Sentara Health Plans

1300 Sentara Park
Virginia Beach, VA 23464
Mid-Market

Employer Group Contract

Sentara®
Health Plans

1300 Sentara Park
Virginia Beach, VA 23464

December 23, 2024

Toni Childress
10035 COURTHOUSE ROAD
CHARLES CITY VA 23030-3440

Dear Toni:

Welcome to Sentara Health Plans!

We look forward to serving you and your employees in the coming year.

Enclosed is a copy of your contract. Please review it thoroughly. Payment of your monthly premium and/or use of the health plan benefits by your members shall mean that:

a. you acknowledge and agree that you have read and had the opportunity to object to the terms of the Agreement; and

b. you intend to be bound by its terms.

If you agree with the terms, no further action is necessary.

Our goal is to provide you and the health plan members of your group with the best service possible in the months to come. If you have any questions or concerns, please feel free to call me at: 757-687-6043.

Thank you,

Theresa Stanley

Theresa Stanley
Account Executive

19-21.8880 00000LKDIDV27 3/114 BIN:0 0-4089

Sentara Health Plans

1300 Sentara Park
Virginia Beach, VA 23464
Mid-Market

Employer Group Contract

SENTARA HEALTH PLANS

MID-MARKET

HEALTH MAINTENANCE ORGANIZATION PLAN

APPLICATION FOR GROUP CONTRACT

A Contract between

SENTARA HEALTH PLANS
(The Plan)

And

Charles City County Public Schools
(The Group Contract Policyholder)

ADDRESS:	10035 Courthouse Road Charles City, VA 23030
POLICY NUMBER:	39651;39651*COBRA
POLICY EFFECTIVE DATE:	10/1/2024 - 9/30/2025
POLICY ANNIVERSARY DATE:	10/1/2025 And the same day each year after.
PREMIUM DUE DATE:	1st of each month

This Application shall be attached to and made part of the Group Contract. Together, this Application and the Group Contract create a legal contract. The first premium is due on the Policy Effective Date. Subsequent premiums are payable on the Premium Due Date. The Policyholder agrees to make payments provided in this Application in accordance with its provisions.

The attached Group Contract remains in force when premiums are paid on time. The Group Contract, however, can be canceled as stated herein.

The Application and attached Group Contract are issued in, and governed by the laws of, the Commonwealth of Virginia.

Sentara Health Plans President

PART A COVERED SERVICES

Eligible Members covered under the Group Contract are entitled to Covered Services listed in the Contract, Evidence of Coverage or Certificate of Insurance, Schedule of Benefits, and any riders or amendment attached to this Application and the Group Contract.

PART B CONTINUATION OF GROUP COVERAGE

The Employer and not Sentara is responsible for providing all required notice(s) and administering continuation of coverage provisions applicable to their Group Plan. If eligibility under the Group Plan ends Members have the right to continue coverage under the existing group plan according to the following:

- For employer groups subject to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) the employer will provide for administration and notice of COBRA continuation of coverage for eligible employees and any eligible dependents;
- For employer groups not subject to COBRA eligible employees and dependents will continue group coverage under Virginia state law provisions for 12 months as described in the Contract and Evidence of Coverage or Certificate of Insurance.

PART C ELIGIBILITY

The following individuals are eligible to be covered under the Group plan:

Employees/Subscribers:

_X_ Active
_____ Full Time working ___ hours per week
_____ Part Time working ___ hours per week
_____ Retirees _____
_____ Other _____

Employees/Subscriber Legal Spouses

Children:
_____ 26 (day they turn 26)
_X_ 26 (end of month)
_____ 26 (end of year)

An Employee's Domestic Partner

A domestic partner is categorized as a relationship between two people who meet all of the following criteria:

- Have shared a continuous committed relationship with each other for no less than 6 (six) months; and
- Are jointly responsible for each other's welfare and financial obligations; and
- Reside in the same household; and

- Are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of their state of residence; and
- Each is over age 18, or legal age of consent in your state of legal residence, and legally competent to enter into a legal contract; and
- Neither is legally married to or legally separated from, nor in a domestic partnership with, a third party.

Other Group Specific Dependent Coverage:

Rules of eligibility: All Employees

Effective Date of Coverage:

X Newly hired employees and their eligible Dependents Coverage becomes effective the first day of the month after hire for which Premiums have been paid.

____ Newly hired employees and their eligible Dependents Coverage becomes effective on the date of hire in the month for which Premiums have been paid

____ Newly hired employees and their eligible Dependents Coverage becomes effective on the first day of the month following days of employment and for which Premiums have been paid

____ Newly hired employees and their eligible Dependents Coverage becomes effective on the first day of the month following ## months of employment and for which Premiums have been paid

____ Other Group Specific Provisions:
Newly hired employees and their dependents coverage becomes effective on the first day after days of employment and for premiums have been paid.

Termination of Coverage:

X Coverage terminates for employees and their eligible Dependents ends on last day of month the employee terminates employment on which employee was eligible and for which Premiums have been paid.

_____ Coverage terminates for employees and their eligible Dependents ends on the day of month the employee terminates employment on which employee was eligible and for which Premiums have been paid.

_____ Other Group Specific provisions: _____

PART D MONTHLY PREMIUMS

Employees must contribute toward the cost of coverage for: __X__ themselves
__X__ eligible Dependents
____ noncontributory

Employer must contribute toward the cost of coverage for:
All Employees - 86 Percent of single rate.
- of the single rate.

Proration Terms:

_____ Daily Proration - Monthly subscription fees will be paid on a daily proration of Premium. Daily proration of Premium is defined as a month's Premium divided by 30 days and then multiplied by the total number of days covered which will equal total Premium paid.

_____ Half Month Proration - A newly eligible Member enrolled on or before the 15th of the month is charged a full month's Premium. If the effective date for the newly eligible Member is after the 15th of the month, no Premium will be charged for that employee for that month. If a Member is terminated on or before the 15th of the month, no Premium will be charged for that employee for that month. If a Member is terminated after the 15th of the month, a full month's Premium will be charged.

_____ Full Month - If a Member is effective for any portion of a month, the entire month's Premium is due (this includes newborns and newly eligible Dependents.) Disenrollment is effective at the end of the last month the member is eligible. Premium is due for that month.

Mid-Market Caveats:

- Group must be a business organization with at least one eligible employee (includes owners, partners; excludes COBRA participants).
- Offering is contingent upon review of completed applications, employer group application, and most recent Virginia Employment Commission Quarterly Wage and Tax Report.
- Groups are recommended to meet 70% participation to avoid potential pricing impacts caused by adverse selection.
- The first month's premium must be submitted prior to the group's enrollment.
- Waiver information is required for eligible employees and/or any of their dependents declining coverage.
- Rates reflect current Census data. Birthdays occurring prior to the group's original effective date or group's renewal may cause a change in premium.
- Any group seeking to return to Optima Health is expected to pay any outstanding premium balances due.
- Proposed rates are on a Total Carrier Replacement basis.
- All Equity plans are offered only as an integrated package that includes HSA administration with Health Equity. If there is any employer contribution to the employees' Health Savings Accounts, it must be through Health Equity. If there is no employer contribution to their employees' Health Savings Accounts, Health Equity must be offered as a payroll option if the employer offers HSA through payroll deduction.

- If the employer contributes more than 50% of the deductible amount to the employee's HSA, Optima reserves the right to re-underwrite rates.
- The HRA commitment from the employer is $250 a year toward the deductible. The maximum HRA commitment from the employer is the deductible amount less $250. All Design plans are offered only as an integrated HRA plan including HRA administration with Health Equity.
- If enrolled membership (at time of enrollment or any other time during the contract) varies by 15% or more, Optima Health reserves the right to adjust its rates.
- Coverage for treatment of morbid obesity (including Vertical banded gastroplasty and Gastric bypass surgery) may be purchased as a benefit rider.
- Rates do not include additional expenses associated with the direct billing of COBRA enrollees.
- This proposal may be subject to change based upon new legislation and/or direction from regulatory agencies.
- Additional Group specific caveats or Contract provisions:

  The Plan will provide a credit equal to the amount of Premium due for the first month of Coverage under the Contract.

3. Rates:

Single	$834.83
Subscriber / Child	$1,140.37
Subscriber / Spouse	$1,870.01
Subscriber / Children	$1,697.20
Family	$2,575.53

BY THE SIGNATURE BELOW, it has been attested that the Group Contract Policyholder's designated representative has read and understood the Application and attached Group Contract, that the person signing for such party is authorized to do so, and that such party intends to be bound by its terms.

_____ By:_____

(Date) (Signature)

_____

(Title)

Sentara Vantage

Mid-Market

Group Contract

Underwritten by

Sentara Health Plans

1300 Sentara Park
Virginia Beach, VA 23464

Guaranteed Renewability

This Plan will renew or continue in force with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, or contract holder, or where the health insurance issuer has not received timely premium payments;
2. When the health insurance issuer is ceasing to offer coverage in the large group market;
3. For fraud or misrepresentation by the employer, with respect to their coverage;
4. With regard to coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her coverage;
5. For failure to comply with contribution and participation requirements defined by the health benefit plan;
6. For failure to comply with health benefit plan provisions that have been approved by the Commission

IMPORTANT INFORMATION TO POLICYHOLDERS

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. The Corporate Office of Sentara Health Plans is located at:

1300 Sentara Park
Virginia Beach, VA 23464
Main Phone Number: 757-552-7401
Toll Free: 1-877-552-7401
TTY for the hearing impaired: 1-800-828-1140 or 711

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

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

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

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

Office of the Managed Care Ombudsman.

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

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

Sentara Health Plans 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.

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INTRODUCTION

This Group Contract is entered into by Sentara Health Plans ("Plan") and the party ("Employer" or "Group") named on the attached application.

The Plan arranges for health services to Members of the Group on a prepayment basis. The Plan operates on a contracted direct-service basis rather than an indemnity basis. The interpretation of this Contract is guided by the direct service nature of the Plan program.

Upon The Plan's receipt and acceptance of Group's signed application and payment of the first Premium, this Contract will be deemed executed by the Group. The Group assures that, by electing to receive Coverage under this Contract or by accepting benefits hereunder, all Members have agreed to all the terms, conditions, and provisions of this Contract. The Plan's standard policies and procedures, as they may be amended from time to time, will be used in the performance of services specified in this Contract and in the provisions of Covered Services contained in the Evidence of Coverage or Certificate of Insurance issued with this Contract.

Sentara Health Plans and Group (individually referred to as "Party" and together referred to as the "Parties") agree to the following terms and conditions:

SECTION 1 DEFINITIONS

For the purpose of this Contract and any Enrollment Application, questionnaire, form, or other document provided or executed in connection with this Contract, the terms used therein shall have the meanings given to them in Section [2 Definitions] of the Evidence of Coverage or Certificate of Insurance attached to this Contract unless the context requires otherwise.

SECTION 2 ELIGIBILITY PROVISIONS

2.1 ELIGIBILITY FOR COVERAGE.

A. **Subscribers**. An employee is eligible for Coverage if he/she:

1. Is employed by the group; and
2. Is actively at work; and
3. Within 31 days of the effective date of Coverage files a complete enrollment application, including any applicable Premium or fees, with the Plan; and
4. Does not knowingly give incorrect, incomplete, or deceptive information regarding his/her eligibility for Coverage to the Plan or to the Group; and
5. Does not knowingly give incorrect, incomplete, or deceptive information regarding his/her eligible Dependents to the Plan or to the Group; and
6. Meets any other requirements as specified herein, or as specified by the Plan or by the Group.

Unless the Plan and Group agree otherwise, Independent contractors, agents or consultants who do not receive W-2 forms and their Dependents are not eligible for Coverage.

B. Actively at Work. Employees must be actively at work to receive Covered 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 beneficiaries, 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 [90 days];
2. For an employee who is totally disabled, coverage will continue for a period of not longer than [180 days]. The Plan may require certification of disability from the employee.

C. Dependents. Eligible Dependents include:

1. A Subscriber's lawful spouse.
2. Children up to the age 26 including:

    - Natural or stepchildren;
    - Legally adopted children;
    - Children placed for adoption;
    - Children placed in foster care;
    - Other Children for whom the Subscriber or covered spouse is a court appointed legal guardian.

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

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

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

    Eligibility to age 26 does not extend to a spouse of a Child Covered as a Dependent.

    Eligibility to age 26 does not extend to a Child of a Child Covered as a Dependent unless the grandparent Subscriber or spouse becomes the legal guardian or adoptive parent of that grandchild.

3. An Employee's Domestic Partner:

    A domestic partner is categorized as a relationship between two people who meet all of the following criteria:

    - Have shared a continuous committed relationship with each other for no less than 6 (six) months;

and

- Are jointly responsible for each other's welfare and financial obligations; and
- Reside in the same household; and
- Are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of their state of residence; and
- Each is over age 18, or legal age of consent in your state of legal residence, and legally competent to enter into a legal contract; and
- Neither is legally married to or legally separated from, nor in a domestic partnership with, a third party.

4. Any other person or persons(s) mutually agreed to by the Plan and the Group.

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 3.5 Additional Termination Provisions.

A person who would otherwise be eligible for Coverage may nonetheless be ineligible if that person would cause Sentara 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. Determining Eligibility for Initial Enrollment in the Plan

The Plan is responsible for verifying that all Subscribers and Dependents meet all requirements of the Plan, and the Group, and are eligible to enroll in the Group's Coverage.

F. Notification of Changes in Eligibility of Covered Members.

The Plan is responsible for verifying that Subscribers and Dependents remain eligible for coverage under the Group's Coverage.

G. Eligibility Provisions for Children.

Unless otherwise stated on Face Sheet or Schedule of Benefits Coverage for a Child ends the last day of the month year in which the Child reaches the Dependent age limit.

Continuation of Coverage for Children with an intellectual or physical disability.

Children who are both (i) incapable of self-sustaining employment by reason of an intellectual or physical disability and (ii) chiefly dependent upon the Subscriber for support and maintenance will continue to be eligible for Coverage beyond the Dependent age limit.

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 an intellectual or physical disability. The Plan may require subsequent statements, but not more than once a year.

H. 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 enrolled in the Group's Coverage.

2.2 ENROLLMENT.

If any information requested on the Enrollment Application, or at any other time during the enrollment process, is missing or incomplete the Subscriber and his or her Dependents may not be enrolled and may not be eligible to enroll until the Group's next Open Enrollment. The Plan 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 Special Enrollment provisions or Group's rules for changing coverage.

A. Plan Open Enrollment.

An Open Enrollment Period shall be held annually. During the 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. The Enrollment Application must be signed, and completely filled out including all required information on the form.

B. 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 limiting 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 next Open Enrollment Period or a qualifying event to apply for Coverage.

C. Newly Eligible Subscriber.

Individuals newly employed by the Group after the initial Open Enrollment Period shall be permitted to apply for Coverage as a Subscriber, and for any eligible Dependents, within 31 days of meeting the Group's eligibility requirements.

D. Newly Eligible Dependents.

Individuals newly eligible to be Covered as a Dependent because of a family status change shall be permitted to apply for Coverage within 31 days of meeting the Group's eligibility requirements. The Subscriber must submit a complete Enrollment Application to add the Dependent to their Coverage.

E. Coverage and Enrollment Changes due to Change in Status

A Subscriber may only make a change in Coverage for him/herself or his/her Dependents in the period between Open Enrollment Periods under certain circumstances as stated below.

1. For Groups that <u>do not offer a cafeteria plan</u> to their employees:

   Standard changes in status for which a benefit election change will be permitted include:

   (a) Change in legal marital status including marriage, death of spouse, divorce, legal separation, and annulment;

   (b) Change in number of Subscriber's dependents including birth, death, adoption, placement for adoption, or court appointed legal guardianship;

(c) Change in employment status, including a change in worksite, 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;

(d) Change in Dependents' eligibility;

(e) Change in residence of employee, spouse, and Dependent that affects eligibility.

2. For Groups that currently offer a cafeteria plan to their employees:

A cafeteria plan may permit a Subscriber to revoke a benefit election during a period of coverage and to make a new election for the remaining portion of the period if the revocation and new election are both on account of a change in family status and are consistent with such change in family status. For purposes of the Contract, examples of changes in family status for which a benefit election change may be permitted include:

(a) Change in legal marital status including marriage, death of spouse, divorce, legal separation, and annulment;

(b) Change in number of Subscriber's Dependents including birth, death, adoption, placement for adoption, or court appointed legal guardianship;

(c) Change in employment status, including a change in worksite, 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;

(d) Change in Dependents eligibility for coverage;

(e) Change in residence of employee, spouse, and Dependent that affects eligibility;

(f) The Plan may allow other change in status events that are permitted under IRS Section 125 rules. The Plan may require appropriate documentation be submitted by the Group if benefits are provided under IRS Regulations Section 125, and qualifying events or family status changes differ from those listed in this section.

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 a Subscriber wants to change his/her coverage status (add or drop coverage) because of a change in family status, he/she must notify the Employee Benefits Administrator and complete the necessary forms within 31 days of the change in family status or wait until the next open enrollment period. If any information requested on the Enrollment Application, or at any other time during the enrollment process, is missing or incomplete the Subscriber and his or her Dependents may not be enrolled and may not be eligible to enroll until the Group's next Open Enrollment Period.

F. Special Enrollment Provisions.

The Plan will provide special late enrollment periods for eligible employees and dependents that fall into the following categories:

1. **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 three conditions are met:

   a. The employee and/or Dependent must be eligible under the Group's terms; and

   b. When the employee declined enrollment for the employee and or Dependent, the employee stated in writing that the reason for declining enrollment was because he or she had other coverage such statement was required and if the employee was notified of the requirement to provide a written statement at the time he or she declined coverage; and

   c. 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 been exhausted; or if the other coverage was not under COBRA, either the other coverage has terminated as a result of loss of eligibility, or employer contributions toward the other coverage have terminated.

   Effective Date of Enrollment. Individuals must request enrollment no more than 31 days from the time that the individual knew or should have known that the other coverage has been exhausted. Late enrollment is effective no later than the first day of the calendar month beginning after the date a completed Enrollment Application is received by the Plan.

2. **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 all dependents are entitled to become covered through special late enrollment. Individuals in this category do not have to have declined coverage because they had other coverage.

   Effective Date of Enrollment. Individuals must request coverage within [30] [60] days of the 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.

3. **Special enrollment for employees and dependents that lose eligibility under Medicaid or Children's Health Insurance Program (CHIP) coverage.**

   Employees or Dependents who are eligible for 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.

2.3 EFFECTIVE DATE OF COVERAGE.

Subject to the Plan's receipt of an Enrollment Application and any applicable Premium, determined in accordance with the Group's terms of proration, if any, from or on behalf of each prospective member, and to the provisions of this Contract, Coverage shall become effective on the earliest of the following dates, unless otherwise specified by the Group on the application to this Contract;

A Subscriber Coverage.

1. When a person makes a written application for Coverage on or prior to the date he or she satisfies the eligibility requirements above, Coverage shall be effective as of the first of the month following the date eligibility requirements are satisfied.

2. When a person makes written application for Coverage after the date he or she satisfies the eligibility requirements above, Coverage will be effective as of the first day of the calendar month following the month in which such application is received by the Plan.

B Effective Date of Coverage. Coverage under this Contract for a Subscriber eligible on the initial effective date of this Contract becomes effective on the effective date of the Contract.

C Multiple Coverage. A Subscriber is not eligible to be the Subscriber on more than one policy with the Plan even if he or she is connected with more than one participant employer. Such a Subscriber will be considered as an employee of one Participant Employer.

D. Eligible Dependents. Eligible Dependent(s), as defined herein, are covered under this Contract only if the Subscriber enrolls each as a Dependent. Coverage Contract for eligible Dependents will become effective on the latter of: (a) the date the Subscriber's Coverage becomes effective; or (b) on the date the Subscriber acquires eligible Dependents, provided notification to the Plan is within enrollment guidelines and the required Premium has been paid on their behalf.

E. Newborn Children. A newborn child will have Coverage 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 31 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 Services. 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 Open Enrollment Period.

F. Adopted Children. An adopted child will be eligible for Coverage from the date of placement with a Subscriber for the purpose of adoption. A child whose placement has occurred within 31 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.

I. Part-time to Full-time Status Change. Coverage of employees whose employment status changes from part-time to full-time is effective on the first day of the month following the date of the status change, unless otherwise agreed to by the Plan and the Group and provided any new hire eligibility waiting period has expired.

SECTION 3 - TERMINATION OF COVERAGE

3.1 TERMINATION OF SUBSCRIBER COVERAGE.

Except as provided below and under the section entitled "Continuation of Care," a Subscriber's Coverage under this Contract will terminate on the first of the following:

A. The date this Group Contract terminates upon 31 days written notice to the Group;

B. The date the Subscriber fails to satisfy the Group's definition of an Eligible Employee or Subscriber as defined herein or on the Application for Group Contract;

C. The date Premium payments to the Plan on his or her behalf cease, in accordance with provisions of the Plan's Grace Period;

D. In accordance with the provisions of the Plan's Grace Period, the date the Subscriber fails to pay, have paid on his or her account or for his or her benefit, or make satisfactory arrangements 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.

3.2 TERMINATION OF DEPENDENT COVERAGE.

Except as provided below and under the section entitled "Continuation of Care," a Dependent's coverage under this Contract will terminate on the first of the following:

A. The date this Contract terminates upon 31 days written notice;

B. In accordance with the provisions of the Plan's Grace Period, the date the Dependent fails to pay, have paid on his or her account or for his or her benefit, or make satisfactory arrangements to pay any amounts due under the Plan, including failure to pay a Premium required under the Plan.

