
- B.** Through the provision of postpartum care directly related to the delivery for Members who have entered the second trimester of pregnancy at the time of a provider's termination;
- C.** For the remainder of the Member's life for care directly related to the treatment of terminal illness. "Terminally ill" is defined under §1861 (dd) (3) (A) of the Social Security Act.
- D.** The Plan will pay a provider according to the Plan's agreement with the provider existing immediately before the provider's termination of participation.



## **SECTION XIII IMPORTANT PLAN NOTICES**

Under state and federal law group health plan members are entitled to certain information about their health plan benefits. If you have any questions about any of the information found in the notices in this section please call Member Services at the number on your Plan Identification Card. This section includes the following notices:

### **Notice of Coverage of Reconstructive Breast Surgery/Women's Health and Cancer Rights Act Notice**

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

### **General Notice of COBRA Continuation Coverage Rights**

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

## **Notice of Coverage for Reconstructive Breast Surgery/Women's Health and Cancer Rights Act Notice**

In the Commonwealth of Virginia and under a federal law known as The Women's Health and Cancer Rights Act of 1998 we are required to notify you of your rights related to benefits provided by the Plan in connection with a mastectomy. This notice provides information on the Member's rights and availability of benefits for the treatment of mastectomy related services, including reconstructive surgery, prostheses, and physical complications, including lymphedemas under the Plan.

You should keep this information with your important health care records. If you have any questions regarding this Notice or the benefits you are entitled to under the Plan please call Member Services at the number listed on your Plan insurance identification card.

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

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

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

# COBRA Continuation of Coverage Notice

## GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

### Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. If you experienced a loss of coverage at some time on or after September 1, 2008 and if your loss of health coverage was due to an involuntary termination of employment you may be eligible for the temporary premium reduction for up to nine months. The ARRA also provides a special enrollment opportunity if you did not elect COBRA when you were first eligible or if you elected and dropped out before your maximum coverage period ended. **Your employer is required to notify you if you are eligible for the premium reduction and enrollment opportunities.**

**YOU MUST CONTACT YOUR EMPLOYER OR YOUR EMPLOYER'S BENEFIT ADMINISTRATOR TO FIND OUT IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR COBRA CONTINUATION COVERAGE. YOU MUST CALL YOUR EMPLOYER WITH ANY QUESTIONS ABOUT THE COBRA PROVISIONS OF THE ARRA. YOUR EMPLOYER, OR YOUR EMPLOYER'S COBRA ADMINISTRATOR, AND NOT THIS PLAN, IS RESPONSIBLE FOR COBRA ADMINISTRATION. THE INFORMATION IN THIS NOTICE IS FOR GENERAL INFORMATION PURPOSES ONLY AND IN NO WAY IMPLIES THAT THE PLAN IS THE COBRA ADMINISTRATOR.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should contact your employer or your employer's COBRA Administrator.

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage usually must pay for COBRA continuation coverage. You should contact your employer or your employer's COBRA administrator for more information on payment for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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;

# COBRA Continuation of Coverage Notice

- 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 any of the following qualifying events happens:

- 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."

If you are a retiree and covered under an employer plan please note the following regarding COBRA qualifying events. 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 your employer, 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 with respect to the bankruptcy. 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 Coverage Available?**

COBRA continuation coverage will be offered to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is 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), the employer must notify the COBRA Administrator of the qualifying event. You must check with your employer or your employer's COBRA administrator if you have questions regarding administration of COBRA continuation coverage.

## **You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator within 60 days after the qualifying event occurs. Check with your employer to find out who you must provide this notice to.

## **How is COBRA Coverage Provided?**

Once the COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying

## **COBRA Continuation of Coverage Notice**

event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### ***Disability extension of 18-month period of continuation coverage.***

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. You must contact your employer or your employer's COBRA administrator for any additional procedures for this notice.

### ***Second qualifying event extension of 18-month period of continuation coverage.***

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **If You Have Questions**

Questions concerning your COBRA continuation coverage rights should be addressed to your employer or your employer's COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep your employer or your employer's COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer or to your employer's COBRA Administrator.

# Sentara HealthCare Integrated Notice of Privacy Practices

## SENTARA HEALTHCARE INTEGRATED NOTICE OF PRIVACY PRACTICES

*Effective Date: June 2, 2005*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact the office of the Sentara Privacy Contact Person.