C. The date Premium payments to the Plan on his or her behalf cease, in accordance with provisions of the Plan's Grace Period, Section [6.2];

D. The date the Subscriber's Coverage terminates, unless otherwise agreed to by the Group and Sentara as stated on the Group Application;

E. The date a spouse or Child ceases to satisfy the Contract's definition of an eligible Dependent; or

F. The date the spouse or Child becomes covered as a Subscriber under this Contract.

3.3 NOTICE OF TERMINATION.

The Plan will not terminate Coverage for services provided under the Group Contract without giving 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 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.

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 health plan coverage under a health maintenance organization for their employees; and (ii) provides a facility for deducting the full amount of the Premium from employees' salaries and remitting such Premium to the health maintenance organization issuer, shall give written notice to participating employees in the event of termination or upon the receipt of notice of termination of any such group health plan contract not later than 15 days after the termination 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 group health plan contracts, or coverages specified in subsection B 1 above and who knowingly fails to remit to the issuer such funds required to maintain coverage in accordance with the 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.

C. For termination due to change of eligibility status of a Member, immediate notice of termination may be given.

D. Sentara will provide at least 30 days' advance written notice or electronic notice to any Covered Person who would be affected by the proposed Rescission of coverage before Coverage under the Plan may be Rescinded, regardless of whether the Rescission applies to the entire Group or only to an individual within the Group. The Covered Person or the Covered Person's authorized representative, prior to the date the advance notice of the proposed Rescission ends, may immediately file an internal appeal to request a reconsideration of the Rescission.

3.4 REINSTATEMENT OF COVERAGE FOLLOWING ABSENCE FROM EMPLOYMENT.

An employee who returns to work after 90 days from the date his or her employment is terminated will be considered a new employee and will be subject to all Plan and Group eligibility requirements, including waiting periods, and effective date provisions as described in [Section 2], with the following exceptions:

A. An employee who has had his or her employment terminated and is rehired and has had no more than a 63-day break in healthcare coverage will have the same employment and eligibility status as immediately prior to employment termination.

B. An employee who returns to work within 90 days after a layoff or an approved leave of absence will keep the same eligibility status as immediately prior to the layoff or leave of absence.

3.5 ADDITIONAL TERMINATION PROVISIONS.

Except as provided in this Contract, Coverage of the Subscriber and Dependents, if any, will terminate as follows:

A. Failure to Pay Required Contributions. In the event any Covered Person fails to pay, have paid on his/her account or for his/her benefit, or make satisfactory arrangements to pay any required contributions for

Coverage, Coverage shall terminate upon 31 days written notice and in accordance with the grace period provisions in the section entitled "Premiums and Other Financial Obligations."

B. Misuse of Plan Identification Card. If any Covered Person permits any other person to use his or her or any other Covered Person's Plan insurance card, or uses another Covered Person's card, the card may be retained by the Plan and Coverage may be terminated upon 31 days written notice. If a Dependent of a Subscriber permits any other person to use his or her or any other Member's Plan insurance card, both the Subscriber and the Dependent shall be jointly and severally liable to the Plan for all costs incurred as a result of the misuse of the identification card.

C. Material Misrepresentation. If a Covered Person, on behalf of him/herself or another Covered Person, knowingly causes or allows incorrect or incomplete information to be furnished to the Plan which constitutes a material misrepresentation, or which is fraudulent or deceptive, then the Plan may terminate coverage upon 31 days written notice. In addition, the Covered Person who either furnished such information or on whose behalf such information was furnished shall be responsible for all costs incurred by the Plan (including but not limited to, legal fees to recover any amounts owed to the Plan.)

D. Nonpayment. If the Group fails to pay Premiums on behalf of the Subscriber, and/or Dependents, if any, Coverage may be terminated upon 31 days written notice in accordance with the Plan's grace period provisions.

3.6 TERM AND TERMINATION OF AGREEMENT.

A. Initial Term and Renewals. This Contract shall be effective as of the date specified in the Application Contract and shall continue in full force and effect until midnight of the last day of the term defined therein ("Initial Term"), unless sooner terminated as hereinafter provided. Thereafter, the Contract shall renew for successive one-year terms on the date specified in the Contract. However, in accordance with state laws and regulations the Plan may decline to renew this Contract after the Initial Term or at the renewal date of any year thereafter, upon 31 days written notice, for one or more of the following reasons:

1. Nonpayment of Premium;

2. Fraud or intentional misrepresentation of material fact under the terms of the coverage by the Policyholder;

3. Violation of Participation or Contribution Rules by the Policyholder;

4. Cessation of offering of Sentara Health Plans Health Maintenance Organization (HMO) plan coverage in the group health plan market by the Plan; and

5. Movement outside the Service Area of all Enrollees so that there is no longer any Enrollee connected to the Group who lives, resides, or works in the Service Area.

The Group may terminate this Contract at the end of the initial term or at any subsequent renewal date by giving at least 31 days written notice of such termination to the Plan.

In the event that the Plan discontinues offering HMO coverage in the group market in this Commonwealth, the Plan will provide notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage. The Plan will offer to each plan sponsor provided coverage of this type in such market, the option to purchase any other Sentara Health Plans coverage currently being offered by the Plan to a group health plan in such market; and the Plan will act uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

B. Termination. This Contract may be terminated by the appropriate party upon the occurrence of any of the following events:

1. **Termination by Contract.** In the event the Group and the Plan shall mutually agree in writing, this Contract shall be terminated on the terms and date set forth therein.

2. **Termination on Notice for Default.** The Plan may terminate this Contract with 31 days written notice to the Group: (a) if the Group materially breaches this Contract in any manner, and such default or material breach continues for a period of 10 days after the date of postmark of written notice given by the Plan to the Group specifying the nature of the default or breach and requesting that it be cured; or (b) the Group enrollment at any time is less than two subscribers. Anything in this Contract to the contrary notwithstanding, no termination shall be made on the basis of a Covered Person's health. Subject to statutory notice requirements, in the event that any payment to the Plan called for by this Contract is not made within 31 days after the date when it is due, the Contract shall terminate and all benefits hereunder, including treatment for ongoing conditions and care for hospitalized Members, shall cease immediately except only for those Members who became totally disabled while a Member of the Plan and remain totally disabled at the time of termination of the Contract. (Refer to the Section entitled "Continuation of Care" for details.)
   Members will be responsible for any claims paid after the Premium due date including during the 31-day grace period.

3. **Termination for Insolvency.** If either the Group or the Plan files in a court of competent jurisdiction a petition in bankruptcy or a petition for protection against creditors, or files an assignment in favor of creditors or has such a petition filed against it, the Contract may be terminated by the other party upon written notice in accordance with this Contract and applicable provisions of state law.

4. **Termination for Fraud or Misrepresentation.** If a Group, on behalf of itself or a Covered Person, knowingly causes or allows incorrect or incomplete information to be furnished to the Plan which constitutes a material misrepresentation or which is fraudulent, then the Group Coverage may be voided upon 31 days written notice. In addition, any person who either furnished such information or on whose behalf such information was furnished shall be responsible for all costs incurred by the Plan, on his or her behalf during the period of coverage, (including but not limited to, legal fees to recover any amounts owed to the Plan, etc.).

   An Employer Group who would otherwise be eligible for Coverage under a Sentara Group Plan may nonetheless be ineligible if by offering coverage to that Employer Group would cause Sentara 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.

3.7 TERMINATION OF PARTICIPANT EMPLOYER'S COVERAGE.

A Participant Employer's coverage under this Contract will automatically terminate on the earliest of the following dates:

A. The date it discontinues or suspends active business operations;

B. The date it no longer exists because of dissolution, merger, or otherwise; or

C. The date on which any grace period ends, and any required Premium payments remain due and unpaid. The Plan shall refund to the Group, within 60 days after termination under this Section, any and all Premium payments made by the Group on behalf of a Member and applicable to period after the effective date of termination, less any amounts due to the Plan.

The Group and the Participant Employer will be jointly and severally liable to the Plan for any and all unpaid Premiums due to the Plan under this Contract.

In the event Coverage is terminated due to nonpayment of Premium by the employer, no such Coverage shall be terminated with respect to a Covered Person 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, upon 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.

A Participant Employer's Coverage under this Contract will automatically terminate on the date the Group's Coverage under this Contract terminates, whether such termination is initiated by the Group or by the Plan.

3.8 REINSTATEMENT FOLLOWING TERMINATION OF EMPLOYER GROUP AGREEMENT.

Acceptance by the Plan, at its sole discretion, of past due fees and/or Premiums and late charges may reinstate the Group's Coverage to the original disenrollment date. Groups that are not accepted for reinstatement may be eligible to reapply for Coverage as a new group.

As a condition for reinstatement or reenrollment the Plan, may require payment of any uncollected Premiums owed by the Group, as well as payment in advance for future Premium payments in advance and/or by certified funds. The Plan may also require a group to enroll in an automatic debit program for Premium payments as a condition of reinstatement or reenrollment.

A Group that has been terminated for non-payment of past due Premiums or other applicable charges three times within a consecutive 24-month period may not be eligible for reinstatement and may not be eligible to re-apply for coverage under the Plan. Any returned check or payment is considered as a non-payment and will count as one of the three times.

No person is eligible to re-enroll hereunder who has had Coverage terminate under the section "Termination of Coverage," If this Contract is terminated, the Plan will make every reasonable effort to provide continuing care to Covered Persons who are undergoing treatment for an ongoing condition at the time of termination (including but not limited to, access to Plan providers and facilities, other Plan resources and pharmacy services, if applicable.). Such Covered Persons will be entirely responsible for the cost of such care at the usual and customary rate for services to non-members.

3.9 EFFECTS OF TERMINATION.

All responsibilities of the Plan pursuant to this Contract shall terminate immediately upon the effective date of termination of the Contract. It shall be the responsibility of the Group to notify Covered Persons promptly that the Plan is no longer responsible to provide any service in connection with the Group Contract.

3.10 RESCISSION OF COVERAGE.

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

- A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage

is effective retroactively to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage; or

- A cancellation or discontinuance of coverage when the health benefit plan covers active employees and, if applicable, dependents and those covered under continuation coverage provisions, if the employee pays no Premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative recordkeeping.

Sentara will not Rescind Coverage after an individual is a Covered Person unless the individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

Sentara will provide at least 30 days' advance written or electronic notice to any Covered Person who would be affected by the proposed Rescission before Coverage may be Rescinded, regardless of whether the Rescission applies to the Group or only to an individual within the Group.

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

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

- Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;
- An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;
- Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;
- A description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and
- The date when the advance notice ends and the date back to which the coverage will be rescinded.

SECTION 4 - CONTINUATION OF CARE

4.1 Upon termination of a contract with a Plan provider, the Plan shall be liable for payment of Covered Services rendered by such provider at the time of termination until services being rendered to the Covered Person by such provider are completed, unless the Plan makes reasonable and medically appropriate provision for assumption of such services by a Plan Provider.

For this section “provider" means a hospital, physician or any type of provider licensed, certified or authorized by statute to provide a Covered Service under the Plan.

If a provider leaves the Plan's network, except when terminated for cause, Members may continue to receive care from that provider subject to the following:

- For a period of at least 90 days from the date the provider's termination;
- Through the provision of postpartum care directly related to the delivery for Members who have been medically confirmed to be pregnant at the time of the provider’s termination;
- 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.
- For up to 180 days for Members determined by a medical professional to have a life-threatening condition at the time of a provider’s termination for care directly related to the life-threatening condition.
- For Members admitted to and receiving treatment in any inpatient facility at the time of a provider's termination admission and treatment will continue until the Enrollee is discharged from the inpatient facility.

The Plan will pay a provider according to the Plan's agreement with the provider existing immediately before the provider's termination of participation. The provider will accept reimbursement from the Plan and any cost sharing payment from the Member as payment in full. Providers will continue to adhere to all policies and procedures imposed by the Plan required immediately before the provider's termination.

SECTION 5 – CONTINUATION OF GROUP COVERAGE UPON LOSS OF ELIGIBILITY

5.1 If a Covered Person loses eligibility after the Group Contract ends, they have the right to continue Coverage according to the following:

- For employer groups subject to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) the employer will provide for administration and notice of COBRA continuation of coverage for eligible employees and any eligible dependents;

- For employer groups not subject to COBRA employees and dependents will continue group coverage under Virginia state law provisions described below for 12 months.

5.2 EMPLOYER NOTICE OF CONTINUATION OPTIONS

The employer must provide each employee, or other Enrollee covered under the Plan, written notice of the availability of COBRA.

If the group is not subject to COBRA, then written notice of the availability of Virginia's 12 month continuation of group coverage option must be provided. The employer notice must include all of the procedures and timeframes for continuation of coverage. The notice must be provided within 14 days of the employer group contract holder's knowledge of the Enrollee or other covered person's loss of eligibility under the group contract.

5.3 COBRA CONTINUATION HEALTH COVERAGE

For those employer groups subject to COBRA the Plan will only allow continuation of coverage in accordance with the requirements of COBRA. The Group is responsible for all COBRA administration. The Group is responsible for provision of all notices required by COBRA.

5.4 CONTINUATION OF COVERAGE FOR EMPLOYER GROUPS NOT ELIGIBLE FOR COBRA.

If Coverage under the Group Plan ends Members are entitled to continuation of coverage under the existing group contract for a period of 12 months immediately following the date of termination of the Enrollee's eligibility for coverage under the Group Plan. Coverage shall be provided without additional evidence of insurability. The Premium for continuing group coverage shall be at the current rate applicable to the group contract, subject to the following requirements:

1. The application and payment for the extended coverage is made to the group contract holder within 31 days after issuance of the written notice by the employer, but in no event beyond the 60-day period following the date of the termination of the person's eligibility;
2. Each Premium for the extended coverage is timely paid to the group contract holder on a monthly basis during the 12-month period; and
3. The Premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy plus any applicable administrative fee not to exceed 2% of the current rate.

The Group is responsible for providing all required notices to its employees that are eligible for continuation of coverage.

Members will not be eligible for continuation of coverage when:

1. The Enrollee is covered by or is eligible for benefits under Title XVIII of the Social Security Act (42 USC § 1395 et seq.) known as Medicare;
2. The Enrollee is covered by or is eligible for a plan administered by the Department of Medical Assistance Services that provides benefits pursuant to Title XIX or XXI of the Social Security Act (42 USC § 1396 et seq. or § 1397aa et seq.);
3. The Enrollee is covered by or is eligible for substantially the same level of hospital, medical, and surgical benefits under state or federal law;
4. The Enrollee is covered by substantially the same level of benefits under any policy, contract, or plan for individuals in a group;
5. The Enrollee has not been continuously covered during the three-month period immediately preceding the Enrollee's termination of coverage;
6. The Enrollee was terminated from a plan administered by the Department of Medical Assistance Services that provided benefits pursuant to Title XIX or XXI of the Social Security Act (42 USC § 1396 et seq. or § 1397aa et seq.);
7. The Member was terminated by the Plan for any of the following reasons:
   a) 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;
   b) Fraud or material misrepresentation in enrollment or in the use of services or facilities;
   c) Material violation of the terms of the contract;

SECTION 6 - PREMIUMS AND OTHER FINANCIAL OBLIGATIONS

6.1 PREMIUMS.

Premiums payable by the Group to the Plan for Covered Services provided to Covered Persons shall be established by the Plan from time to time. If Members must make contributions towards the cost of their Coverage, the Coverage will be indicated as "contributory" on the Application to the Group Contract and on the Face Sheet or Schedule of Benefits of the Evidence of Coverage or Certificate of Insurance issued.

Premiums may be changed by the Plan effective on any anniversary date by giving 31 days prior written notice, or 60 days prior written notice if the Premium will increase more than 35% over the previous year's Premium, to the Group, addressed to the Group, or to the Group's designated representative, or the Group's Insurance Broker of record at its address of record on file with the Plan. During the contract period, the Plan also may increase

Premiums payable by the Group to the Plan, with 31 days prior written notice (or 60 days prior written notice if the Premium will increase by more than 35%) to the Group, where any state or federal legislative, judicial, or administrative body requires coverage of a benefit not included in the benefits purchased by the Group.

Premiums for any Covered Person who is accepted for enrollment during any month are due and payable with respect to that month on or before the first day of the following month. All other Premiums are payable in advance on the first day of the month to which they apply. Payment shall be deemed made when actually received by the Plan either at the Plan's post office box identified on the Plan's monthly invoices or at the Plan's corporate office. Late Premium payments shall be credited to the longest outstanding arrearage, and then in succession to the most recent arrearage or payment due.

6.2 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 Group contract holder has given the Plan written notice of discontinuance in accordance with the terms of the Group contract and in advance of the date of discontinuance. The Group contract holder shall be liable to the Plan for the payment of a pro rata Premium for the time the Group contract was in force during the grace period.

If the rights of a Member are terminated under this section, prepaid Premiums received on behalf of a terminated Member(s) applicable to periods after the effective date of termination, minus any amounts due to the Plan, will be refunded to the Group within 60 days thereafter.

6.3 RETROACTIVE DISENROLLMENT IN THE NORMAL COURSE OF BUSINESS.

Other than for a Rescission of Coverage for material misrepresentation, Sentara can only terminate a Member's coverage retroactively to a date in the past in specific circumstances.

The Group's Coverage may be terminated due to failure to timely pay required Premiums in accordance with Section 6.2 the Plan's 31-day Grace Period for Premium payment.

For Groups that cover active employees and, if applicable dependents, and those covered under state or federal continuation of coverage provisions, coverage may be terminated retroactively due to a delay in the Group's administrative record keeping if the employee or Member did not pay any Premium or contribution for coverage past the termination date or the date eligibility was lost. However, Sentara will not retroactively cancel coverage effective during any period where the employee or Member has incurred claims.

Coverage cannot be terminated retroactively if the employee or Member was allowed to continue coverage and incurred claims after termination of employment or eligibility, and the employee or Member paid Premium or contributed to the cost of coverage after termination of employment or eligibility. In these cases Sentara can only terminate the Member's coverage with a future date of termination. Coverage will usually end on the date through which Premiums were paid.

If a Group submits a retroactive termination request to Sentara, the Group must ensure that Covered Persons did not pay Premiums/contributions during the retroactive termination time period. When retroactive terminations are submitted, Sentara will regard the submission as verification that no Premium/contribution was paid by the Member/Dependent for that period.

The Group shall notify the Plan of any Covered Person who has become ineligible for continued coverage under the Plan for any reason. Notification must be made in writing and include the date of ineligibility. Notification must be received by the last day of the month in order to be incorporated into the next monthly billing cycle. Upon such notification, the Plan may refund to the Group up to two months of Premium payments made by the Group on behalf of the ineligible person subject to the following examples:

- If notification is received no later than January 31 for a requested termination date of November 30, and the Covered Person has made no Premium contribution, and no claims have been incurred, Sentara will authorize retro-termination of November 30 and a credit for billed Premiums should occur on the Group's next billing cycle.

- If notification is received in February for a requested termination date of November 30 and a Covered Person has made no Premium contribution, and no claims have been incurred, Sentara will authorize retro termination date of December 31 and a credit for billed Premiums should occur on the group's next billing cycle.

The Group will maintain adequate records and provide any information required by Sentara to verify that all PPACA and all state healthcare reform conditions for retroactive termination of coverage have been met. The Plan may examine the Group's records relating to the coverage under this Contract during normal business hours at a location mutually agreeable to the Group and the Plan. "PPACA" means the Patient Protection and Affordable Care Act (P.L. **111-148**), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. **111-152**), and as it may be further amended.

6.4 DISHONORED CHECKS AND COLLECTION EXPENSES.

If any check tendered by the Group in payment of any fees or other amounts payable by the Group to the Plan hereunder is dishonored or returned unpaid for any reason, the Group shall pay to the Plan a service charge of $25.00 and, at the Plan's option, may require the Group to tender future fees and other amounts owed in cash, by certified or cashier's check or other cash equivalent forms of payment designated by the Plan. The Group shall pay or reimburse the Plan for all expenses paid or incurred by the Plan in collecting overdue fees and other amounts payable by the Group hereunder, including attorneys' fees actually paid or incurred by the Plan and all court costs if suit is instituted. The Group's obligations under this section shall survive termination of this Contract.

For purposes of this section, the effective date of notice of termination shall be the date on which the notice of termination is mailed.

6.5 EMPLOYEE SUBGROUP ADMINISTRATION.

To help facilitate Group's internal accounts payable process or for other business reasons, Group may choose to structure its total membership into subgroups using an employment-based classification of Covered Persons that is consistent with the Group's usual business practice and applicable law and not based on health factors. Employee subgroup classifications may include but are not limited to: full-time versus part-time; hourly versus salaried; different geographic location; permanent versus temporary or seasonal status; current employee versus former employee status; and/or different occupations.

Plan shall administer and process the benefits, claims, Premium rates, reports and/or Premium application for a specified number of subgroups as if each were a separate employer group. The Group may designate a specific number, based on the number of Members within the Group, of subgroups that Plan will administer for no additional charge to the Group. Should the Group have less than 1000 Members, it may designate up to 5 subgroups; should the Group have 1000 to 3000 Members, it may designate up to 10 subgroups; and should the Group have greater than 3000 Members, it may designate up to 15 subgroups.

Group may request that Plan administer a number of subgroups in addition to those that Plan administers at no additional charge to Group. Should Plan agree to such request, Group shall pay Plan a yearly fee for administering said additional subgroups in an amount of $300 per subgroup per year. Such yearly fee shall be due to Plan on or before the Effective Date and any subsequent Renewal Date of this Group Contract.

6.6 MEDICAL LOSS RATIO REBATE DISTRIBUTION

Under PPACA Sentara Health Plans is required to provide an annual rebate to Enrollees if the insurer's medical loss ratio ("MLR") fails to meet minimum requirements. If the Plan's MLR fails to meet the minimum requirements set by PPACA, Sentara shall provide any such MLR rebate directly to the Group Contract Holder. The Group is solely responsible for distribution of the MLR rebate to the Group Enrollees subject to the following conditions:

A. Sentara Health Plans shall remain liable for complying with all of its obligations under ACA concerning MLR rebates;

B. The Group shall maintain and provide to Sentara upon request any and all records and documentation evidencing accurate distribution of any rebate owing, sufficient to demonstrate compliance with the ACA, including, but not limited to, the following:

1. The amount of the Premium paid by each Subscriber under the Group Plan;
2. The amount of the Premium paid by Group;
3. The amount of the rebate provided to each Subscriber;
4. The amount of the rebate retained by Group; and
5. The amount of any unclaimed rebate and how and when it was distributed.

SECTION 7 – COVERED SERVICES AND BENEFITS

7.1 COVERED SERVICES.

In consideration of payments of required fees, the Plan will provide to any eligible Covered Person the Covered Services set forth in the Evidence of Coverage or Certificate of Insurance issued, subject to the exclusions, limitations, and conditions set forth therein.

7.2 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 Covered Persons written notice of any benefit reductions during the contract period at least 30 days before such benefit reductions become effective.

SECTION 8 - MISCELLANEOUS

8.1 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 in 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.

8.2 INCONTESTABILITY.

All statements made by a Covered Person 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.

8.3 SEVERABILITY.

In the event any paragraph, article, or provision of this Contract is declared invalid, unlawful, or unenforceable, such declarations shall neither nullify nor affect the validity, legality, or enforceability of any other paragraph, article, or provision of this Contract or the Evidence of Coverage or Certificate of Coverage issued. Furthermore, the invalid provision shall be amended to whatever extent is needed to make such provision acceptable and enforceable by the applicable court while retaining the intent of the provision to the greatest possible extent.

8.4 POLICIES AND PROVISIONS.

The Plan may develop and adopt policies, procedures, rules, and interpretations to promote orderly, equitable, and efficient administration of coverage. The Group accepts and agrees to cooperate with these policies and provisions.

8.5 MODIFICATIONS.

Modifications to the Group Contract and its attachments may be made, in accordance with the terms of the Group Contract between the Plan and Group. This may be done without Subscribers' consent or concurrence.

8.6 ENTIRE CONTRACT.

The Evidence of Coverage or Certificate of Insurance, Face Sheet or Schedule of Benefits, and this Group Contract together with all exhibits and amendments thereto, the individual Enrollment Applications of Covered Persons, and any other questionnaire, form, or other document provided in execution with the Group Contract 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 Contract 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.

8.7 WORKERS' COMPENSATION.

This Contract is not in lieu of and does not affect any requirement or coverage by Workers' Compensation Insurance.

8.8 ARTICLES OF INCORPORATION OR BYLAWS.

None of the terms or provisions of the Articles of Incorporation or Bylaws of the Plan shall form a part of this Contract or be used in any suit hereunder unless the same is set forth in full herein.

8.9 AMENDMENT.

By this Contract, the Group makes Coverage available to persons who are eligible. However, this Contract is subject to amendment, modification, or termination in accordance with any provision hereof or by mutual agreement between the Plan and the Group without the consent or concurrence of the Covered Persons. The Group warrants that, by electing coverage pursuant to this Contract or accepting benefits hereunder, all Members (or, if applicable, their legal representatives on their behalf) agree to all terms, conditions and provisions of this Contract and any subsequent amendments thereto. The Group shall inform Subscribers of the terms and conditions of this Contract which are applicable to Covered Persons, including but not limited to the conditions of eligibility, dates of commencement and termination, and the terms and conditions of coverage. Any changes to this Contract which can reasonably be considered an enhancement (i.e. increased benefit) with no Premium increase may be executed by the

Plan with notice to the Group and to the Subscriber(s). Except for changes required by law or regulation, all other changes must be by written instrument executed by authorized representatives of the Plan and the Group.

8.10 COMPLETED FORMS.

Covered Persons or applicants for Coverage shall complete and submit to the Plan such enrollment applications, medical review questionnaires, and other forms or statements as the Plan may reasonably request. Persons shall represent that all information contained in such enrollment applications, questionnaires, forms, or statements submitted to the Plan incident to enrollment under this Contract or the administration hereof are true, correct and complete. **If any information requested on the Enrollment Application, or at any other time during the enrollment process, is missing or incomplete the Subscriber and his or her Dependents may not be enrolled, and may not be eligible to enroll until the Group's next Open Enrollment Period**

8.11 LIABILITY TO PLAN PROVIDER.

In the event the Plan fails to pay an In-Network Provider for Covered Services provided to a Covered Person, pursuant to this Contract, the Covered Person shall not be liable to the Plan provider for any sums owed by the Plan.

8.12 NOTICE TO GROUP.

The Plan shall give the Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any Plan provider if the Group may be materially and adversely affected thereby.

8.13 NOTICE.

Any notice under this Contract may be given by United States mail, postage paid, addressed as follows:

IF to the Plan:

Sentara Health Plan

1300 Sentara Park
Virginia Beach, Virginia 23464
(757) 552-7401

IF to a Subscriber:
To the latest address provided for the Subscriber on the Enrollment Application or the last address change on file with the Plan.

IF to the Group:
To the address indicated on the Application to the Group Contract.

IF to the Group's broker or agent:
To the address on file with the Plan.

The Group shall be solely responsible for notifying Subscribers of any changes in fees or any other material matter respecting the Members' rights or obligations in connection with this Contract. Except as specifically provided in this Contract, the Plan shall have no obligation to notify the Subscribers, or any other Covered Person of any matters related to this Contract. Notice delivered to a Subscriber shall be deemed as notice to him/her and to his/her Dependents.

Except as otherwise provided in this Contract, notice shall be deemed to have been received by the party to whom addressed 24 hours after the same is placed in the United States mail, postage prepaid, and addressed as set forth above.

8.14 OBTAINMENT OF RECORDS.

Each Covered Person shall agree that the Plan may obtain from and provide to any person or organization (including internal and external medical review bodies) all information (including medical records) with respect to him/her where such information is reasonably necessary to administer this Contract or for the Plan to fulfill its responsibilities under any applicable laws or regulations. Each Covered Person shall agree to provide the Plan with information within his possession or control and authorizes and directs any person or institution that has attended, examined, or treated him/her to furnish the Plan, at any reasonable time upon its request, any and all information and records or copies of records relating to attendance, examination, or treatment rendered to the Member when requested for the above purposes. By execution of an Enrollment Application under this Contract, each Covered Person shall be deemed to have agreed to the foregoing and to have waived any claims of privilege or confidentiality with respect to such information when released or obtained for the purposes described herein to the maximum extent permitted by law. Except as necessary to administer this Contract or for the Plan to fulfill its responsibilities under any applicable laws or regulations, the Plan shall maintain confidentiality of all information pertaining to Members.

8.15 INDEMNIFICATION.

Sentara and the Group shall each be and remain responsible for any and all claims, liabilities, damages, or judgments which may arise as a result of its own negligence or intentional wrongdoing in connection with the performance of its obligations under this Contract. To the extent not otherwise covered by insurance, Sentara and the Group shall hold the other harmless and indemnify the other for any claims, liabilities, damages, or judgments arising from its own negligence or intentional wrongdoing in connection with the performance of its obligations under this Contract, including but not limited to reasonable attorneys' fees and defense costs, which may be asserted against, imposed upon, or incurred by the other party. The above in no way limits or negates the rights of the Group to sue Sentara Health Plans for The Plan's own negligence, breach of contract, or wrongful acts in connection with or in the course of the performance of this contract nor does it limit or negate the rights of Sentara Health Plans to sue the Group for the Group's own negligence, breach of contract, or wrongful acts in connection with or in the course of the performance of this contract.

8.16 ASSIGNMENT.

This Contract may not be assigned by the Group to any third party without the written consent of the Plan.

8.17 CLAIMS EXPERIENCE.

The Plan, upon request, shall provide a policy holder that employed an average of at least 100 individuals who were insureds, subscribers, or Enrollees on business days during the preceding 12-month period with a complete record of the policyholder's medical claims experience or medical costs incurred under the group policy, group agreement, contract, or plan. This record shall include all claims incurred for the lesser of (i) the period of time since the policy was issued or issued for delivery or (ii) the period of time since the policy was last renewed, reissued, or extended, if already issued. This record shall be made available promptly to the policyholder upon request made not less than 30 days prior to the date upon which the Premiums or contractual terms of the, Contract, may be amended. Nothing in this section shall require the disclosure of personal or privileged information about an individual that is protected from disclosure under any applicable federal or state law or regulation. No policyholder shall be required to pay for information requested pursuant to this section.

A policyholder that employed an average of at least 100 individuals who were insureds, subscribers or Enrollees on business days during the preceding 12-month period shall receive from the Plan, upon request, at the time that the Plan provides claims experience under subsection A of this section (i) a summary of medical claims charges or

medical costs incurred and the amount paid with respect to those claims for the most recently available 24-month period; (ii) a listing of the number of insured, subscribers, or Enrollees for whom combined medical claims payments or medical costs exceed $100,000 for the most recently available 12-month period, and for the preceding 12 months if not previously provided, with information as to whether these Enrollees from the most recently available 12-month period remain enrolled under the policy, and provided that a policyholder and insurer may agree by contract to provide the listing for amounts less than $100,000; and (iii) total enrollment in each membership type as of the end of the most recently available 12-month period. This record shall be made available to the policyholder within 20 business days upon written request made not less than 45 days prior to the date upon which the Premiums or contractual terms of the policy may be amended. Nothing in this section shall require the disclosure of personal or privileged information about an individual that is protected from disclosure under any applicable federal or state law or regulation. No policyholder shall be required to pay for information requested pursuant to this section.

8.18 OTHER EMPLOYEE AND BENFICIARY NOTICES

The Group and not the Plan is responsible for provision of all required COBRA notices. The Group and not the Plan is responsible for provision of all required notices regarding continuation of coverage under Virginia State law.

The Group and not the Plan is responsible for the provision of any other notices required by Federal law including, but not limited to, notification of Special Enrollment Rights, CHIP Special Enrollment Rights, Women's Health and Cancer Rights Act (WHCRA), New Born and Mothers Health Protection Act (NMHPA), and ERISA rights.

The Group is responsible for provision of notices required by The Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act.

8.19 MEDICARE SECONDARY PAYOR REPORTING REQUIREMENTS

The Group agrees to cooperate with Sentara in complying with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) for provision of health plan Members' Social Security Numbers (SSNs), or annual refusal forms, to the Centers for Medicare & Medicaid Services (CMS) to ensure proper coordination of benefits between Medicare and private insurers.

8.20 UNFAIR DISCRIMINATION.

The Plan will not unfairly discriminate against an Enrollee on the basis of the age, sex, gender identity or status as a transgender individual, health status, race, color, creed, national origin, ancestry, religion, marital status, or lawful occupation of the Enrollee, or because of the frequency of utilization of services by the Enrollee. However, nothing shall prohibit the Plan from setting rates or establishing a schedule of charges in accordance with relevant actuarial data.

The Plan will not unreasonably discriminate against physicians as a class or any class of providers listed in § 38.2-4312 and § 38.2-3449.1 of the Code of Virginia when contracting for Specialty or referral practitioners, provided the plan covers services that the class of providers are licensed to render. Nothing in this section shall prevent a health maintenance organization from selecting, in the judgment of the health maintenance organization, the number of providers necessary to render the services offered by the health maintenance organization, or from limiting certain Specialty services to particular types of practitioners, provided these services are within the scope of their license.

8.21 EXTENSION OF BENEFITS FOR TOTAL DISABILITY.

If Coverage ends under the Group Contract Covered Persons who become totally disabled while enrolled and who continue to be totally disabled when the Group Contract 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 individual is no longer totally disabled, or a succeeding carrier elects to provide replacement coverage to that individual without limitation as to the disabling condition. Upon termination of the extension of benefits, the Enrollee shall have the right to continue coverage as provided herein.

8.22 TRANSPARENCY IN COVERAGE DISCLOSURES

Sentara Health Plans agrees to provide the information required under 45 CFR 147.212 (Transparency in coverage – requirements for public disclosure) on behalf of group in compliance with such section.

Starting the later of January 1, 2023 and the group's effective date, with respect for the 500 items and services, Sentara agrees to provide the information required under 45 CFR 147.211 (Transparency in coverage – required disclosures to participants, beneficiaries, or Enrollees) on behalf of group in compliance with such section.

Starting the later of January 1, 2024 and the group's effective date, Sentara agrees to provide the information required under 45 CFR 147.211 (Transparency in coverage – required disclosures to participants, beneficiaries, or Enrollees) on behalf of group in compliance with such section.

8.23 PRESCRIPTION DRUG DATA COLLECTION (RxDC).

Sentara will collect and submit data required under Section 204 (of Title II, Division BB) of the Consolidated Appropriations Act, 2021 (CAA) for Covered Services administered by Sentara. The Group Policyholder agrees to provide Sentara all requested and required data needed to complete and submit the report on the Group's behalf.

8.24 PROHIBITION ON GAG CLAUSES AND QUALITY INFORMATION IN PROVIDER AGREEMENTS AND ANNUAL ATTESTATION.

In accordance with Internal Revenue Code (Code) section 9824, Employee Retirement Income Security Act (ERISA) section 724, and Public Health Service (PHS) Act section 2799 A-9, as added by section 201 of Title II (Transparency) of Division BB of the CAA, group health plans and health insurance issuers offering group health insurance coverage are prohibited from entering into an agreement with a health care provider, network or association of providers, third-party administration, or other service provider offering access to a network of providers that would directly or indirectly restrict a plan or issuer from:

4. **providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means to: referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;**
5. **electronically accessing de-identified claims and encounter information or data for each participant, beneficiary, or enrollee in the plan or coverage upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Americans with Disabilities Act of 1990 (ADA), including, on a per claim basis—**
    - i. **financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;**
    - ii. **provider information, including name and clinical designation;**
    - iii. **service codes; or**
    - iv. **any other data element included in claim or encounter transactions; or**

Additionally, plans and issuers must annually submit to the Departments of Labor, Health and Human Services, and the Treasury an attestation that the plan or issuer is in compliance with Code section 9824, ERISA section 724, and PHS Act section 2799A-9, as applicable (Gag Clause Prohibition Compliance Attestation). Sentara will work with the Group Policyholder to collect information needed to submit the annual attestation for Covered Services under the Plan administered by Sentara. The Group Policyholder agrees to timely and accurately provide Sentara all requested and required data elements needed to submit the attestation; and authorizes Sentara to submit the attestation on the Group's behalf.

Sentara Health Plans

Underwritten by: Sentara Health Plans
1300 Sentara Park, Virginia Beach VA, 23464

Health Maintenance Organization (HMO)
Evidence of Coverage

Sentara Health

Sentara Vantage

Mid-Market

Effective Date: 10/1/2024

Sentara Health Plans
sentarahealthplans.com

Important Information About Your 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:

Sentara Health Plans
1300 Sentara Park
Virginia Beach, VA 23464
Main Phone Number: 757-552-7401 or 1-877-552-7401
TTY for the hearing impaired: 1-800-828-1140 or 711

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

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

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

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

Office of the Managed Care Ombudsman.

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

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

Guaranteed Renewability

This Plan will renew or continue in force with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, or contract holder, or where the health insurance issuer has not received timely premium payments;
2. When the health insurance issuer is ceasing to offer coverage in the large group market;
3. For fraud or misrepresentation by the employer, with respect to their coverage;
4. With regard to coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her coverage;
5. For failure to comply with contribution and participation requirements defined by the health benefit plan;
6. For failure to comply with health benefit plan provisions that have been approved by the Commission.

Introduction and Welcome

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

In this EOC You will find important information on:

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

Sentara Health Plans

This health plan is offered and underwritten by Sentara Health Plans. In this document We may use the term Sentara or Plan to refer to this plan.

The Sentara Health Plans Corporate Office is located at 1300 Sentara Park, Virginia Beach, Virginia 23464.

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

How to Get Language Assistance

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

Need help in another language? Call us.
需要以其他语言获得帮助？ 联系我们。
다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.
Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.
Kailangan ng tulong sa ibang wika? Tawagan kami.
¿Necesita ayuda en algún otro idioma? Llámenos.
Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.
1-855-687-6260

Optima Health Plan
Optima Vantage 1000/30/30%
10101VA000700400
CHARLES CITY COUNTY PUBLIC
39651
10/01/2023
Large Group Schedule of Benefits

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

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

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

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

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

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

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

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

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

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

Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Contract Year	$1,000/Individual; $2,000/Family	Not Covered
Most amounts You pay for In-Network Covered Services will count toward meeting the In-Network Deductible. The Deductible applies to all Covered Services except for: • In-Network Preventive Care Services required by law; • Other services in this document shown as Covered without a Deductible. If You are the Subscriber, and the only Member covered under Your Plan, the Individual Deductible amount applies. If You have other Family Members on Your Plan the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one Family Member meets the Individual Deductible his or her benefits will begin. Once the total Family coverage Deductible is met benefits are available for all Family Members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a Member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible. Any amounts applied to the Plan Deductible during the last three months of the Contract Year can be carried forward to the next year.		
	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Contract Year	$4,500/Individual; $9,000/Family	Not Covered
Most amounts You pay, or that are paid on Your behalf, for In-Network Covered Services will count toward meeting the In-Network Maximum Out-of-Pocket Amount. The following will not count toward the Plan Maximum Amount(s): • Amounts You pay for services not covered under Your Plan; • Amounts You pay for any services after a benefit limit has been reached; • Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers; • Premium amounts; • Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits; • Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available; • Other services in this document that are shown as excluded from the Maximum Amount. If You are the Subscriber, and the only Member Covered under Your Plan, the Individual Maximum applies. If You have other Family Members on Your Plan the Family Maximum applies. Under Family coverage the Individual Maximum applies separately to each covered Family Member. Once the total Family coverage Maximum is met the Family Maximum Amount is satisfied. No one Member can contribute more than their Individual Maximum Amount to the Family limit.		

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

Benefit	In-Network	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Optima Health approved providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	You Pay $30	Not Covered
Virtual Consult	No Charge	Not Covered
Specialist Visit	You Pay $50	Not Covered
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 50%	Not Covered
Preventive Care Recommended Preventive Care Services are Covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.		
Recommended exams, screenings, tests, immunizations, and other services	No Charge	Not Covered
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Contract Year.	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	Not Covered

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

Benefit	In-Network	Out-of-Network
Speech Therapy* Services limited to 30 visits per Contract Year.	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Cardiac Rehabilitation* Services limited to 30 visits per Contract Year.	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Pulmonary Rehabilitation* Services limited to 30 visits per Contract Year.	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Vascular Rehabilitation* Services limited to 30 visits per Contract Year.	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Vestibular Rehabilitation* Services limited to 30 visits per Contract Year.	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	Not Covered
IV Infusion Therapy	**PCP Office Visit** You Pay $30 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $30 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 30%	Not Covered

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

Benefit	In-Network	Out-of-Network
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** You Pay $30 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Radiation Therapy*	**PCP Office Visit** You Pay $30 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient Facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 30%	Not Covered
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.		
Dialysis Services	After Deductible You Pay 30%	Not Covered
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.		
Surgery Services*	After Deductible You Pay 30%	Not Covered
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient Facility or lab or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Diagnostic Procedures	After Deductible You Pay 30%	Not Covered
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 30%	Not Covered
Lab Work	After Deductible You Pay 30%	Not Covered

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

Benefit	In-Network	Out-of-Network
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a freestanding outpatient Facility or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	After Deductible You Pay 30%	Not Covered
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.		
Maternity Care ***Pre-Authorization is required for prenatal services**	You Pay $500 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
Inpatient Services		
Inpatient Hospital Services*	After Deductible You Pay 30%	Not Covered
Transplants* Covered at contracted facilities only.	After Deductible You Pay 30%	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Contract Year.	After Deductible You Pay 30%	Not Covered
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Air, Water, Ground Services*	After Deductible You Pay 30%	Not Covered

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

Benefit	In-Network	Out-of-Network
Emergency Services Includes medical and mental health and substance use disorder Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including and independent freestanding Emergency Department, In-Network or Out-of-Network.		
Emergency Services	After Deductible You Pay 30%	After Deductible You Pay 30%
Emergency Ambulance	After Deductible You Pay 30%	After Deductible You Pay 30%
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	You Pay $50	Not Covered
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Optima Health providers. ***Pre-Authorization is required for Inpatient Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**		
Inpatient Hospital Services*	After Deductible You Pay 30%	Not Covered
Residential Treatment Services*	After Deductible You Pay 30%	Not Covered
Outpatient Office Visits (PCP, Specialist or Virtual Consults)	You Pay $40	Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	After Deductible You Pay 30%	Not Covered
Other Outpatient Services	After Deductible You Pay 30%	Not Covered
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Not Covered
Employee Assistance Visits Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174.	No Charge for up to 3 visits from Optima Health Employee Assistance providers per presenting issue as determined by treatment protocols.	
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating VSP Vision Care provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps*	No Charge	Not Covered

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

Benefit	In-Network	Out-of-Network
Pump Infusion Sets and Supplies*	After Deductible You Pay 30%	Not Covered
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution, and continuous glucose monitors, sensors and supplies. ***Pre-Authorization is required for talking blood glucose monitors**	Covered under the Plan's Prescription Drug Benefit	Not Covered
Insulin, and Needles and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	Not Covered
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible You Pay 30%	Not Covered
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement and rental items.**	After Deductible You Pay 30%	Not Covered
Early Intervention Services For Dependent children from birth to age three.		
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices.*	Cost sharing determined by the type and place of service.	Not Covered
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home.		
Home Health Care* Limited to a maximum of 100 visits per Contract Year.	You Pay $30	Not Covered
Hospice Care		
Hospice Care*	After Deductible No Charge	Not Covered

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

Benefit	In-Network	Out-of-Network
Vision Care Optima Health contracts with VSP Vision Care to administer this benefit. Services must be received from VSP Vision Care providers.		
Vision Exams Limited to one routine eye exam every 12 months from a participating VSP provider.	No Charge	Members will be reimbursed up to $30 for one routine eye exam only
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing determined by the type and place of service.	Not covered
Infertility Services Includes limited services, for Members only, to diagnose and treat underlying medical conditions resulting in Infertility.		
Endometrial biopsies Limited to 2 per lifetime **Semen analysis** Limited to 2 per lifetime **Hysterosalpingography** Limited to 2 per lifetime **Sims-Huhner test (smear)** Limited to 4 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime	Cost sharing determined by the type and place of service.	Not Covered
Clinical Trials Includes “routine patient costs” for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.		
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Not Covered
Allergy Care		
Allergy Care, Testing, and Serum	Cost sharing determined by the type and place of service.	Not Covered
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.		
Telemedicine Services	Cost sharing determined by the type and place of service.	Not Covered

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

Benefit	In-Network	Out-of-Network
Out of Area Dependent Program Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits when Covered Services are received from Optima Health providers that participate in the Out of Area Program. The Plan will require eligible out of area Dependents to complete an annual certification form prior to being eligible for the program. Except for Emergency Services any Covered Services received outside of the service area from Out of Network Non-Plan Providers that are not included in the Out of Area Dependent Program will not be covered.		
Out of Area Program Services *Pre-Authorization requirements apply depending on the type and place of service.	Cost sharing determined by the type and place of service	Not Covered

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

Prescription Drugs
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This document describes Your Plan's outpatient prescription drug Coverage for medical and mental health and substance use disorder treatment. All drugs must be United States Food and Drug Administration (FDA) approved, and You must have a prescription. You will need to pay Your Copayment or Coinsurance when You fill your prescription at the pharmacy. If Your Plan has a Deductible, You must meet that amount before Your Coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. Details about Covered Services are in the section "What is Covered". Details about services and treatments that are not covered are in the section "What is Not Covered."