### WHO WILL FOLLOW THIS NOTICE.

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

- All divisions, affiliates, facilities, medical groups, departments and units of Sentara Healthcare;
- Any member of a volunteer group we allow to help you while you are in a Sentara Healthcare facility;
- All employees, staff and other Sentara Healthcare personnel; and
- Sentara Hospital-based residents, medical students, physicians and physician groups with regard to services provided and medical records kept at a Sentara facility (all together "Sentara" or "we").

### OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Sentara care sites. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by a Sentara entity, whether made by Sentara personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice tells you about the ways in which we may use and disclose your medical information. It also describes your rights and certain obligations we have regarding use and disclosure of information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices; and
- follow the terms of the notice that is currently in effect.

### HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and give examples. Not every use or disclosure in a category will be listed, however all of the ways we are permitted to use and disclose information fall within one of the categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Sentara personnel and care providers who are involved in your care. Among those caring for you are medical, nursing and other health care personnel in training who, unless you request otherwise, may be present during your care as part of their education. We may use still or motion pictures and closed circuit television monitoring of your care. We may also share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, x-rays and emergency medical transportation, as well as with family members or others providing services that are part of your care.

SENTARA HEALTHCARE PRIVACY NOTICE. THIS IS NOT PART OF THE POLICY OR CONTRACT.

## Sentara HealthCare Integrated Notice of Privacy Practices

- **For Payment.** Sentara may use and disclose your medical information so that it or other entities involved in your care may obtain payment from you, an insurance company or a third party for treatment and services you receive. We and your physician(s) may disclose your medical information to any person, Social Security Administration, insurance or benefit payor, health care service plan or workers' compensation carrier which is, or may be, responsible for part or all of your bill. For example, we may give your insurer information about surgery you received at a Sentara hospital so they will pay us or reimburse you. We may also tell your insurer about a treatment you are going to receive to obtain prior approval, to determine whether your plan will cover the treatment, or to resolve an appeal or grievance. Information on members of Sentara managed care plans may be used and disclosed to determine if services requested or received are covered benefits under its insurance, and to underwrite your group's health plan.
- **For Health Care Operations.** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to run Sentara and make sure that all of our patients and members receive quality services. For example, we may use medical information to review our treatment and services, to evaluate the performance of our staff, and to survey you on your satisfaction with our treatment and/or services. We may combine medical information to decide what additional services or health benefits Sentara should offer, what services are not needed, and whether certain new treatments are effective. We may disclose information to doctors, nurses, technicians, students training with Sentara, and other Sentara personnel for review and learning purposes. We may combine the medical information we have with medical information from other health care entities to compare how we are doing and see where we can make improvements in the care and services we offer. Sentara may also disclose information to private accreditation organizations, such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee on Quality Assurance, in order to obtain accreditation from these organizations. We may use your information to credential providers in our health plan network and to grant hospital privileges to providers. We may also provide to others information that does not identify you so that they may use it to study health care.
- **Appointment Reminders.** We may use and disclose your information to remind you of an appointment at a Sentara location.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health Related Benefits and Services.** We may use and disclose your information to tell you about health related benefits or services.
- **Fundraising Activities.** We may use and disclose medical information about you so that we or a foundation related to Sentara may contact you in an effort to raise money for Sentara. We only release information such as your name, address and phone number and the dates you received treatment or services. If you do not want Sentara to contact you for fundraising efforts, please notify the Privacy Contact Person.
- **Hospital Directory.** We may include your name, location in the hospital, and your general condition (e.g., fair, stable, etc.) in the hospital directory while you are a patient at a Sentara hospital. The directory information may be released to people who ask for you by name so your family, friends and clergy can visit you in the hospital and generally know how you are doing. You may ask to restrict some or all of the information contained in the directory.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes, regardless of the funding for such research. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research the project will have been approved through this research approval process. However, we may disclose medical information about you to, for example, people preparing to conduct a research project to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Sentara facility.