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

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

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

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

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

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

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

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

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

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

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

Refills

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

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

Deductibles, Maximum Out of Pocket Amount (MOOP), and Benefits	
Deductibles	Your Plan does not have a Deductible
Maximum Out-of-Pocket Amount	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Maximum Medical Out-of-Pocket Limit. Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available are not Covered, do not count toward the Plan's Maximum Out-of-Pocket Amount and must continue to be paid after the Maximum Out-of-Pocket Amount has been met.
Insulin, and Needles and Syringes for Injection	You pay the cost sharing for the applicable Tier. A Member's cost sharing payment for a covered insulin drug will not exceed $50 per 30-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. Deductible does not apply.
Diabetic Testing Supplies including test strips, lancets, lancet devices, blood glucose monitors and control solution	No Charge Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. Members that request other brand name supplies will pay the applicable cost share depending on the Tier. *Pre-Authorization is required for talking blood glucose meters.
Continuous Glucose Monitors, Sensors and Supplies	You pay the cost sharing for the applicable Tier.
Formulary	This Plan has a closed formulary and covers a specific list of drugs and medications. If Your drug is not on Our formulary, We have a process in place to request coverage. Please use the following link to see a list of drugs on the Plan's formulary: optimahealth.com/documents/drug-lists/form-doc-drug-list-standard-formulary.pdf. If a brand name medication is dispensed instead of a generic equivalent, You must pay the cost difference between the dispensed brand name drug and the generic drug in addition to the Copayment or Coinsurance charge, unless authorized by the Plan.

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

Retail Pharmacy Cost Sharing When You pick up Your drug at a retail pharmacy You will pay the Copayment (one Copayment for each 30-day supply) or the Coinsurance amount listed under the applicable Tier for Your Drug: • You pay one Copayment or the Coinsurance for up to a 30-day supply; • You pay two Copayments or the Coinsurance for a 31 to 60-day supply; • You pay three Copayments or the Coinsurance for a 61 to 90-day supply. Tier 4 Specialty Drugs are only available from an Optima Health Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge. Deductible does not apply. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs **Tier 1**	You Pay $15
Preferred Brand & Other Generic Drugs **Tier 2**	You Pay $40
Non-Preferred Brand Drugs **Tier 3**	You Pay $75
Specialty Drugs **Tier 4**	You Pay 20% up to a maximum Copayment of $300.

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

Copayment and Coinsurance Mail Order (If Your Drug is available) for up to a 90-day supply Some Outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available from the Plan's Mail Order Pharmacy Express Scripts. You may call Express Scripts at 1-888-899-2653 to find out if Your drug is available. Tier 4 Specialty Drugs are only available from an Optima Health Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge. Deductible does not apply. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs **Tier 1**	You Pay $38
Preferred Brand & Other Generic Drugs **Tier 2**	You Pay $100
Non-Preferred Brand Drugs **Tier 3**	You Pay $225
Specialty Drugs **Tier 4**	Tier 4 Specialty Drugs are only available from an Optima Health Specialty Pharmacy including Express Scripts at 1-888-899-2653 and are limited to a 30-day supply.

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

Notice/Notes/Terms & Conditions:

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

This Plan does not have pre-existing condition exclusions.

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

This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

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

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

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

1-855-687-6260

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

Amendments/Riders

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

Table of Contents

Section 1
How Your Plan Works

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

Patient Protections Disclosure Notice

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

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

Your Evidence of Coverage or EOC

This booklet, any endorsements, the Schedule of Benefits, riders, and Your Enrollment Application make up Your policy. Please read every part of this booklet carefully, so You will understand how Your Coverage works. Call Member Services if You have any questions.

Words or Terms We Use in this EOC

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

Your Plan ID Card

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

Section 1
How Your Plan Works

Your Schedule of Benefits and Your Out-of-Pocket Expenses

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

Benefit Limits

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

Pre-Authorization

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

Plan Provider Network

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

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

Section 1
How Your Plan Works

Primary Care Providers

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

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

Specialty Care Providers

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

Choosing a Provider for Your Covered Services

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

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

- Air ambulance services provided by an Out-of-Network Provider.

- Non-emergency services provided by an Out-of-Network Provider at an In-Network Facility if the non-emergency services involve otherwise Covered Surgical or Ancillary Services, or other Covered Services provided by an Out-of-Network Provider.

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

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

Service Area

Your Plan has a specific Service Area in the Commonwealth of Virginia where We have arranged directly or indirectly to provide Covered Services.

The Plan contracts with providers outside of Our Service Area so that Members are able to receive care from Participating Providers and use In-Network benefits when they are away from home, or when residing outside the Service Area while Covered under a Plan issued to an employer group located in Our Service Area.

Out-of-Area Dependent Program

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How Your Plan Works

Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits listed on the Plan Schedule of Benefits when Covered Services are received from Plan providers that participate in the Out-of-Area Program. A list of contracted providers that participate in the program is available at sentarahealthplans.com or by calling Member Services at the number on the Member's ID card.

The Plan will require eligible out-of-area Dependents to complete an annual certification form prior to being eligible for the program. Completed certification forms must be submitted directly to the Plan. A copy of the form is available at sentarahealthplans.com or by calling Member Services. All other eligibility requirements under the Plan must be met.

Eligible Dependents who are enrolled in the program will have a unique ID card that must be presented to the provider when services are received.

All Pre-Authorization requirements apply depending on the type and place of service. Members must pay all applicable In-Network Copayments, Coinsurance, and/or Deductibles listed on the Plan's Schedule of Benefits.

Except for Emergency Services any Covered Services received outside of the Service Area from Out-of-Network Non-Plan Providers that are not included in the Out-of-Area Dependent Program will not be covered.

Providers will usually file Claims for Members. If a Provider is unable to file a Claim, Members may have to pay the provider directly for services and file a Claim with Us for reimbursement. Please see the Claims and Payments section in this Evidence of Coverage for help in filing a Claim directly with the Plan.

Pre-existing Conditions

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

Special Enrollment Opportunity for Children under Age 26

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

Lifetime Limits and Opportunity to Enroll

Section 1
How Your Plan Works

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.

Coverage Under a Group Plan

This Plan is an employer group plan sponsored by Your employer. Your employer sends Premiums to the Plan each month on Your behalf to pay for Your Coverage. Your employer will let You know if You must contribute any amount for Coverage.

The Plan will provide employer Group Policyholders written notice of any benefit reductions during the contract period at least 60 days before such benefit reductions become effective. Employer Group Policyholders shall, in turn, provide to their enrollees written notice of any benefit reductions during the contract period at least 30 days before such benefit reductions become effective. The Plan will provide 60 days advance notice to enrollees before the effective date of any material modification including changes in preventive benefits, benefit changes, Premium changes, Copayment or Coinsurance changes, or changes to the Service Area.

If Your employer is offering Coverage under an HMO health plan, You should be offered the option to enroll in an optional point of service plan which permits eligible dependents to receive the full range of Covered benefits from non-plan providers.

After-Hours Nurse Triage Program

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

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

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

Section 1
How Your Plan Works

Wellness and Disease Management Programs

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

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

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

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

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

All of Our wellness programs are voluntary. Rewards will not be based on a health outcome. If You decide to participate in a program, or not to participate, it will not affect Your eligibility to enroll or remain enrolled in Your health Plan or to receive Covered Services.

Stop Health Care Fraud!

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

- Do not give Your Plan identification (ID) number or other personal information over the telephone or email it to people You do not know, except for Your health care providers or a Plan 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.

Section 1
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We provide health Plan Members a way to report situations or actions they think may be potentially illegal, unethical, or improper. If You want to report fraudulent or abusive practices, You can call the Fraud & Abuse Hotline at the number below. You can also send an email or forward Your information to the address below. All referrals may remain anonymous. Please be sure to leave Your name and number if You wish to be contacted for follow up. If appropriate, the necessary governmental agency (DMAS, CMS, OIG, BOI, etc.) will be notified as required by law.

Fraud & Abuse Hotline: (757) 687-6326 or 1-866-826-5277 or
E-mail: compliancealert@sentara.com
U.S. Mail: Sentara Health Plans c/o Special Investigations Unit
1300 Sentara Park
Virginia Beach, VA 23464

Section 2
Definitions

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

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

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

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

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

ALLOWABLE CHARGE or ALLOWABLE AMOUNT or ALLOWED AMOUNT is the amount the Plan determines will be paid to a Provider for a Covered Service. When You use In-Network benefits the Allowable Charge is the lesser of: (1) the Provider's contracted rate with the Plan or its third-party administrator or (2) the Provider's actual charge for the Covered Service. When You use

an Out-of-Network Provider, the Allowable Charge is the lesser of the usual and customary charge for the service as determined by the Plan or the actual charge. For Out-of-Network Emergency Services, Out-of-Network air ambulance services, or Out-of-Network ancillary and surgical services received at an In-Network Facility, the Allowable Charge will be determined using the Plan's average In-Network contracted rate for the same or similar service in the same or similar location.

AUTHORIZED OUT-OF-NETWORK SERVICE means a Covered Service provided by an Out-of-Network Provider, which has been specifically authorized in advance by Us to be Covered under the Plan's In-Network level of benefits.

BLOOD GLUCOSE METER(S) means a small, portable machine that measures how much glucose (a type of sugar) is in the blood (also known as the blood glucose level). Blood Glucose Meters measure glucose levels at a single moment in time.

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

CHILD/CHILDREN means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child, or any other child eligible for Coverage under the Plan.

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

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

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

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

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

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

CONTINUOUS BLOOD GLUCOSE MONITOR(S) means a compact medical system that continuously monitors how much glucose (a type of sugar) is in the blood (also known as the blood

glucose level). Continuous Glucose Monitors measure glucose levels continuously in several minute increments throughout a 24-hour period.

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

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

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

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

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

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

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

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

Section 1
How Your Plan Works

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. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

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

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

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

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

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 Contract.

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

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Definitions

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

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

EVIDENCE OF COVERAGE means this document evidencing Covered Services which is issued to each Subscriber.

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

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

FACILITY or FACILITIES is an institution providing health care related services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

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

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How Your Plan Works

GROUP HEALTH CONTRACT or GROUP CONTRACT 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).

GROUP or SUBSCRIBING GROUP or EMPLOYER 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.

HABILITATIVE SERVICES means services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupation therapy, speech-language pathology, medical devices, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

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

HOSPITAL means an institution which:

1. Is accredited under one of the programs of the Joint Commission on Accreditation of Healthcare 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; and
4. Is under the direction of a staff of Physicians; and
5. Provides 24-hour nursing service rendered or supervised by a registered graduate nurse; and
6. Has facilities on its premises for major surgery (or a written contractual agreement with an accredited Hospital for the performance of surgery).

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

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

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

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

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

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

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

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

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

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

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

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.

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

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.

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.

1. This term does not include: (1) an intern; or (2) a person in training.

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

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

Plan Provider or PLAN FACILITY means a Physician, Hospital, Skilled Nursing Facility, urgent care center, laboratory or any other duly licensed institution or health professional under contract to provide professional and Hospital services to Members. A list of Plan Providers and

their locations is available to each Subscriber upon enrollment. Such list shall be revised from time to time as necessary and is available upon request. A Plan Provider's contract may terminate, and a Subscriber may be required to use another Plan Provider.

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

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

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

PREMIUM means the amount of money prepaid to the Plan by the Group, including Subscriber contributions, if any, on behalf of enrolled Subscribers and Dependents enrolled through that Group.

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

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

REHABILITATIVE SERVICES include Medically Necessary inpatient, home and other outpatient services provided directly by, or under the direction of, a licensed provider or clinician to restore, and in some cases, maintain capabilities lost due to disease, Illness, Injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment. Rehabilitation services must involve a treatment plan including goals that a Covered Person can reach in a reasonable period of time and will end when treatment is no longer Medically Necessary, and the Covered Person stops progressing toward those goals. Care will not be Covered if the services are merely custodial, residential, or domiciliary in nature.

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

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

RESIDENTIAL TREATMENT SERVICES mean inpatient services for treatment of mental health, and/or substance use disorder, eating disorders and the like provided in a Hospital or treatment facility that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-day nursing care. Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly, and rehabilitation, therapy, education, and recreational or social activities provided by Psychiatrist, Psychologist, Neuropsychologist, Licensed Clinical Social Worker (L.C.S.W.), clinical nurse specialist. Licensed Marriage and Family Therapist (L.M.F.T.), Licensed Professional Counselor (L.P.C.) or any agency licensed by the state to give these services, when we have to Cover them by law. Residential Treatment Services will not be Covered if the services are merely custodial, residential, or domiciliary in nature.

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.
Emergency Services will be Covered regardless of the final diagnosis given.

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SKILLED NURSING FACILITY means a Facility 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 nurse (RN). Individualized and intensive treatment includes observation and assessment by a Physician at least weekly. Care will not be covered if the services are merely custodial, residential, or domiciliary in nature.

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

STABILIZE means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

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.

SURGICAL or ANCILLARY SERVICES are any professional services, including:

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

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

URGENT CARE SERVICES means those Covered outpatient services which are non-life threatening but Medically Necessary in order to prevent a serious deterioration of the Member's health that results from an unforeseen Illness or injury. An urgent health problem calls for care that cannot wait until a regularly scheduled office visit but do not call for the use of an Emergency Room.

USUAL AND CUSTOMARY RATE means the rate determined by the Plan to be the rate paid by the Plan (or when unavailable the rate paid by other health plans that is publicly available) and customarily accepted by other providers who render or furnish such treatments, services or supplies to persons: (1) who reside in the same area; and (2) whose Injury or Illness is comparable in nature and severity. When applied to a Plan Provider, "Usual and Customary Rate" means the rate agreed to by the Plan Provider in its contract with the Plan with respect to Covered Persons.

VIRTUAL CONSULT means a clinical consult between a healthcare provider and a patient using a secure platform (as selected by the Plan in its sole discretion), that allows for interactive video/audio connection.

Section 2
Definitions

WE, US, or OUR means this plan or Sentara Health Plans**.**

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

Section 3
Who is Eligible to Enroll

To enroll, and to continue enrollment, You must meet all of the eligibility requirements described in this section. You must also meet all of Your Group's eligibility requirements that We have approved. All of Your required premium payments must be current. Unless We agree otherwise, Independent contractors, agents or consultants who do not receive W-2 forms are not eligible. Unless We agree otherwise, You must provide all required enrollment information within 31 days of Your effective date or You may have to wait until Your group's next Open Enrollment Period.

WHO IS ELIGIBLE FOR COVERAGE UNDER THE PLAN

You may be eligible to enroll and continue enrollment as a Subscriber if:

- You are an employee of Your group; **and**
- You are Actively at Work (defined below); **and**
- You provide Us a complete enrollment application and any premiums or fees for yourself and any dependents within 31 days of Your Coverage effective date; **and**
- You do not knowingly give Us any incorrect, incomplete, or deceptive information about Yourself or Your Dependents; **and**
- You meet all other requirements listed in this document or specified by Your employer.

ACTIVELY AT WORK

You must be "actively at work" to receive Covered benefits and services. 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. Actively at work means:

- You are employed by the Group; **and**
- You meet all eligibility requirements; **and**
- Your premiums are being paid to Us.

If You are absent from work because of a health factor (such as being absent from work on sick leave) You are still considered actively at work.

Retired employees, COBRA beneficiaries, or employees receiving Workers' Compensation will be considered actively at work on any day that all of the eligibility requirements are met and premiums are being paid to Us.

SHORT TERM LEAVE OF ABSENCE

During a short-term leave of absence, You may still be considered actively at work and eligible for Coverage. The leave of absence must be approved by the Group. Coverage may continue for up to three months if Your Group Plan remains in effect, **and** Your premiums continue to be paid to Us. The Group and the Plan may agree to continue Coverage for a longer leave of absence.

ABSENCE FROM WORK DUE TO DISABILITY

For an employee who is totally disabled, Coverage will continue for a period of no longer than six months or until the date the employee is covered under Medicare or Medicaid, whichever happens first. We may require certification of disability from the employer or the employee.

COVERAGE FOR YOUR DEPENDENTS.

If You are a Subscriber, the following persons may be eligible to enroll as Your Dependents:

- Your lawful spouse;
- Children up to the age 26 including:

    - Natural or stepchildren;
    - Legally adopted Children;
    - Children placed for adoption;
    - Foster children;
    - Children placed in foster care; or
    - Other Children for whom the Subscriber or Covered spouse is a court appointed legal guardian.

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

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

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

    Eligibility to age 26 does not extend to a spouse of a Child Covered as a Dependent.

    Eligibility to age 26 does not extend to a Child of a Child Covered as a Dependent unless the grandparent Subscriber or spouse becomes the legal guardian or adoptive parent of that grandchild.

- An Employee's Domestic Partner:

    A domestic partner is categorized as a relationship between two people who meet all of the following criteria:

- Have shared a continuous committed relationship with each other for no less than 6 (six) months; and
- Are jointly responsible for each other's welfare and financial obligations; and
- Reside in the same household; and
- Are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of their state of residence; and
- Each is over age 18, or legal age of consent in your state of legal residence, and legally competent to enter into a legal contract; and
- Neither is legally married to or legally separated from, nor in a domestic partnership with, a third party.

- Any other person or persons(s) mutually agreed to by the Plan and the Group.

To complete enrollment We must receive all required information on the Enrollment Application and all premiums for each Dependent. Unless We agree otherwise, You must provide all required enrollment information within 31 days of Your effective date or You may have to wait until Your group's next Open Enrollment Period.

INELIGIBLE INDIVIDUALS

In certain circumstances a person who meets eligibility requirements may not be able to enroll in the plan. Anyone terminated from the plan for cause is not eligible. A person may be ineligible if that person or someone else in his or her family unit has been terminated for specific reasons as defined in Section 11.

A person who would otherwise be eligible for Coverage may not be eligible if that person would cause the Plan 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.

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.

WHEN A CHILD AGES OFF THE PLAN

Unless otherwise stated, Coverage for a Child ends the last day of the month the child reaches the limiting ages on Your Schedule of Benefits.

CONTINUATION OF COVERAGE FOR CHILDREN WITH AN INTELLECTUAL OR PHYSICAL DISABILITY

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

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

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

VERIFICATION OF ELIGIBILITY

Your Employer is responsible for determining Your eligibility and the eligibility of any of Your Dependents for Coverage under the Plan. However, We reserve the right to request or review at any time, at Our sole and absolute discretion, proof of eligibility of any Subscriber or other Covered family member.

Section 4
When You Can Enroll and When Coverage Begins

When You are eligible to enroll in the Plan You must provide a signed completed application with all required information for yourself and any Dependents that will be Covered under the Plan. To complete enrollment, We must receive all required information on the Enrollment Application and all premiums. Unless We agree otherwise, You must provide all required enrollment information within 31 days of Your effective date or You may have to wait until Your group's next Open Enrollment Period. If We determine Your application is incomplete and We request additional information You must provide the information in a timely manner, or You may not be able to enroll until Your group's next Open Enrollment Period. We may not recognize retroactive adjustments of enrollment due to the group's failure to furnish Enrollment Applications or fees to Us within 31 days of the Coverage effective date.

PLAN OPEN ENROLLMENT

Your group will hold an annual Open Enrollment Period. During open enrollment, eligible employees and Dependents can apply for Coverage. Your group will let You know when Your Open Enrollment Period starts and when Your Coverage is effective.

NEW EMPLOYEES

When Your Group tells You that You are eligible to enroll as a Subscriber You may apply for Coverage for Yourself and Your Dependents within 31 days.

NEW DEPENDENTS

A Subscriber may enroll or disenroll an eligible Dependent within 31 days of the occurrence of one of the following qualifying events:

- Change in legal marital status including marriage, death of a spouse, divorce, legal separation, and annulment;
- Change in number of Subscriber's Dependents including birth, death, adoption, placement for adoption or court appointed legal guardianship;
- 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;
- Change in Dependent's eligibility for Coverage;
- Change in residence of employee, spouse, or Dependent that affects eligibility; or
- Other changes in status that the Group and the Plan agree to.

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.

EFFECTIVE DATE OF SUBSCRIBER COVERAGE

If We have received and accepted a complete Enrollment Application, Coverage will become effective on the earliest of the following dates, unless otherwise agreed to by the Plan and the Employer:

- When a person makes a written application for Coverage on or prior to the date he or she satisfies the eligibility requirements above, Coverage shall be effective as of the first of the month following the date eligibility requirements are satisfied, unless otherwise agreed to by the Plan and the Employer; or
- When a person makes a written application for Coverage after the date he or she satisfies the eligibility requirements above, Coverage will be effective as of the first day of the calendar month following the month in which such application is received by the Plan, unless otherwise agreed to by the Plan and the employer.

A Member can only be a Subscriber under one Group Plan even if he or she is connected with more than one employer. A Subscriber will be considered an employee of one employer.

EFFECTIVE DATE OF DEPENDENT COVERAGE

A Subscriber must enroll all Dependents. If We have received and accepted a complete Enrollment Application(s), Coverage will become effective on the latter of:

- The date the Subscriber's Coverage becomes effective; or
- On the date the Subscriber acquires eligible Dependents.

Newborn Children

A newborn Child will be Covered from the moment of birth for thirty-one (31) days if the Subscriber's Coverage under this Plan is in effect. An adopted Child whose placement has occurred within thirty-one (31) 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. In order for Coverage to continue beyond the first thirty-one (31) days, the Subscriber must add the newborn to the Plan within thirty-one (31) days of birth. If the newborn is not added to the Plan within thirty-one (31) days of birth, the newborn may not be eligible to enroll until the next Plan Open Enrollment Period.

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 (31) 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 thirty-one (31) days from the date of placement. If the adopted Child is not added to the Plan within thirty-one (31) days of placement, the Child may not be eligible to enroll until the next Open Enrollment Period.

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 thirty-one (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.

SPECIAL LATE ENROLLMENT PROVISIONS

The Plan provides special late enrollment periods for eligible Subscribers and Dependents that fall into the following categories:

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;
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.

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.

Late Enrollees Due to Marriage, Birth, Adoption, or Placement for Adoption or Placement of a Child in Foster Care

If a Dependent is added through marriage, birth, adoption, placement for adoption or placement in foster care, 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 30 days of marriage, birth, adoption, placement for adoption or placement in foster care.

For special enrollment due to birth, adoption, or placement of a Child in foster care, late enrollment is effective on the date of the birth, adoption, placement for adoption or placement in foster care.

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.

Special Enrollment for Employees and Dependents that Lose Eligibility Under Medicaid or Children's Health Insurance Program (CHIP) Coverage

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

ENROLLMENT IN 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 5
Utilization Management Procedures for Coverage Decisions for Claims for Covered Services

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

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

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

PRE-AUTHORIZATION.

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

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

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

- Inpatient hospital services;
- Partial hospitalization services;
- Residential treatment services;
- Non-emergency ambulance transport;
- Inpatient and outpatient surgery;
- Surgery in a physician's office;
- Single items of durable medical equipment and orthopedic and prosthetic appliances over $750;
- Rental of durable medical equipment and orthopedic and prosthetic appliances;
- Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances;
- Artificial prosthetic limbs;
- Prenatal maternity services;
- Home health care;

- Skilled Nursing Facility care;
- Physical, occupational, and speech therapy;
- Cardiac, pulmonary, and vascular rehabilitation;
- IV therapy with medications;
- Inhalation therapy;
- Early intervention services;
- Clinical trials;
- Hospice services;
- Oral surgery;
- TMJ services;
- Tubal ligation;
- Hospitalization and anesthesia for dental procedures;
- Treatment of lymphedema;
- Magnetic Resonance Imaging (MRI);
- Magnetic Resonance Angiography (MRA);
- Positron Emission Tomography (PET) scans;
- Computerized Axial Tomography (CT) scans;
- Computerized Axial Tomography Angiogram (CTA) scans;
- Sleep studies;
- Transplant services;
- Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee;
- Intensive outpatient programs (IOP);
- Medical, psychological and neuro psychological diagnostic procedures and testing;
- Electro-convulsive therapy (ECT);
- Telemedicine services;
- Transcranial Magnetic Stimulation (TMS);
- Insulin pumps and insulin pump infusion sets and supplies;
- Chemotherapy and Chemotherapy Drugs;
- Radiation Therapy;
- Dialysis Services;
- Genetic Testing and Counseling;
- Other ridered services. If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

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

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

"Radiation Therapy Treatment" means a cancer treatment through which a dose of radiation to induce tumor cell death is delivered by means of proton radiation therapy, intensity modulated

radiation therapy, brachytherapy, stereotactic body radiation therapy, three-dimensional conformal radiation therapy, or other forms of therapy using radiation.

The Plan will not hold Proton Radiation Therapy to a higher standard of clinical evidence for decisions regarding Coverage under the Plan than is applied for decisions regarding Coverage of other types of Radiation Therapy Treatment.

Nothing in this section shall be construed to mandate the Coverage of Proton Radiation Therapy under the Plan.

ORGAN TRANSPLANT

For Covered organ transplants, including eye or tissue transplants and related services, the Plan will not discriminate in Coverage decisions based on disability.

NEWBORN MOTHER TRANSFER

The Plan will not require Pre-Authorization for the interhospital transfer of:

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

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

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

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

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

PRE-SERVICE CLAIMS DECISIONS

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

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

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

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

EXPEDITED DECISIONS FOR URGENT CARE CLAIMS

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

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

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

EXPEDITED DECISIONS FOR CANCER PAIN MEDICATIONS

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

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

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

Plan Providers must follow certain procedures to make sure that if a previously authorized course of treatment or hospital stay needs to be extended, the extension is requested in time to minimize disruption of needed services. We will notify the Member of a Coverage decision within 24 hours of the

request. Notification will include information on how to appeal an Adverse Benefit Determination prior to services being discontinued. Requests for extensions of therapy or rehabilitative treatment plans must be made 7 days prior to the end of the authorized timeframe to avoid disruption of care or services.

RETROSPECTIVE REVIEW OF POST-SERVICE CLAIMS

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

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

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

ADVERSE BENEFIT DETERMINATIONS

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

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

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

Section 6
What is Covered

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

- Medically Necessary;
- Listed as a Covered Service;
- Ordered or provided by a licensed Provide or Facility;
- Non-excluded.

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

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

ACCIDENTAL DENTAL SERVICES

Pre-Authorization is Required.

We Cover Medically Necessary dental services as a result of accidental Injury, regardless of when the Injury occurred. For injuries that happen on or after Your effective date of Coverage, treatment must be sought within 60 days of the accident.

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

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

If You choose to receive care from a Non-Plan dentist or oral surgeon, the provider may bill You for amounts in excess of the Plan's fee schedule or Allowable Charge. We will not pay for these amounts over Our Allowable Charge.

We Cover dental services performed during an Emergency Department visit immediately after an Accidental Injury in conjunction with the initial stabilization of the Injury. Emergency Department visits will not be subject to pre-authorization. You will pay Your Emergency Department Copayment or Coinsurances.

ALLERGY CARE

Pre-Authorization is Required.

We cover the following Allergy Care, Testing and Treatment services:

- Physician office visits;
- Performance and evaluation of scratch, puncture, or prick allergy tests;

- Allergy shots and serum; and
- Professional services for supervising and providing allergy serum antigens for allergy injections.

AMBULANCE, STRETCHER, & WHEELCHAIR SERVICES

Pre-Authorization is Required for Non-Emergency Transportation.

We Cover ambulance services that are:

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

Emergency Air, Ground, Water Transportation Services

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

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

- For Covered emergency or non-emergency air ambulance services from Out-of-Network Providers Members are responsible for In-Network Copayments, Coinsurance and Deductibles listed on the Plan's Schedule of Benefits. Member cost sharing will be applied to In-Network Maximum Out-of-Pocket Amounts listed on the Plan's Schedule of Benefits. Members are protected from balance billing for air ambulance services received from Out-of-Network Providers.
- Benefits are available for air Emergency transportation when using ground ambulance would endanger Your health, and Your medical condition requires more urgent transportation to an acute care Hospital than a ground ambulance can provide.
- Your benefits include air transportation to the closest Hospital that can treat You.
- Transportation or transfer by air ambulance from one Hospital to another Hospital is only a Covered Service when Your condition requires certain specialized medical services that are not available at the Hospital that first treats You and using a ground ambulance would

endanger Your health.
- Transportation or transfer by air is not a Covered Service just because You, Your family, or Your provider prefers You receive treatment by a specific provider or at a specific Hospital.
- Air ambulance is not Covered for transportation to other facilities such as a Skilled Nursing Facility, a doctor's office or Your home.
- You will not be balance billed for Out-of-Network air ambulance services that would have been Covered if In-Network, according to the above criteria.

Non-Emergency Stretcher & Wheelchair Transportation Services

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

The Federal No Surprises Act prohibits balance billing for Out-of-Network air ambulance services. Air ambulance service provided by an Out-of-Network Provider is Covered under In-Network benefits. Members will be responsible for in-network cost sharing including Copayment, Coinsurance, and Deductible amounts under the Plan. Providers cannot balance bill members for amounts above In-Network cost sharing.

If You are balance billed, please contact Member Services at the number on Your Plan ID Card. You may also file a complaint with the Plan. Please see **Section 13 How to File a Complaint, Grievance, or Appeal an Adverse Benefit Determination.** Please also see the Plan's full notice on balance billing protections.

ANESTHESIA SERVICES

Pre-Authorization is Required.

When Medically Necessary the following are Covered Services:

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

AUTISM SPECTRUM DISORDER

Pre-Authorization is Required.

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

Section 6
What is Covered

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 or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

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

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

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

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

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

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

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

Except for inpatient services, 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.

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

Pre-Authorization is Required.

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

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

CLINICAL TRIALS

Pre-Authorization is Required.

For a Qualified Individual Covered Services includes:

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

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

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

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

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

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

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

DIABETIC EQUIPMENT AND SUPPLIES

Pre-Authorization is Required for Insulin Pumps and Insulin Pump Infusion Sets.

Some equipment and supplies under this benefit may be Covered under the Plan's outpatient prescription drug benefits. However, if Your Plan excludes Coverage for outpatient prescription drugs the Plan will provide Coverage under the Plan's medical benefits for treatment of diabetes as shown on the Schedule of Benefits.

Section 6
What is Covered

We cover FDA approved equipment, supplies, and education as prescribed by a provider for the treatment of these types of conditions:

- Insulin dependent diabetes;
- Gestational diabetes;
- Non-Insulin dependent diabetes.

We also Cover outpatient self-management training and education when provided in person. This training and education includes medical nutrition therapy. Training must be provided by a certified, registered or licensed health care professional. Members may call 1-800-SENTARA for information on educational classes.

An annual diabetic eye exam is Covered from a Plan Provider or a participating VSP Vision Care Provider at the applicable office visit Copayment or Coinsurance amount.

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

DIAGNOSTIC, X-RAY, AND LABORATORY SERVICES

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

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

- Diagnostic Radiology including X-rays, mammograms, ultrasound or nuclear medicine;
- Diagnostic Lab and pathology services or tests;
- Diagnostic hearing and vision tests;
- Diagnostic EKGs, EEGs, and Echocardiograms;
- Advanced Diagnostic Imaging procedures including Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), Positron Emission Tomography (PET Scans), Computerized Axial Tomography (CT Scans), Computerized Axial Tomography Angiogram (CTA Scans), Single Photon Emission Computed Tomography (SPECT Scans), QCT Bone Densitometry, PETCT Fusion scans, Diagnostic CT Colonography, and nuclear cardiology;
- Professional services for test interpretation, X-ray reading, lab interpretation, and scan reading;
- Diagnostic Sleep Testing;
- Tests ordered before a surgery or Admission;

- BRCA and fetal screening;
- Genetic testing and counseling is Covered when Medically Necessary.

DIALYSIS TREATMENTS

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

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

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

Pre-Authorization is Required for Items Over $750.

Pre-Authorization is Required for All Rental Items.

Pre-Authorization is Required for All Repair and Replacement.

We only cover DME that is Medically Necessary and prescribed by an appropriate Provider. We also cover colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters. We do not cover DME used primarily for the comfort and wellbeing of a Member. We will not cover DME if We deem it useful, but not absolutely necessary for Your care. We will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items.

Coverage for Orthopedic appliances includes the initial appliance. Repair and replacement are Covered unless due to Member's neglect, misuse or abuse. We may also cover Medically Necessary customized splints and customized braces when pre-authorized by the Plan.

Coverage for Prosthetic appliances includes Medically Necessary surgically implanted prosthetic devices. For children up to age 18, We will cover replacement of prosthetic devices for growth if Medically Necessary. This also applies if the child's condition is from an injury or Illness which happened before the child became a Member under this Plan.

EARLY INTERVENTION SERVICES

Pre-Authorization is Required.

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

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

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

We may ask You to provide a copy of the certification. Deductible, Copayment, or Coinsurance amounts apply depending on what type of service is provided. This benefit is not subject to any maximum dollar limits.

EMERGENCY SERVICES

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

"Emergency Services" means, with respect to an emergency medical condition – (A) A medical screening examination (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. Emergency Services also include emergency air ambulance services, and post stabilization services including any additional Covered Services furnished by an Out-of-Network Provider or Emergency Facility (regardless of the department of the Hospital in which the items and services are furnished) after a Member is stabilized as part of outpatient observation, or as part of inpatient or outpatient stay with respect to the visit in which Emergency Services are furnished.

"Stabilize" means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

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The Plan Covers Emergency Services In or Out-of-Network. Emergency Services do not require Pre-Authorization In or Out-of-Network. Your Copayment or Coinsurance amount will be determined by the type and place of service associated with the Emergency. Your Schedule of Benefits lists Your out-of-pocket Copayment or Coinsurance rate for Emergency Services, inpatient Hospital Admissions, ambulance services and urgent care visits. If You receive Emergency Services Out-of-Network from a Non-Plan Provider Your Copayment or Coinsurance rate cannot exceed the cost-sharing requirement that would apply if services were provided In-Network from Plan Providers.

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

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

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

Some examples of Emergency Medical Conditions include:

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

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

"Ambulance Services" means transportation services from the place of Injury to the nearest Hospital where treatment can be provided. Transportation must be provided by a professional agency authorized to provide service in a vehicle staffed by medically trained personnel equipped

to handle a medical Emergency. Air ambulance services are also Covered when pre-authorized or in cases of threatened loss of life.

"Urgent Care Center Services" means Facility, Physician, and other services provided during an urgent care center visit for treatment of medical conditions from an unforeseen Illness or Injury which are non-life threatening, but Medically Necessary to prevent a serious deterioration of a Member's health. Members should get care at the nearest Plan urgent care center.

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

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

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

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

The After-Hours Nurse Triage Program is available twenty-four (24) hours a day seven days a week. The After-Hours Program can be reached by calling 757-552-7250 or 1-800-394-2237. This program is not a substitute for contacting your doctor.

FAMILY PLANNING SERVICES

We Cover the following services:

- Counseling and education for birth control options;
- Tubal ligation services **(Pre-Authorization is required);**
- Vasectomy services;
- Depo-Provera or other injections approved by the Plan;
- Intrauterine devices (IUDs) and cervical caps and their insertion;
- All other Food and Drug Administration approved contraceptive methods as required by Women's Preventive Services;

- A prescription for up to a 12-month supply of hormonal contraceptive when dispensed or furnished at one time.
  - The Plan will cover up to a 12-month supply of hormonal contraceptives when dispensed or furnished at one time for a Covered Person by an In-Network provider or pharmacy or at a location licensed or otherwise authorized to dispense drugs or supplies that participates in the Plan's provider network.
  - Members will be responsible for payment of their outpatient prescription cost sharing based on a 12-month supply when the prescription is filled.
  - **"Hormonal Contraceptive"** means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration for such purpose.
  - **"Provider"** means a facility, physician or other type of health care practitioner licensed, accredited, certified, or authorized by statute to deliver or furnish health care items or services.

HEARING AIDS AND RELATED SERVICES FOR CHILDREN AGE 18 AND YOUNGER

Pre-Authorization is Required.

"Hearing Aid" means any wearable, non-disposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Hearing aids are not to be considered durable medical equipment.

"Related Services" includes earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

Coverage includes hearing aids and related services for children 18 years of age or younger. Coverage is limited to the cost of one hearing aid per hearing-impaired ear every 24 months, up to $1,500 per hearing aid. Members may choose a higher-priced hearing aid and pay the difference in cost above $1,500.

Coverage is limited to services and equipment recommended by an otolaryngologist (ENT) and provided or dispensed by an otolaryngologist (ENT), licensed audiologist, or licensed hearing aid specialist.

HEMOPHILIA AND CONGENITAL BLEEDING DISORDERS

Pre-Authorization is Required for Home Treatment.

We Cover the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits include the purchase of blood products and blood

infusion equipment required for home treatment. The home treatment program must be under the supervision of a state-authorized hemophilia treatment center.

HOME HEALTH CARE SKILLED SERVICES

Pre-Authorization is Required.

We cover Medically Necessary **Home Health Care Skilled Services** provided in the home or to the extent available through remote patient monitoring. See Your Schedule of Benefits for visit limits.

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

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

The following definitions apply to services under this section:

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

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

"Home Health Care Plan" means a program:

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

"Home Health Care Skilled Services" means:

1. Part-time or intermittent nursing care by a nurse; 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; or
4. Surgical dressings, medical appliances, oxygen and supplies which are Medically Necessary for treatment of the Member at home, but only to the extent such items or services would have been Covered under this Plan if the Member had been confined in a Hospital or Skilled Nursing Facility.

"Home Health Skilled Care Visit" means:

1. Each visit by an RN or by an LPN to provide nursing care; or
2. Each visit by a therapist to provide physical, occupational, or speech therapy.

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

HOSPICE CARE

Pre-Authorization is Required.

We cover **Hospice Services** for members whose condition has been diagnosed as terminal with a life expectancy of six months, and who elect to receive **Palliative Care** instead of curative care.

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

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

HOSPITAL SERVICES

Pre-Authorization is Required.

Inpatient Room and Board

We cover room and board in a semi-private room including general nursing care, and meals and special diets. We do not cover private duty nursing while in the Hospital.

Other Hospital Services

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

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

Inpatient Length of Stay Requirements

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

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

HOSPITALIZATION AND ANESTHESIA FOR DENTAL PROCEDURES

Pre-Authorization is Required.

We Cover hospitalization and anesthesia for dental procedures in certain circumstances. The Covered Person must be determined by a dentist, in consultation with their treating Physician, to

require general anesthesia and Admission to a Hospital or outpatient Facility. The Covered Person must also:

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

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

INFANT HEARING SCREENINGS

Pre-Authorization is Required.

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

INFUSION SERVICES

Pre-Authorization is required.

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

- Infusion therapy and medications;
- Professional nursing services and DME required for the infusion;
- Blood products and injectables that are not self-administered;
- Drug Infusion Therapy;
- Total Parenteral Nutrition (TPN);
- Enteral nutrition therapy;
- Antibiotic therapy;
- Chemotherapy;
- Pain care;

- Infusion of special medical formulas that are the primary source of nutrition for Members with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

INTERRUPTION OF PREGNANCY SERVICES

Pre-Authorization is Required.

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

LYMPHEDEMA

Pre-Authorization is Required.

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

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

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

MATERNITY SERVICES

Pre-Authorization is Required for Prenatal Services.

We Cover the following maternity services:

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

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

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

MEDICAL SUPPLIES AND MEDICATIONS

Pre-Authorization is Required.

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

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

MEDICALLY NECESSARY FORMULA AND ENTERAL NUTRITION PRODUCTS

Pre-Authorization is Required.

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

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

Covered Services:

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

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

MEDICATIONS ADMINISTERED BY A MEDICAL PROVIDER

Pre-Authorization is Required.

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

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

MENTAL HEALTH/BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Pre-Authorization is Required for all Inpatient Services, Partial Hospitalization Services, Intensive Outpatient Program (IOP), Electro-Convulsive Therapy (ECT), and Transcranial Magnetic Stimulation (TMS).

The Plan does not apply financial requirements or treatment limits under Mental Health and Substance Use Disorder Services that do not also apply under other medical or surgical benefits within the same classification under the Plan. Classification generally means inpatient services, outpatient services, Emergency Services, Physician services, and other plan services.

You can select any mental health or substance use disorder provider that is a Plan Provider. Call Member Services at the number on Your Plan ID card if You need help selecting a Plan Provider. If there is no Plan Provider available to provide a Covered Service, You must contact Us before You have the service or treatment from an Out-of-Network Provider. We may be able to help You find a Plan Provider; or We may approve Your service or treatment as an Authorized Out-of-Network Service. An Authorized Out-of-Network Service means a Covered Service provided by an Out-of-

Network Provider, which has been specifically authorized in advance by Us to be Covered under the Plan's In-Network level of benefits and cost sharing. All other requirements for Pre-Authorization under the Plan will also apply to Covered Services from Out-of-Network Providers. Except as stated above, if You see an Out-of-Network provider without advance approval from the Plan We may deny Your Claim and You may be responsible for the entire cost or all charges for your services.

Emergency Mental Health or Substance Use Disorder Services are Covered the same as Emergency medical care and do not require Pre-Authorization. Please refer to Emergency Services in the Evidence of Coverage.

Coverage under the Plan includes mobile crisis response services and support and stabilization services provided in a residential crisis stabilization unit to the extent that such services are covered in other settings or modalities, regardless of any difference in billing codes.

Outpatient Mental Health/Behavioral Health and Substance Use Disorder Services

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

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

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

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

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

Partial Day/Intensive Outpatient Services

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

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

Residential Treatment Facilities/Centers (RTFs or RTCs)

Coverage includes inpatient services for mental health and/or substance use disorder treatment provided in a Facility licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-day nursing care by, or under the supervision of a registered nurse (RN). Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly. Residential Treatment Services will not be Covered if the services are merely custodial, residential, or domiciliary in nature.