## Sentara HealthCare Integrated Notice of Privacy Practices

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law. This includes, but is not limited to, disclosures to mandated patient registries.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to a person able to help prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **To Sponsors of Group Health Plans.** Sentara Health Plans, Inc., on behalf of Optima Health Plan, Optima Health Group, or Optima Health Insurance Company, may disclose your medical information to the sponsor of a self-funded group health plan, as defined under ERISA. We may also give your employer information on whether you are enrolled in or have disenrolled from a health plan offered by the employer.
- **Marketing.** We must obtain your prior written authorization to use your protected health information for marketing purposes except for a face-to-face encounter or a communication involving a promotional gift of nominal value. We are prohibited from selling lists of patients and enrollees to third parties or from disclosing protected health information to a third party for the marketing activities of the third party without your authorization. We may communicate with you about treatment options or our own health-related products and services. For example, our health care plans may inform patients of additional health plan coverage and value-added items and services, such as special discounts.

### SPECIAL SITUATIONS

- **Organ and Tissue Donation.** We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** We may release medical information about members of the domestic or foreign armed forces as required by the appropriate military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence where you agree or when required or authorized by law.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, but are not limited to, audits, investigations, examinations, inspections, and licensure.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only

## Sentara HealthCare Integrated Notice of Privacy Practices

if efforts have been made to tell you about the request. We also may disclose your information to Sentara's attorneys and, in accordance with applicable state law, to attorneys working on Sentara's behalf.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the location of a Sentara entity; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of person(s) who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner, medical examiner or funeral director as necessary for them to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Uses and Disclosures Regarding Food and Drug Administration (FDA)-Regulated Products and Activities.** We may disclose protected health information, without your authorization, to a person subject to the jurisdiction of the FDA for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products.

### YOUR RIGHTS REGARDING MEDICAL INFORMATION WE MAINTAIN ABOUT YOU.

You have the following rights regarding your medical information:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing on a form provided by Sentara to the Privacy Contact Person. Your request should indicate in what form you want the information (for example, on paper, electronically.) If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Sentara will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

## Sentara HealthCare Integrated Notice of Privacy Practices

➤ **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for a Sentara entity.

To request an amendment, your request must be made in writing on a form provided by Sentara and submitted to the Privacy Contact Person. You must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for a Sentara entity;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

➤ **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. It does not include disclosures made for treatment, payment, health care operations, disclosures you authorize or other disclosures for which an accounting is not required under HIPAA.

To request this list or accounting of disclosures, you must submit your request in writing on a form provided by Sentara to the Privacy Contact Person. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically.) The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

➤ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request on a in writing on a form provided by Sentara to the Privacy Contact Person. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, i.e. disclosures to your spouse.

➤ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work or by mail.

To request confidential communications, you may make your request in writing to the Privacy Contact Person. You may also telephone the office of the Privacy Contact Person, however in order to protect your privacy we may not be able to accommodate requests made by telephone. We will not ask you the reason for your request, and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

➤ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice at any time, even if you have previously agreed to receive this notice electronically. To obtain a paper copy of this notice, please write or call the Privacy Contact Person.

***You may also obtain a copy of this notice at our web site, [www.sentara.com](http://www.sentara.com).***

### CHANGES TO THIS NOTICE

## **Sentara HealthCare Integrated Notice of Privacy Practices**

➤ We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice with the effective date in Sentara health care treatment facilities. In addition, each time you have an appointment at, register at, or are admitted to a Sentara hospital or other Sentara treatment location for treatment or health care services, we will offer you a copy of the current notice. If you are a member of a Sentara health plan, your Evidence of Coverage or Certificate of Insurance will contain the version of the notice in effect as of the printing of those documents, plus any amendment to the notice. Subsequent amendments will be mailed to you.

### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Sentara or with the Secretary of the Department of Health and Human Services. To file a complaint with Sentara, contact the Privacy Contact Person. All complaints must be submitted in writing.

**You will not be penalized or retaliated against for filing a complaint.**

### OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care and services that we provided to you.

### ADDITIONAL NOTICES.

If you have insurance through Optima Health Plan, Optima Health Group, or Optima Health Insurance Company, please refer to your Evidence of Coverage or Certificate of Insurance for the Notice of Insurance Information Practices and notice of Financial Information Practices required by Virginia law.

### **Sentara HIPAA Privacy Contact Person**

**PO Box 2200**

**Norfolk, VA 23501**

**757-857-8494**