The following definitions apply to this section:

"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 pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the Department of Behavioral Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 or (ii) a state agency or institution.

"Inpatient Treatment" means mental health or substance use disorder services delivered on a 24-hour per day basis in a Hospital, alcohol or drug rehabilitation facility, RTF or RTC, 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 24-hour per day, state-approved program of inpatient substance use disorder services.

"Medication Management Visit" means a visit no more than 20 minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance use disorder treatment.

"Mental Health Services" or **"Mental Health Benefits"** means benefits with respect to items or services for mental health conditions as defined by the Plan. Any condition defined by the Plan as being or as not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice.

"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.

"Mobile crisis response services" means services delivered to provide for rapid response to, assessment of, and early intervention for individuals experiencing an acute mental health crisis that are deployed at the location of the individual.

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

"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 mental health disorders or alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Residential crisis stabilization unit" means a short-term residential program providing support and stabilization for individuals who are experiencing an acute mental health crisis.

"Substance Use Disorder Services" or **"Substance Use Disorder Benefits"** means benefits with respect to items or services for substance use disorders as defined under the Plan. Any disorder defined by the Plan as being or as not being a substance use disorder shall be defined to be consistent with generally recognized independent standards of current medical practice.

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

Employee Assistance Visits

Services include short-term counseling by licensed mental health providers and referral services 24 hours a day, seven days a week for employees and their immediate family members and household members who are experiencing personal problems of such a level that their ability to work and function is, or may be, impaired.

Using employee assistance visits will not reduce Covered mental health benefits.

Non-emergency appointments are scheduled within 72 hours after the person calls. Whenever possible, appointments are scheduled to meet the person's time and location requests. For more information or to schedule an appointment, call (800) 899-8174 or 363-6777.

ORAL SURGERY

Pre-Authorization is Required.

We cover the following:

- Surgical procedures required to repair accidental injuries to the jaws, mouth, lips, tongue or hard and soft palates;
- Treatment of fractures of the facial bones;
- Excision including diagnostic biopsy of malignant and/or symptomatic tumors and cysts of the jaws, gums, cheeks, lips, tongue, hard and soft palates, and salivary glands;
- Orthognathic surgical procedures such as osteotomy or other reconstruction of the jaws and/or facial bones (when associated with severe malocclusion) that are necessary to restore and maintain function; and
- 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.

OTHER OUTPATIENT THERAPY SERVICES

Includes Chemotherapy, Radiation Therapy, IV Infusion Therapy, and Respiratory/Inhalation Therapy

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

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

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

PPACA RECOMMENDED PREVENTIVE CARE SERVICES

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

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

1. Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; and
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings not described in item (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph including:

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

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

PHYSICIAN SERVICES

All Pre-Authorization and Referral Requirements Apply Depending on the Type and Place of Service.

We cover the physician services listed below:

- Surgical, home, Hospital, and office visits, for diagnosis and treatment of an Injury or Illness;
- Covered preventive care and preventive screenings;

- Professional services received while You are receiving Covered Services in an Inpatient Hospital, Skilled Nursing Facility, Emergency Department; ambulatory surgery, or other outpatient Facility;
- Specialist care and consultations;
- A second opinion from a Plan Provider;
- A second opinion from a Non-Plan Provider only if a Plan Provider is unavailable;
- Virtual Consults when provided by a Plan approved provider;
- Maternity care and related checkups; and
- Annual school and sports physicals.

PRESCRIPTION INSULIN DRUG COST SHARING

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

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

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

PREVENTIVE CARE SERVICES AND SCREENINGS

Annual Physicals

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

Annual Gynecological (GYN) Exams

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

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

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

Screening Mammograms

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

Pap Smears

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

Prostate Screening Tests (PSA)

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

Colorectal Cancer Screening

We Cover colorectal cancer screening with no Member cost sharing if services are received from In-Network Plan Providers. Services are Covered in accordance with most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in the recommendations including:

- An annual occult blood test;
- Flexible sigmoidoscopy or colonoscopy;
- Radiologic imaging in appropriate circumstances;
- Follow-up colonoscopies following a positive non-invasive stool-based screening test;
- Polyp removal; and
- Anesthesia provided in conjunction with preventive or diagnostic colonoscopies.

Routine Hearing Tests

We Cover one annual routine hearing test.

Well Child Care

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

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

- Well-baby services which are rendered during a periodic review will be Covered to the extent that such services are provided by or under the supervision of a single Physician during the course of one office visit.

Immunizations for Newborn Children from Birth to Age 36 Months

We Cover immunizations for each Child from birth to thirty-six (36) months of age including:

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

Immunizations for older Children and Adolescents ages 7-18

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

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

PREVENTIVE VISION CARE SERVICES
In-Network Coverage

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

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To receive Covered Services:

1. Select a participating VSP Vision Care network provider from the Plan's provider directory or by calling 1-800-877-7195. Automated location information is available 24 hours a day. Customer service representatives are available Monday through Saturday 9 a.m.–8 p.m.
2. Visit or call the participating provider and identify yourself as a participant by providing Your Member ID information. The provider will verify eligibility, Your Plan's Covered Services and any applicable Copayment or Coinsurance. Payment is due when You receive services.
3. If the vision provider determines that You need additional medical care, You should contact Your PCP or other Physician for treatment options.

Out-of-Network Coverage

If You use a provider that is not in the VSP Vision Care network for an examination, You must pay the provider in full when You receive services. Only the eye examination is Covered as listed on Your Schedule of Benefits. For reimbursement call VSP Vision Care Customer Service at 1-800-877-7195. VSP Vision Care will verify eligibility and give You a Claim form. Mail the completed form with a copy of Your bill to:

Vision Service Plan
PO Box 385018
Birmingham, AL 35238-5018
Attn: OON Claims

PROSTHETIC COMPONENTS AND DEVICES

Pre-Authorization is Required for All Services.

Services include Coverage for Medically Necessary prosthetic devices. This also includes repair, fitting, replacement, and components.

Definitions:

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

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

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device Coverage does not mean or include repair and replacement due to Enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.

RECONSTRUCTIVE BREAST SURGERY

Pre-Authorization is Required.

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

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

SKILLED NURSING SERVICES

Pre-Authorization is Required.

Covered Services include:

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

SMOKING AND TOBACCO CESSATION

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

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

TELEMEDICINE SERVICES

Telemedicine services, as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, selected by a provider and agreed to by a patient, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided.

Telemedicine services do not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. We will not exclude a service for Coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

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

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

THERAPY AND REHABILITATION SERVICES

Pre-Authorization is Required.

We Cover the following therapy and rehabilitation services:

- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Cardiac rehabilitation;
- Pulmonary rehabilitation;
- Vascular rehabilitation; and
- Vestibular rehabilitation.

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

We Cover physical therapy only to the extent of restoration to the level of the pre-trauma, pre-Illness, or pre-condition level.

We Cover occupational therapy services which assist the Member to restore self-care and improve functionality in activities of daily living.

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

All therapy and Rehabilitation Services must be provided by a Physician, or by a licensed or certified physical, occupational or speech therapist. We cover therapy and rehabilitation services furnished to a Member on an outpatient or inpatient basis according to a specific written treatment plan that:

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

TRANSITION RELATED CARE

Pre-Authorization is Required.

Covered Services include “Medically necessary transition-related care” consistent with current medical standards. The Plan provides coverage without discrimination on the basis of “gender identity” or status as a “transgender individual;” and will treat covered individuals consistent with their “gender identity.”

"Gender identity" means an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female and which may be different from an individual's sex assigned at birth.

"Medically necessary transition-related care" means any medical treatment prescribed by a licensed physician for treatment of gender dysphoria and includes:

- Outpatient psychotherapy and mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses;
- Continuous hormone replacement therapy;
- Outpatient laboratory testing to monitor continuous hormone therapy; and
- Gender reassignment surgeries.

"Transgender individual" means an individual whose gender identity is different from the sex assigned to that individual at birth.

The Plan will not deny or limit coverage or impose additional cost sharing or other limitations or restrictions on coverage for Covered Services that are ordinarily or exclusively available to Covered Persons of one sex, to a transgender individual on the basis of the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

TRANSPLANT SERVICES

Pre-Authorization is Required.

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

We cover Medically Necessary human organ and tissue transplants for members who meet Medical Necessity criteria established by the Plan. We do not Cover transplants that are Experimental. We Cover the following transplants:

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

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

Donor Searches

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

Organ Donor Benefits

When both the person donating the organ and the person receiving the organ are Covered Plan Members each will get benefits under their Plan.

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

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

TRAVEL EXPENSES

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

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

VIRTUAL CONSULTS

"Virtual Consult" means a clinical consult between healthcare provider and a patient using a secure platform (as selected by the Plan in its sole discretion) that allows for interactive video/audio connection.

Virtual Consults will be Covered exclusively when furnished by providers who are authorized by the Plan to provide Virtual Consults who utilize the secure platform selected by the Plan.

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

OUTPATIENT PRESCRIPTION DRUG COVERAGE

Your Plan Formulary

Section 6
What is Covered

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

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

Choosing a Pharmacy to Fill Your Prescription

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

Retail Pharmacy

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

Mail Order Pharmacy Benefit

Most outpatient prescription drugs are available through the Plan's Mail Order Provider. This does not include Specialty Drugs. You may call Express Scripts at 1-888-899-2653 to find out if a drug is available

Specialty Pharmacy

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

Non-Plan Out-of-Network Pharmacies

You may use a Non-Plan Out-of-Network Pharmacy, including a specialty pharmacy, or its intermediary that has previously notified the Plan or its Pharmacy Benefit Manager of its agreement to accept reimbursement for its services at rates applicable to Our In-Network pharmacies including accepting Your applicable Copayment, Coinsurance and/or Deductible (if any) amounts as payment in full to the same extent as Coverage for outpatient prescription drug services provided to You by an In-Network Provider. This provision will not apply to any pharmacy which does not execute a participating pharmacy agreement with the Plan or its Pharmacy Benefit Manager within thirty (30) days of being requested to do so in writing by the Plan or its Pharmacy Benefit Manger unless and until the pharmacy executes and delivers the agreement.

Section 6
What is Covered

Pharmacy and Therapeutics Committee

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

Pharmacy Tiers and Determining Your Cost Sharing

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

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

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

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

- **Specialty Drugs (Tier 4)** includes those drugs classified by the Plan as Specialty Drugs. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional. Specialty Drugs include the following:

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

Tier 4 also includes Covered compound prescription medications.

Compound Medications

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

Medications Requiring Pre-Authorization

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

Step Therapy Protocols and Exception Requests

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

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

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

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

The Plan will respond to a step therapy exception request within 72 hours of receipt, including hours on weekends. We will confirm that the request is approved, denied, or requires supplementation or additional information. In cases where exigent circumstances exist, We will respond with Our decision within 24 hours of receipt, including hours on weekends. A Member may appeal any step therapy exception request denial under the Plan's existing appeal procedures.

Quantity Limits

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

Refills

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

Prescription Cancer Drugs

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

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

Flu Shots and Other Covered Vaccines

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

Self-Administered Injectable Drugs

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

Diabetic Insulin, Testing Supplies, Equipment, and Education

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

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

Women's Contraceptives

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

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

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

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

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

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

- If the formulary drug is determined by Us, after reasonable investigation and consultation with the prescribing Physician, to be an inappropriate therapy for the medical condition of the Member; or
- When the Member has been receiving the specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and the prescribing physician has determined that the formulary drug is an inappropriate therapy for the specific Member or that changing drug therapy presents a significant health risk to the specific Member.

We will make a decision on a standard exception request and notify the Member, representative, and/or physician no later than one business day following receipt of the request. If the request is approved, Coverage of the non-formulary drug will be provided for the duration of the prescription

including refills and without additional cost sharing beyond that provided for formulary prescription drugs in the Member's Covered benefits.

Any exception request for Coverage of non-formulary drugs can be made by the Member, a designated representative, the prescribing physician or other prescriber. Requests can be made in writing, electronically and telephonically. To request a non-formulary drug, have Your doctor send a medical necessity form to Our pharmacy authorization department at PO Box 66189, Virginia Beach, VA 23466 or call Us at 757-552-7540 or 1-800-229-5522.

Expedited Exception Request Based on Exigent Circumstances

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

External Exception Request Review

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

Synchronization of Medication

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

The Plan will not deny Coverage for the dispensing of a medication by an In-Network pharmacy on the basis that the dispensing is for a partial supply if the prescribing provider or the pharmacist

determines the fill or refill is in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the Member's medications.

Lost or Stolen Medication

Pre-Authorization is required.

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

- You've lost Your medication;
- Your medication was stolen.

Section 7
What is Not Covered (Exclusions and Limitations)

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

A

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

Administrative Charges or fees are not Covered including charges or costs for:

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

Alternative Medicine services are not Covered including:

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

Non-emergency **air, ground, water, or other Ambulance transport** services are not Covered unless we have approved the services.

Non-medical **Ancillary Services** are not Covered including:

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

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

Autopsies are not Covered.

B

Batteries are not Covered except for use in:

- Motorized wheelchairs;
- Left ventricular assist device (LVAD);
- Cochlear implants;
- Hearing aids for children age 18 and under and limited to one initial set of batteries.

Biofeedback and neurofeedback therapies and related testing are not Covered unless We approve the services.

Birthing Center Services are Covered at contracted facilities only.

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

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

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

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

Section 7
What is Not Covered (Exclusions and Limitations)

Breast Milk from a donor is not Covered.

C

Chelation Therapy is not Covered unless We have approved the services.

Chiropractic Care is not a Covered Service unless Your Plan includes a rider. Chiropractic care means diagnosis, correction, and management of vertebral subluxations or neuromusculoskeletal conditions.

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

Contact Lenses are not Covered Services. Fitting of lenses or eyeglasses is not Covered. However, the first pair of lenses following cataract surgery including contact lens, or placement of intraocular lens or eyeglass lens only are Covered Services.

The following are also not Covered Services:

- Services to preserve, change or improve how a person looks;
- Services to change the texture or look of skin, the size, shape or look of facial or body features;
- Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Any service or supply that is a direct result of a non-covered service;
- Non-medically necessary treatment or services resulting from complications due to cosmetic experimental procedures;
- Breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following mastectomy;
- Tattoo removal;
- Keloid treatment as a result of the piercing of any body part;
- Consultations or office visits for obtaining cosmetic or experimental procedures;
- Cosmetic Botox injections;
- Penile implants; or
- Cosmetic skin condition treatments by laser, light or other methods unless Medically Necessary.

Section 7
What is Not Covered (Exclusions and Limitations)

Costs of Services paid for by Another Payor are not Covered Services. We do not cover the cost of services, which are or may be Covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of Covered Services in those cases where You received services in accordance with the Plan's authorization procedures. We will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

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

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

D

Dentistry/Oral Surgery/Dental Care.

The following services are not Covered:

- Treatment of natural teeth due to disease;
- Routine dental care;
- Routine dental X-rays;
- Dental supplies;
- Extraction of erupted or impacted wisdom teeth except to prepare the mouth for medical services and treatments;
- Oral surgeries or periodontal work on the hard and/or soft tissue supporting the teeth to help support structures;
- Periodontal, prosthodontic, or orthodontic care;
- Cosmetic services to restore appearance;
- Restorative services and supplies necessary to treat, repair or replace sound natural teeth;
- Dental implants or dentures and preparation work;
- Dental services performed in a Hospital or any outpatient facility. This does not include Covered Services listed under "Hospitalization and Anesthesia for Dental procedures."
- Oral surgery which is part of an orthodontic treatment program;
- Orthodontic care.

Driver Training is not a Covered Service.

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

E

The following **Educational services** are not Covered Services:

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

Enteral or Parenteral Feeding supplements are not Covered Services unless included under the Plan's benefit for Medically Necessary Formula and Enteral Nutrition Products. Over-the-counter supplements, over-the-counter infant formulas, or over-the-counter medical foods are not Covered Services unless We have approved them.

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

Experimental or Investigative drugs, devices, treatments, or services are not Covered Services. **Experimental or Investigative means any of the following situations:**

- The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable value as reported by current scientific literature and/or regulatory agencies; or
- The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
- The drug or device is not approved for marketing by the United States Food and Drug Administration (FDA); or
- The drug, device, medical treatment or procedure is currently under study in a **Non-FDA approved** Phase I or Phase II clinical trial, an experimental study/investigational arm of a

Phase III clinical study, or otherwise under study to determine safety and efficacy or to compare its safety and efficacy to current standards of care; or
- The drug, device, medical treatment or procedure is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment or procedure.

Eye examinations, surgery, and other services are not Covered Services including:

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

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

F

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

The following **Foot Care Services are not Covered Services** unless Medically Necessary:

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

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

G

Genetic Testing and Counseling are not Covered Services unless We have approved the services. Counseling is a Covered Service only as part of the approved genetic test unless considered preventive care.

H

Hearing Aids and related services, including examinations, fittings, molds, batteries or other supplies or repair services, for Members over age 18 are not covered unless Your Plan has a hearing aid rider.

Home Births are not a Covered Service.

Home Health Care Skilled Services are not Covered unless Medically Necessary and We have approved the services. Services and visits are limited as stated on Your schedule of benefits. We do not Cover any services after You have reached Your Plan's benefit limit. We do not cover Custodial Care. We do not cover homemaker services, food and home delivered meals.

Hospital Services listed below are not Covered Services:

- Guest meals;
- Telephones, televisions, and other convenience items;
- Private inpatient Hospital rooms unless You need a private room because You have a highly contagious condition or are at greater risk of contracting an infectious disease because of Your medical condition.

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not Covered Services.

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

Unless listed as a Covered Service in this EOC, or under a Rider, **Infertility Services** listed below are not Covered Services:

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as a Covered Service;
- Services, tests, medications, and treatments for the enhancement of conception;
- In-vitro Fertilization programs;
- Artificial insemination or any other types of artificial or surgical means of conception;
- Drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- Reproductive material storage;
- Treatment or testing related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage,
- Sperm washing;

- Services to reverse voluntary sterilization;
- Infertility Treatment or services from reversal of sterilization;
- Drugs used to treat infertility;
- Surrogate pregnancy services when the person is not covered under Your Plan.

J

K

L

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

M

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

Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not a Covered Service.

Medical Equipment, Services, Exercise equipment, Devices and Supplies that are disposable, available over the counter, or mainly for convenience are not Covered Services. **The following are not Covered Services:**

- Adaptations to Your home, car, van, other vehicle or office;
- Bicycles, treadmills, stair climbers, and other exercise equipment;
- Free weights, exercise videos and other training equipment;
- Air conditioners, purifiers, humidifiers and dehumidifiers;
- Whirlpool baths;
- Hypoallergenic pillows or bed linens;
- Under pads and diapers;
- Telephones;
- Televisions;
- Handrails, ramps, elevators, escalators, and stair glides;
- Orthotics not approved by Us;
- Adaptive feeding devices;
- Adaptive bed devices;
- Water filers or purification devices;
- Disposable Medical Supplies such as medical dressings and disposable diapers;
- Over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, and peroxide;
- Heating pads;

- Thermometers;
- Raised toilet seats;
- Shower chairs;
- Waterbeds;
- Pools, hot tubs, or spas;
- Pool, gym or health club membership fees;
- Personal trainers or other fitness instruction;
- Ice bags;
- Chairs or recliners;
- Other personal comfort or over the counter hygienic items.

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not Covered Services unless Your Plan includes these services in a rider and We have approved the services for Members who meet established criteria.

Motorized or Power Operated Vehicles or chair lifts are not Covered Services unless We have approved Coverage . This does not include wheelchairs or scooters.

N

Neuro-cognitive therapy is not a Covered Service.

Newborns or other children of a Covered Dependent Child are not Covered Persons under the Plan unless mutually agreed to by the Plan and the Group.

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

O

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

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

- If during treatment at an In-Network Hospital or other In-Network Facility You receive Covered Services from an Out-of-Network Non-Plan Provider those services will be Covered under the Plan's In-Network benefits. Members are responsible for In-Network cost sharing credited toward In-Network Deductibles and maximum Out-of-Pocket Amounts;
- Emergency Services and Air Ambulance services received from Out-of-Network Non-Plan Facilities and Providers will be Covered under the Plan's In-Network benefits. Members

are responsible for In-Network cost sharing credited toward In-Network Deductibles and maximum Out-of-Pocket Amounts.

P

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

Pass Devices (Patient Activated Serial Stretch) are not a Covered Service.

Paternity Testing is not a Covered Service.

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

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

Private Duty Nursing is not a Covered Service.

Prosthetics for sports or cosmetic purposes are not a Covered Service.

Non-Covered **Providers,** and services they provide such as massage therapists and physical therapist technicians are not Covered unless We have approved the services.

Pulsed Irrigation Evacuation System is not a Covered Service.

Q

R

Reconstructive surgery is not a Covered Service unless Medically Necessary and surgery follows trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is a Covered Service.

Remedial Education and Programs are not Covered Services. Services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities **are not Covered Services.**

Residential treatment center care or care in another non-skilled setting are not Covered Services when services are merely custodial, residential, or domiciliary in nature.

S

Services – <u>The following are not Covered Services:</u>

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

Skilled Nursing Facility (SNF) stays are not covered unless We have approved the services. The following services are not Covered:

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

Spinal Manipulation is not a Covered Service unless Covered under a Chiropractic Care Rider.

T

Charges for non-interactive **Telemedicine Services** such as fax, telephone only conversations, email, or online questionnaire are not Covered Services under the Plan's Telemedicine benefits.

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

Therapies. Physical, Speech, and Occupational **Therapies** are limited as stated on Your schedule of benefits. Therapies will be Covered Services only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. **<u>The following are not Covered Services except</u>**

for those services that are listed under Early Intervention Services or under Autism Spectrum Disorder:

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

Total Body Photography is not a Covered Service.

Transplant Services -The following are not Covered Services:

- Organ and tissue transplant services not listed as a Covered Service;
- Organ and tissue transplants not Medically Necessary;
- Organ and tissue transplants considered Experimental or investigative;
- Services from non-contracted providers unless pre-authorized by the Plan;
- Travel and lodging services not approved by the Plan including childcare, mileage, and rental cars;
- Services not listed as Covered under the Plan's Transplant Services benefit; or
- Services related to donor complications following an approved transplant are limited to Medically Necessary charges, not covered by any other source, for up to six weeks from the date of procurement;
- **Donor Benefits** are not Covered Services if the Covered individual is donating an organ to a non-covered member.

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

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

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

U

V

Treatment of **varicose veins** or **telangiectatic dermal veins** (spider veins) for cosmetic purposes are not Covered Services.

Video Recording or Video Taping of any service or procedure is not a Covered Service.

W

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

Wisdom Teeth extraction is not a Covered Service unless under a rider**.**

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

X

Y

Z

Section 7
What is Not Covered (Exclusions and Limitations)

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

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

Limitations

1. Amounts You pay for any outpatient prescription drug after a benefit Limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.
2. Over the Counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage. However, the Plan may approve Coverage of limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of Covered Preferred and Standard drugs.
3. Unless required by law, certain Prescription Drugs may not be Covered under the Plan if You could use a "clinically equivalent drug." "Clinically equivalent drug" means a drug that for most individual s will give You similar results for a disease or condition. If You have questions about whether a certain drug is Covered by the Plan, please call the Member Services number on the back of Your Plan Identification card. If You or Your doctor believes You need to use a different Prescription Drug, please have Your doctor contact Us. If We agree that it is Medically Necessary and appropriate, We will cover the other Prescription Drug instead of the "clinically equivalent drug" at the non-preferred tier.
4. Our formulary is a list of FDA-approved medications that We cover. At its sole discretion, the Plan Pharmacy and Therapeutics Committee reviews medications for placement onto the formulary. The Plan's Pharmacy and Therapeutics Committee is composed of Physicians and pharmacists. For all drugs, including new drugs, the committee looks at the medical literature and then evaluates whether to add or remove a drug from the formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration.
5. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies Covered under the Plan's prescription drug benefit or the Plan's medical benefit.
6. Intrauterine devices (IUDs), implants, and cervical caps and their insertion are Covered under the Plan's medical benefits.
7. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to # 90-day courses of treatment per year when prescribed by a health care provider.

Prescription Drug Coverage Exclusions

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

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.

2. Medications with no approved FDA indications are excluded from Coverage.
3. Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
4. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as Covered are excluded from Coverage.
6. Immunization agents other than those Covered by the formulary, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage, unless authorized by the Plan.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage, unless authorized by the Plan.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. Therapeutic devices or appliances, including but not limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
13. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
14. Drugs with a therapeutic over the counter (OTC) equivalent are excluded from Coverage unless authorized by the Plan.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded from Coverage.
18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage.
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an Emergency while traveling out of the country.
20. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
21. Nutritional and/or Dietary Supplements, except as required by law, are not Covered Services. Nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription are not Covered Services. This exclusion does not apply to Plan Covered Services under the "Medically Necessary Formula and Enteral Nutrition Products" benefits in Section 6 "What is Covered "of Your Evidence of Coverage.

22. Drugs not meeting the minimum levels of evidence based on one or more of the following standard reference compendia are not Covered Services:
    a. American Hospital Formulary Service Drug Information;
    b. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
    c. Elsevier Gold Standard's Clinical Pharmacology.
23. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
24. Non-Sedating antihistamines are excluded from Coverage.
25. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage unless authorized by the Plan.
26. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
27. Prescriptions written by a licensed dentist are excluded from Coverage, except for the prevention of infection or pain in conjunction with a Covered dental procedure.
28. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription.
29. Sexual dysfunction drugs are excluded from Coverage.
30. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
31. Infertility drugs are excluded from Coverage.
32. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
33. Digital Therapeutics, including digital devices, software and applications are excluded from Coverage.
34. **This plan uses a Closed Formulary. Any prescription drugs, over-the-counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are not Covered.**

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

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

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

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

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

When a Member is covered under more than one insurance Plan, the Plan that covers the Member as the Subscriber (not a spouse or Dependent) is normally the primary Plan. If the Plan that covers the person as the Subscriber is a government Plan, the law may require the other Plan to pay first.

Depending on the circumstance We use the following rules to determine which plan is primary and which plan is secondary.

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

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

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

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

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

  1. The Plan of the parent with custody of the child pays its benefits.

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

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

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

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

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

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

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

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

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

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

FACILITY OF PAYMENT.

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

RIGHT OF RECOVERY.

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

- The person(s) it paid; or
- Health insurance companies and health maintenance organizations (HMOs).

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

WE DO NOT COVER ANY OF THE FOLLOWING:

- Benefits available under **Worker's Compensation**. If We provide services covered under Worker's Compensation, Worker's Compensation will pay the provider of the services directly for those services. The Plan will coordinate benefits with the provider of the service. Any money received by Us belongs to Us.
- Benefits available under **Medicare Parts A, B, C, or D** unless required to do so by federal law. If We provide services covered under Medicare, Medicare will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us.
- Benefits available under **any other government program**, unless required to do so by law. If We provide services under a government program, the government program will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us.

THE FOLLOWING DEFINITIONS APPLY TO THIS SECTION.

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

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

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

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

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

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

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

"**Allowable Expense**" means an expense for which the Plan will pay. It is the usual and customary charge for an item or service covered at least in part by the Member's insurance. The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an allowable expense unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

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

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.

Section 9
Your Out-of-Pocket Cost Sharing

This section explains the amounts that You must pay out-of-pocket when You receive covered services. See Your Schedule of Benefits for the specific out-of-pocket amounts You must pay for each Covered Service.

COPAYMENT AND COINSURANCE

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

A Copayment is a flat dollar amount.

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

DEDUCTIBLE

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

Any applicable Deductible, Coinsurance, or Copayment You pay for a Covered Service will be included as part of the payment of the Allowable Charge.

Section 9
Your Out-of-Pocket Cost Sharing

MAXIMUM OUT-OF-POCKET LIMIT or MAXIMUM OUT-OF-POCKET AMOUNT

Maximum Out-of-Pocket Limit or Amount means the total amount You or Your Dependents pay, or that are paid on behalf of You or Your Dependents by another person, during a year as specified on Your Plan's Schedule of Benefits. Deductible, Copayment and Coinsurance amounts for certain services will be accumulated and will apply toward the maximum dollar amount listed on the Schedule of Benefits.

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

EMERGENCY DEPARTMENT COPAYMENT

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

INPATIENT HOSPITAL COPAYMENT

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

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

BALANCE BILLING PROTECTION FOR OUT-OF-NETWORK SERVICES

You are protected from "balance billing" if You receive Emergency Services from an Out-of-Network Provider, non-emergency surgical or ancillary services provided by an Out-of-Network Provider at an In-Network Facility, or air ambulance services from an Out-of-Network Provider.

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

Section 9
Your Out-of-Pocket Cost Sharing

What is balance billing?

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

When You cannot be balance billed:

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

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

- Air ambulance services provided by an Out-of-Network provider.

- Non-emergency services provided by an Out-of-Network provider at an In-Network Facility if the non-emergency services involve otherwise Covered Surgical or Ancillary Services, or other Covered Services provided by an Out-of-Network provider

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

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

Your health plan contracts with certain health care professionals and facilities. These are called "In-Network" Providers. The Plan is required to advise You, via Our website or on request, which Providers and facilities are in Your Plan's network. Health care professionals and facilities must

also tell You which health plan provider networks they participate in either on their website or on request. Using In-Network Providers may help You avoid additional costs.

Other Out-of-Network Services:

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

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

- Air ambulance services provided by an Out-of-Network provider.

- Non-emergency services provided by an Out-of-Network provider at an In-Network Facility if the non-emergency services involve otherwise Covered Surgical or Ancillary Services, or other Covered Services provided by an Out-of-Network provider.

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

MONTHLY PREMIUM

The Application to the Group Contract lists the monthly premium. If Members must contribute toward the cost of Coverage, the Application to the Group Contract and the Schedule of Benefits of the Evidence of Coverage will indicate so. If a Member fails to pay, or arrange for payment of, any amount due under the Plan, including failure to pay a premium required by the Plan, Coverage will terminate upon 31 days written notice.

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.

OFFICE VISIT COPAYMENTS FOR PREVENTIVE CARE

Section 9
Your Out-of-Pocket Cost Sharing

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

1. You will pay office visit cost sharing if Your preventive care item or service is billed separately or is tracked as individual encounter data separately from the office visit.
2. You should not pay a cost sharing for an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit, and the primary purpose of the office visit is the delivery of the preventive item or service.
3. You will pay office visit cost sharing if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.
4. You will pay all charges for any preventive care and office visits You receive from Out-of-Network Non-Plan Providers.

Section 10
Claims and Payments

WHEN YOU HAVE TO FILE A CLAIM FOR BENEFITS

Plan Providers will usually file Claims for You. You may have to file a Claim if Your Provider is unable to file for You, or if You see a Non-Plan Provider. We do not use Claim forms, but You must send Us complete written proof of loss. Proof of loss means that We have all the information We need to process Your Claim. You can provide proof of loss by sending Us an itemized bill for services You received. An example would be a bill from a doctor's office or Hospital listing the cost of services or tests You had done.

- **The bill must be in English and include all of the following:**

  - The name and address of the provider; and
  - The name and Member number of the Member who received services; and
  - The date of the services; and
  - The diagnosis and type of services received; and
  - The charge for each type of service.

- **Send the itemized bill and any other information You have about Your Claim to**:

  MEDICAL CLAIMS
  PO Box 8203
  Kingston, NY 12402-8203

  BEHAVIORAL HEALTH CLAIMS
  PO Box 8204
  Kingston, NY 12402-8203

TIMELY FILING OF CLAIMS AND WRITTEN PROOF OF LOSS

Proof of loss means that We have all the information We need to process Your Claim. You must submit written proof of loss to the Plan within 90 days after You receive the Covered Services. If You do not send written proof of loss within 90 days Your Claim will not be reduced or invalid as long as You send it to Us as soon as reasonably possible.

Unless You are not legally competent to act, We require that You send Us proof of loss no later than one year after the date of service or We will not provide benefits.

CLAIMS FROM NON-PLAN PROVIDERS

Non-Plan Providers must submit Claims for Covered Services provided to Members to:

MEDICAL CLAIMS
PO Box 8203

Kingston, NY 12402-8203

BEHAVIORAL HEALTH CLAIMS
PO Box 8204
Kingston, NY 12402-8203

Claims must be received by the Plan within 365 days of the date the Member received the Covered Service. We will not be liable for or pay a Claim We receive from a Non-Plan Provider more than 365 days from the date of service.

PROCESSING A CLAIM

We process Claims, make Coverage decisions, and provide notice according to the procedures and timeframes described in Section 5. All of Our requirements for Pre-Authorization apply. All of the Member's Coverage exclusions and limitations apply.

If We deny a Claim for benefits the Member has the right to a full and fair review of the Plan's determination according to Our appeal process in Section 13.

CLAIMS PAYMENT

We usually pay the provider or the Facility that provided the Covered Service. If a Member has provided proof that they paid the provider directly for a Covered Service, We will reimburse the Member less any amounts We have already paid the provider for the Claim. We will pay the estate of the Member if the Member is dead.

RIGHT OF EXAMINATION AND AUTOPSY

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

CLAIMS PAID DIRECTLY TO MEMBERS FOR SERVICES FROM NON-PARTICIPATING PHYSICIANS

If We send payment directly to a Member for a Claim for Covered Services from a non-plan physician or osteopath, the Member must apply the plan payment to the Claim from the non-plan provider. We will include the name and any last known address of the physician or osteopath with any payment sent directly to the Member.

Section 11
When Your Coverage Will End

WHEN YOUR COVERAGE WILL END

Under certain circumstances Your Coverage under Your employer group plan will end. Your Coverage will not be canceled based on Your health. Your Coverage will not be canceled because You have exercised Your right to file a complaint under Our grievance system. If Your Coverage ends, We will no longer pay for any services You receive after the date Your Coverage ends.

A Subscriber or Employee's Coverage ends on:

- The date the employer group Plan ends, upon 31 days written notice;
- The date the subscriber fails to meet the Plan's eligibility requirements;
- The date the grace period for payment of premiums to the Plan ends; or
- The date the subscriber dies.

A Dependent's Coverage ends:

- The date the employer group Plan ends, upon 31 days written notice;
- The date the Dependent fails to meet the Plan's eligibility requirements;
- The date the grace period for payment of premiums to the Plan ends;
- The date the subscriber's Coverage under the Plan ends unless otherwise agreed to by the Plan and the employer group;
- The date a Dependent spouse or child becomes Covered as an employee under the Plan; or
- The date the Dependent dies.

RESCISSION 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.

The Plan will not rescind Coverage after an individual is Covered under the Plan unless the individual, or a person seeking Coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

The Plan will provide at least 30 days' advance written or electronic notice to any Covered Person who would be affected by the proposed rescission of Coverage before Coverage under the Plan may be rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group. The written or electronic advance notice will at a minimum include the following:

1. Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

2. An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

3. Notice that the Covered Person or the Covered Person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;

4. A description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and

5. The date when the advance notice ends and the date back to which the Coverage will be rescinded.

If Coverage is rescinded, a Covered Person losing Coverage is entitled to a refund of any paid premiums from the date Coverage is voided or rescinded.

REASONS YOUR GROUP COVERAGE WILL END

We have a contract or Group Contract with Your employer to provide Your benefits. We will not end or cancel a Member's Coverage under the Group Contract except for one or more of the following reasons:

- Failure to pay the amounts due under the Plan, including failure to pay a premium required by Our contract with the Group;
- Fraud or material misrepresentation in enrollment, or in the use of services or facilities;

  Fraud or Misrepresentation. We may cancel Coverage of any Subscriber or Member who knowingly gives incorrect, incomplete, or deceptive information about themselves or their Dependents eligibility for Coverage. This applies if the information is given to Us or to Your employer. This also 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 their Plan ID card. Use by anyone else is fraud. The Plan may prosecute the Member and the person using the card. Both the Member and the person using the Member's card are liable to the Plan for all costs resulting from the misuse of the identification card.

- Material violation of the terms of the Plan Group Contract.
- Failure to meet the eligibility requirements under the Plan Group Contract.
- Termination of the Group Contract under which the Member was Covered.

Section 11
When Your Coverage Will End

NOTICE THAT COVERAGE HAS ENDED

We will not end Coverage for services provided under the employer Group Contract without giving the Subscriber written notice effective at least 31 days from the date of mailing or, if not mailed, from the date of delivery, except that:

- For cancelation due to nonpayment of premium the Plan's grace period will apply. The contract holder is entitled to a grace period of 31 days for the payment of any premium due except the first premium. During the grace period Coverage will 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 will 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.
- For cancelation due to nonpayment of premium by an employer, the following additional provisions 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 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 is canceled 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.

- For cancelation due to change of eligibility status of a Member, immediate notice may be given.
- The Plan will provide at least 30-days' advance written or electronic notice to any Covered Person who would be affected by the proposed rescission of coverage before coverage under the Plan may be rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group. The Covered Person or their authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission.

CONTINUATION OF CARE EXTENSION OF BENEFITS FOR TOTAL DISABILITY

If Coverage ends under the Group Contract members who become totally disabled while enrolled under the Plan and who continue to be totally disabled when the Group Contract 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.

REINSTATEMENT OF COVERAGE FOLLOWING ABSENCE FROM EMPLOYMENT

Unless otherwise agreed to by the Employer and the Plan the following provisions apply to employees following an 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 waiting periods, and effective date of Coverage requirements, as described in **Section 3 Who is Eligible to Enroll and Section 4 When You Can Enroll and When Coverage Begins.**
- 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.

TERMINATION OF THE GROUP CONTRACT

Unless otherwise stated, and in accordance with all notice requirements, on the date the Group Contract is ended:

- Coverage of Subscribers and Dependents will end immediately. The Group must notify Members promptly that We are no longer required to provide any service in connection with the Group Contract.

- 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 Contract.

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

Section 12
Continuing Coverage Options When Eligibility Ends

When Your Coverage or Your Dependent's Coverage ends Your employer must tell You and Your Dependents in writing what options are available to continue Coverage.

The following options may be available:

- Continue group Coverage under federal Consolidated Omnibus Budget Reconciliation Act (COBRA); or
- Continue group Coverage under Virginia state law for 12 months.

REQUIRED EMPLOYER NOTICE OF CONTINUATION OPTIONS

Your employer must provide each employee, or other enrollee Covered under Your Plan, written notice of the availability of COBRA or, if Your group is not subject to COBRA, written notice of the availability of Virginia's twelve-month continuation of group Coverage option. The employer notice must include all of the procedures and timeframes for continuation of Coverage. The notice must be provided within 14 days of the employer group contract holder's knowledge of the enrollee or other Covered person's loss of eligibility under the group contract.

COBRA CONTINUATION HEALTH COVERAGE

When group health plan coverage ends the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most group health plans to provide a temporary continuation of group health coverage for certain qualifying events. COBRA generally applies to all group health plans maintained by private-sector employers (with at least 20 employees) or by state and local governments. The law does not apply, however, to plans sponsored by the Federal government or by churches and certain church-related organizations.

COBRA requires continuation coverage to be offered to covered employees, their spouses, their former spouses, and their dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination, or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce, or legal separation from a covered employee, a covered employee's becoming entitled to Medicare, and a child's loss of dependent status (and therefore coverage) under the plan.

Employers may require individuals who elect continuation coverage to pay the full cost of the coverage, plus a 2 percent administrative charge. For more information about COBRA please read the General Notice of COBRA Continuation Coverage Rights in the back of this document. Your employer and not the Plan is responsible for administering COBRA benefits.

STATE CONTINUATION OF GROUP PLAN COVERAGE

Section 12
Continuing Coverage Options When Eligibility Ends

This section will apply to You only if Your employer's group plan is not subject to COBRA continuation.

If Coverage under the Group Plan ends Members are entitled to continuation of Coverage under the existing group contract for a period of 12 months immediately following the date of termination of the enrollee's eligibility for Coverage under the Group Plan. Coverage shall be provided without additional evidence of insurability. The premium for continuing group Coverage shall be at the current rate applicable to the group contract subject to the following requirements:

1. The application and payment for the extended Coverage is made to the group contract holder within 31 days after issuance of the written notice by the employer, but in no event beyond the 60-day period following the date of the termination of the person's eligibility.
2. Each premium for the extended Coverage is timely paid to the group contract holder on a monthly basis during the 12-month period; and
3. The premium for continuing the group Coverage shall be at the insurer's current rate applicable to the group policy plus any applicable administrative of 2% of the current rate.

Members will not be eligible for Continuation of Coverage if any conditions below are true.

- The Member is covered by, or is eligible for benefits under Title XVIII, under the United States Social Security Act.
- The Member is covered by or is eligible for substantially the same level of Hospital, medical, and surgical benefits under state or federal law.
- 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.
- The Member has not been continuously covered during the three-month period immediately preceding the Member's termination of Coverage.
- 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; or
    3. Material violation of the terms of the contract.

Section 13
How to File a Complaint, Grievance, or Appeal an Adverse Benefit Determination

YOUR RIGHT TO FILE A COMPLAINT OR APPEAL

We want You to be satisfied with Your health plan services. If You are not satisfied, We have a formal complaint process to handle Your concerns. We also have an Internal and an External Appeal Process to resolve benefit disputes and respond to requests to reconsider Coverage decisions You find unacceptable.

Some examples of typical complaints or grievances are:

- You are unhappy with a doctor or Hospital;
- You feel You received poor care at a Hospital; or
- You are unhappy with Our services.

Some examples of when You are entitled to an appeal are:

- We did not approve a request for Pre-Authorization;
- We did not cover a treatment because it is experimental;
- We did not cover a service because it is not medically necessary;
- We did not pay for a treatment or service according to Your benefits; or
- We have notified you that Your Coverage is being rescinded for fraud or material misrepresentation.

We suggest You call Member Services first and one of Our customer service representatives will assist You with the problem. Most problems can be handled in this manner. If You are still not satisfied You can file a formal written complaint or an appeal by following one of processes below.

Remember, You have the right to file a complaint or an appeal. We will not penalize You or cancel Your Coverage because You exercise Your rights.

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

Write:

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

Telephone:

Toll-Free: 1-877-310-6560
Richmond Metropolitan Area: 1-804-371-9032

E-Mail:

ombudsman@scc.virginia.gov

HOW TO FILE A COMPLAINT

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

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

Sentara Health Plans
Appeals Department
P.O. Box 66189
Virginia Beach, VA 23466-6189
Fax: 1-877-240-4214
Toll Free: 1-833-702-0037

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

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

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

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

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

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

- **The Managed Care Ombudsman**:

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

APPEALS OF AN ADVERSE BENEFIT DETERMINATIONS

An Adverse Benefit Determination means that We have made a decision not to pre-authorize, cover, or pay (in whole or in part) for a service because:

- You are not eligible for benefits under the plan;
- The service does not meet Our requirements for:
  - Medical necessity;
  - Appropriateness;
  - Health care setting;
  - Level of care;
  - Effectiveness; or
- The service is Experimental or Investigational; or
- The Plan has notified You that Your Coverage is being rescinded.

You have the right to a full and fair appeal of an Adverse Benefit Determination. You have 180 days from Our notice to You of an Adverse Benefit Determination to ask for an appeal.

You can have someone else, such as a doctor or family member file an appeal for You. We may ask You to sign a form to authorize this person to act for You.

When We review Your appeal, We will look at all comments, documents, records, and other information submitted to Us. We will do a new review without regard to the first review of Your case. Make sure You send Us any new information You want Us to review. You can submit new information to Us in writing or in person.

The person reviewing Your appeal will not have participated in the original Coverage decision.

Appeals involving a medical judgment, including whether a particular treatment, drug, or other service is experimental, investigational, or not Medically Necessary will be reviewed by a clinical peer reviewer who did not participate in the first Coverage decision.

Before We make Our final decision on Your appeal, We will provide you free of charge any new information We relied on; and We will give you time to provide comments.

Appeals of Pre-Service Claims

A **Pre-service Claim** is a claim for a benefit or service that requires Pre-Authorization before You receive care. An example would be obtaining Pre-Authorization for a diagnostic test or medical procedure.

For Pre-Service Claims, We will make a decision and notify You within 30 calendar days of receipt of Your written request for the appeal.

Reconsideration of an Adverse Decision

Your treating provider may request a reconsideration of an Adverse Decision on Your behalf. A request for reconsideration is optional, and available only to Your treating health care provider. You or Your Authorized Representative may file an appeal regardless of whether your provider requests a reconsideration. We will make a decision on a reconsideration and notify the provider and the member in writing within ten (10) working days of the date of receipt of the request. If we deny the reconsideration request the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate recommendation, and the Member's right to appeal the decision.

Appeals of Post-Service Claims

A Post-Service Claim is any Claim for a benefit that is not a Pre-Service Claim. An example would be a Claim for payment for a diagnostic test or other services You have already had done.

If Your appeal involves a Post-Service Claim, We will make a decision and notify You within 60 calendar days of receipt of Your written request for the appeal.

Appeals of Concurrent Claims or Review Decisions

A Concurrent Care Claim is a Claim for a benefit where We are reducing or ending a service previously approved. It can also be a request to extend a course of treatment. An example would be a review of an inpatient Hospital stay approved for five days on the third day to determine if the full five days is appropriate. Another example would be a request for additional outpatient therapy visits.

For Concurrent Care Claims, We will make a decision and notify You as soon as possible; and prior to the benefit being reduced or terminated.

We will continue to provide Coverage during Your appeal of a concurrent review.

Expedited Appeals for Urgent Claims

You can request an expedited appeal if Your claim for medical care or treatment is urgent and using Our normal appeal process would:

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

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

We will make a decision on an expedited appeal and notify You as soon as possible, but no later than:

- One business day after We receive all information necessary to make a decision; or
- Not later than 72 hours from the receipt of the request.

Expedited appeals relating to a prescription to alleviate cancer pain will be decided not more than twenty-four (24) hours from receipt of the request.

You also have the right to file an external review at the same time as Your request for an expedited internal appeal. **Please see the section below "YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR A FINAL ADVERSE BENEFIT DETERMINATION."**

Adverse Determinations Involving The Treatment of Cancer

If You receive an Adverse Determination involving the treatment of Cancer You are not required to exhaust Our internal appeal processes before requesting a standard or expedited independent

external review. **Please see the section below "YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR A FINAL ADVERSE BENEFIT DETERMINATION."**

HOW TO BEGIN YOUR APPEAL

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

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

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

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

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

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

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

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

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

  1. Reasonable access to, and copies of, all documents, records, and other information relevant to Your appeal;

2. Copies of any internal rule, guideline, protocol, or other criteria We relied on for Our decision; and
3. For denials due to medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to Your medical circumstances.

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

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

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

We will send You copies of the forms and instructions that You need to file an external review or an expedited external review with Our notice of an Adverse Benefit Determination or final Adverse Determination. You can also get copies of the forms and instructions that You need by calling Member Services at the number on Your Plan ID card or on Our web site at sentarahealthplans.com.

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

You may file a request for an External Review of an Adverse Determination in the following situations:

- If We have denied Your request for a Covered Service, or We have denied payment for a Covered Service or course of treatment, and Our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested;
- If the Adverse Determination involves the treatment of cancer, or You have a medical condition where the time frame for completion of an expedited internal appeal of an Adverse Determination would seriously jeopardize Your life or health or would jeopardize

Your ability to regain maximum function, You, or Your authorized representative may file a request for an expedited external appeal;

- If the Adverse Determination involves a denial of Coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and Your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, You or Your authorized representative may file a request for an expedited external review;
- If You or Your authorized representative files a request for an expedited internal appeal with Us, You may file at the same time a request for an expedited external review of an Adverse Determination. The independent review organization assigned to conduct the expedited external review will determine whether the Covered Person shall be required to complete the expedited internal appeal prior to conducting the expedited external review;
- If You or Your authorized representative files a standard appeal with Our internal appeal process, and We do not issue a written decision by either 30 days from the date of filing for a Pre-Service Claim or by 60 days from the date of filing for a Post-Service Claim, and You or Your authorized representative did not request or agree to a delay, You or Your authorized representative may file a request for external review, and will be considered to have exhausted Our internal appeal process.

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

- You have a medical condition where the time frame for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, You or Your authorized representative may file a request for an expedited external.
- If the final Adverse Determination involves an Admission, availability of care, continued stay, or health care service for which You received Emergency Services, but have not been discharged from a Facility, You or Your authorized representative may request an expedited external review.
- If the final Adverse Determination involves a denial of Coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, You or Your authorized representative may file a request for a standard external review; or if Your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, You or Your authorized representative may request an expedited external review.

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

Section 13
How to File a Complaint, Grievance, or Appeal an Adverse Benefit Determination

You must have exhausted Our internal appeal process. Exhaustion of the internal appeal process will not be required if the Adverse Determination is related to the treatment of cancer. Depending on Your situation exhausted means:

1. You have filed an internal appeal and We have notified You of Our final adverse benefit decision;
2. You filed an internal appeal, and We have not given You a response on Our determination by either 30 days from the date of filing for a Pre-Service Claim or by 60 days from the date of filing for a Post-Service Claim. This does not apply if You agreed to give Us more time to work on Your appeal;
3. You filed an expedited or urgent appeal with Us. At the same time, You can request an External review; or
4. We have agreed to waive the exhaustion requirement for Your appeal.

How Your External Appeal will be handled

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

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

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

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

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

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

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

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

SOURCES FOR ADDITIONAL HELP

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

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

- You may contact the Office of the Managed Care Ombudsman to seek assistance in understanding and exercising Your right to appeal an Adverse Determination at:

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

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

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

Section 14
General Provisions

MAJOR DISASTERS AND OTHER CIRCUMSTANCES BEYOND THE PLAN'S CONTROL

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

INCONTESTABILITY

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

SEVERABILITY

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

POLICIES AND PROVISIONS

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

MODIFICATIONS

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

ENTIRE CONTRACT

The Group Contract 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 Contract 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 Contract and no waiver of any of its provisions shall be valid unless evidenced by a written endorsement or amendment signed by a

duly authorized officer of the Plan. Any insurance agent or broker licensed through the Plan who may have assisted in the contract for this Plan is not an authorized officer of the Plan for this or any other purpose.

OMISSIONS

Neither the 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 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.

RELATIONSHIP BETWEEN THE PLAN AND HOSPITALS

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

RELATIONSHIP BETWEEN THE PLAN AND HEALTH PROFESSIONALS

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

PRESCRIPTION DRUG BENEFITS

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

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

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

The Plan will not exclude Coverage for any prescription drug solely on the basis of the length of time since the drug obtained FDA approval.

Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy or its intermediary that has agreed to accept as payment in full reimbursement from the Plan or its Pharmacy Benefit Manager at the same level as the Plan or its Pharmacy Benefit Manager gives to participating pharmacies.

Step Therapy Protocols

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

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

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

- The required prescription drug is contraindicated;
- The required drug would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

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

The Plan will respond to a step therapy exception request within 72 hours of receipt, including hours on weekends. We will confirm that the request is approved, denied, or requires supplementation or additional information. In cases where exigent circumstances exist, We will respond with our decision within 24 hours of receipt, including hours on weekends. A Member may appeal any step therapy exception request denial under the Plan's existing appeal procedures.

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.

LIMITATIONS OF DAMAGES

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

TIME LIMITS ON LEGAL ACTION

No action at law or suit in equity shall be brought against the Plan more than one year after the date the cause of action first accrued with respect to any matter relating to this Evidence of

Coverage, the Plan's performance under this Evidence of Coverage, or any statements made by an employee, officer, or director of the Plan concerning the Evidence of Coverage or the benefits available.

THE PLAN'S CONTINUING RIGHTS

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

CONTINUITY OF CARE

For this section “provider" means a Hospital, Physician or any type of provider licensed, certified or authorized by statute to provide a Covered Service under the Plan.

If a provider leaves the Plan's network, except when terminated for cause, Members may continue to receive care from that provider subject to the following:

- For a period of at least 90 days from the date the provider's termination;
- Through the provision of postpartum care directly related to the delivery for Members who have been medically confirmed to be pregnant at the time of the provider’s termination;
- 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.
- For up to 180 days for Members determined by a medical professional to have a life-threatening condition at the time of a provider’s termination for care directly related to the life-threatening condition.
- For Members admitted to and receiving treatment in any inpatient facility at the time of a provider's termination admission and treatment will continue until the enrollee is discharged from the inpatient facility.

The Plan will pay a provider according to the Plan's agreement with the provider existing immediately before the provider's termination of participation. The provider will accept reimbursement from the Plan and any cost sharing payment from the Member as payment in full. Providers will continue to adhere to all policies and procedures imposed by the Plan required immediately before the provider’s termination.

CONSIDERATION OF MEDICAID ELIGIBILITY PROHIBITED

Section 14
General Provisions

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

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

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.

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.

DISCRIMINATION

The Plan will not unfairly discriminate against an enrollee on the basis of the age, sex, gender identity or status as a transgender individual, health status, race, color, creed, national origin, ancestry, religion, marital status, or lawful occupation of the enrollee, or because of the frequency of utilization of services by the enrollee. However, nothing shall prohibit the Plan from setting rates or establishing a schedule of charges in accordance with relevant actuarial data.

The Plan will not unreasonably discriminate against physicians as a class or any class of providers when contracting for specialty or referral practitioners, provided the plan covers services that the class of providers are licensed to render. Nothing in this section shall prevent a health maintenance organization from selecting, in the judgment of the health maintenance organization, the number of providers necessary to render the services offered by the health maintenance organization, or from limiting certain specialty services to particular types of practitioners, provided these services are within the scope of their license.

Section 14
General Provisions

THIS IS THE END OF YOUR EVIDENCE OF COVERAGE.

Attachments

Under state and federal law Sentara Health Members are entitled to certain information about their health plan benefits. Your employer may be required to provide You additional notices or information about Your coverage rights. On the following pages You will find the following:

Notice of Maternity Coverage (NMHPA)

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

Notice of Coverage for Reconstructive Breast Surgery (WHCRA)

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

Information on COBRA Continuation of Coverage

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. Your employer and not Sentara Health is responsible for giving You all the required information and notices about COBRA coverage.

Your Rights Under ERISA

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).

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

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

Sentara Healthcare Integrated Notice Of Privacy Practices

Sentara Health is part of the Sentara Healthcare integrated health care system. This system is made up of companies owned by Sentara Healthcare. Every member of the Sentara Healthcare family, including Sentara Health, must comply with the basic privacy principles found in the "Sentara Healthcare Integrated Notice of Privacy Practices." A copy of the notice is attached to this booklet. In the notice there is an explanation of how the Sentara Healthcare system uses and safeguards Your personal and medical record information.

Attachments

Notice Of Protection Provided By Virginia Life, Accident And Sickness Insurance Guaranty Association

This notice provides **a brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

Notice of Insurance Information and Financial Information Practices

This notice will help You understand how We may collect information about You, the type of information that may be collected, and what information may be disclosed about You to the Plan's affiliates and to non-affiliated third parties.

Balance Billing Protection

This notice will help You understand balance billing protection for Out-of-Network Services

Notice of Maternity Coverage (NMHPA)

Under Virginia law and under federal law You have certain rights and protections regarding Your maternity benefits under the Plan.

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

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

Notice of Coverage for Reconstructive Breast Surgery (WHCRA)

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

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

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

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

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

Information on COBRA Continuation of Coverage

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do *not* need to include this instruction page with the model general notice.

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0123.

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would

otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Information on COBRA Continuation of Coverage

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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 Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or

former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.
-

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Your Rights Under ERISA

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.

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.

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.

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	**CALIFORNIA-Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child HealthPlan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711

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

Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	CHP+: https://www.colorado.gov/pacific/hcpf/child-health- plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268
ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecov ery.com/hipp/index.html Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: : https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid Phone 1-800-457-4584
CALIFORNIA – Medicaid	
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 1-916-445-8322 Email: hipp@dhcs.ca.gov	
COLORADO – Medicaid	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366

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

Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618- 5488 (LaHIPP)	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**

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

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/indexes.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medica l/HIPP-Program.aspx Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
VIRGINIA – Medicaid and CHIP	
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Sentara HealthCare Integrated Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

References to "Sentara," "we," "us," and "our" means the members of the Sentara Healthcare ACE, which is an affiliated covered entity. An affiliated covered entity is a group of organizations under common ownership or control who designate themselves as a single affiliated covered entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The Sentara Healthcare ACE, and its employees and workforce members who are involved in providing and coordinating your health care, are all bound to follow the terms of this Notice. The members of the Sentara Healthcare ACE will share federally protected health information (i.e., your medical information) with each other for treatment, payment, and health care operations as permitted by HIPAA and this Notice. A complete list of the members of the Sentara Healthcare ACE is provided at the end of this Notice.

Our Pledge Regarding Your Protected Health Information

Sentara is committed to safeguarding protected health information about you. We create a record of certain health information related to your health benefit plan administered by certain Sentara entities. We need this information to provide you with quality services and to comply with certain legal requirements.

This Notice applies to all the health information records related to your health benefit plan administered by certain Sentara Health Plans.

We are required by law to:

- Maintain the privacy of your medical information;
- Provide you this Notice describing our legal duties and privacy practices with respect to your medical information;
- Notify you following a breach of your unsecured medical information; and
- Follow the terms of this Notice.

How We May Use and Disclose Protected Health Information About You Without Your Authorization (Permission)

The following sections describe different ways that we may use and disclose your protected health information without your authorization (permission). For each category of uses or disclosures, we will describe them and give some examples. Some medical information, such as certain genetic information, certain drug and alcohol information, HIV information, and mental health information, may be entitled to special restrictions by state and federal laws. We abide by all applicable state and federal laws related to the protection of such medical information. Not every use or disclosure will be listed, but all of the ways we are permitted to

use and disclose protected health information about you will fall within one of the following categories.

Treatment: We may use or disclose medical information about you to provide you with medical treatment and/or coordinate with health care providers on treatment for you.

Health Care Operations: We may use and disclose protected health information about you for our health care operations and for certain health care operations of other providers who furnish care to you. These uses and disclosures are necessary to operate our health plans and to make sure that all of our members receive quality services. We may use and disclose protected health information to provide customer services. For example, we may use protected health information about you to review our services, to evaluate the performance of our staff, and to survey you on your satisfaction with our services. We may review and/or aggregate member information to decide what additional services or benefits our health plans should offer, what services are not needed, and whether certain new services are effective. We may combine the protected health information we have about you with other members' protected health information to compare how we are doing and see where we can make improvements in the services we offer.

Business Associates: We may share your protected health information with certain third parties referred to as "business associates." Business associates provide various services to or for Sentara. Examples include billing services, transcription services, and legal services. We require our business associates to sign an agreement requiring them to protect your protected health information and to use and disclose your protected health information only for the purposes for which we have contracted for their services.

Individuals Involved in Your Care or Payment for Your Care: Unless you tell us not to, we may release protected health information about you to individuals involved in your medical care such as a friend, a family member, or any individual you identify. We also may give your protected health information to someone who helps pay for your care. Additionally, we may disclose protected health information about you to your legal representative, meaning generally, a person who has the authority by law to make healthcare decisions for you. Sentara typically will treat your legal representative the same way as we would treat you with respect to your medical information.

Communications with You: We, or our Business Associates, may contact you via telephone, email, or text message about your treatment, care, or payment related activities. As an example, we may remind you that you have an appointment for medical care and provide information about treatment. We or our Business Associate may also use your protected health information to communicate with you about health-related benefits or services that may be of interest to you, such as available immunizations.

If you provide us with your email address and/or phone number, you acknowledge that we, or our Business Associates, may exchange protected health information with you by email, text, or phone call. These messages may be sent using automated dialing and/or pre-recorded messages. You agree we can communicate with you through these methods via phone calls, emails, text messages, or other means based on the contact information you have on file with

us. You also understand and agree that communication via email and text or are inherently unsecure and that there is no assurance of confidentiality of information communicated in this manner. You agree that you are the user and/or subscriber of the e-mail address and/or phone number provided to us, and you accept full responsibility for e-mails, phone calls, and/or text messages made or sent to or from this e-mail address or phone number. If you prefer not to exchange protected health information via email, text or over the phone, you can choose not to communicate with us via those means by notifying the Privacy Officer (see contact information at the end of this Notice).

As Required or Permitted by Law: We will disclose medical information about you when required to do so by federal and/or state law. This includes sharing information with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Legal Proceedings, Lawsuits and Other Legal Actions: We may disclose protected health information about you to courts, attorneys, court employees, and others when we receive a court order, subpoena, discovery request, warrant, summons, or other lawful instructions. We also may disclose protected health information about you to those working on Sentara's behalf in a lawsuit or action involving Sentara. We may also disclose information for law enforcement purposes as required by law or in response to a valid subpoena, summons, court order, or similar process.

Incidental Disclosures: There are certain disclosures of protected health information that may occur while we are providing service to you or conducting our business. We will make reasonable efforts to limit these incidental disclosures.

Additional Uses and Disclosures of Your Protected Health Information Without Your Authorization (Permission)

We may use and disclose your protected health information in the following special situations:

- **Disaster-Relief Efforts**: We may disclose protected health information about you to an organization assisting in a disaster-relief effort so that your family can be notified about your condition, status, and location. If you do not want us to disclose your protected health information for this purpose, you must tell your caregivers so that we do not disclose this information unless we must do so to respond to the emergency.

- **To Avert a Serious Threat to Health or Safety**: We may use and disclose protected health information about you to help prevent a serious and imminent threat to your health and safety or the health and safety of the public or another person.

- **Military**: If you are a member of the armed forces, domestic (United States) or foreign, we may release protected health information about you to the military authorities as permitted or required by law.

- **Workers' Compensation**: We may disclose protected health information about you for workers' compensation or similar programs as permitted or required by law.

- **Coroners, Medical Examiners and Funeral Directors**: We may disclose protected health information about you to a coroner, medical examiner, or funeral director as necessary for them to carry out their duties.

- **National Security and Intelligence Activities**: We may disclose protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities as permitted or required by law.

- **Protective Services for the President of the United States and Others**: We may disclose protected health information about you to authorized federal officials so they may conduct special investigations or provide protection to the President of the United States, other authorized persons, or foreign heads of state as permitted or required by law.

- **Inmates**: If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release protected health information about you to the correctional institution or law enforcement officials as permitted or required by law.

How We May Use and Disclose Protected Health Information About You Upon Your Written Authorization (Permission)

Marketing: We must obtain your written permission to use or disclose your protected health information for marketing purposes except in certain circumstances. For example, written permission is not required for face-to-face encounters involving marketing, or where we are providing a gift of nominal value (for example, a coffee mug), or a communication about our own services or products (for example, we may send you a postcard announcing the arrival of a new surgeon or x-ray machine).

Sale of Protected Health Information: We must obtain your written permission to disclose your protected health information in exchange for remuneration (payment).

Other Uses and Disclosures of Your Protected Health Information Without Your Authorization (Permission): Other uses and disclosures of your protected health information not covered by the categories included in this Notice or applicable laws, rules, or regulations will be made only with your written permission. If you provide us with such written permission, you may revoke it at any time. We are not able to take back any uses or disclosures that we already made in reliance on your written permission.

Your Rights Regarding Protected Health Information About You

You have the following rights regarding your protected health information:

Right to Inspect and Copy: With certain exceptions, you have the right to inspect and/or receive a copy of the protected health information that is used by us to make decisions about your benefits. The exceptions to this are any psychotherapy notes, information collected for certain legal proceedings, and any protected health information restricted by law.

To inspect and/or receive a copy of your medical information, we require that you submit your request in writing to the Health Plan's Members Services. If you are unsure where to submit your request, please contact the Sentara Health Plans Privacy Officer (contact information below). If you request a copy of your medical information, we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. Your request will be fulfilled in a timely manner not to exceed 30 days.

Under certain circumstances, we may deny your request to inspect or copy your protected health information, such as if we believe it may endanger you or someone else. If you are denied access to your protected health information, you may request that another licensed health care professional review the denial. We will comply with the outcome of the review.

Right to Request Confidential Communications: You have the right to request that we use a certain method to communicate with you about Sentara Health Plan matters or that we send Sentara Health Plan information to you at a certain location if the communication could endanger you. For example, you may ask that we send your information by a specific means, such as by U.S. mail only, or to a specified address. If you want us to communicate with you in a certain way, you will need to give us specific details about how you want to be contacted including a valid alternative address. We will not ask you the reason for the request, and we will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have. We require that you submit your request in writing to the Health Plan's Members Services. If you are unsure where to submit your request, please contact the Sentara Health Plan Privacy Officer (contact information below).

Right to Request an Amendment: If you feel that the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the protected health information. To request an amendment, we require that you submit your request in writing and that you provide the reason for the request. You should direct your request to the Health Plan's Members Services. If you are unsure where to submit your request, please contact the Sentara Health Plans Privacy Officer (contact information below). If we agree to your request, we will amend your record(s) and notify you of such. In certain circumstances, we cannot remove what was in the record(s), but we may add supplemental information to clarify. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to an Accounting of Disclosures: You have a right to make a written request to receive a list of the disclosures we have made of your protected health information in the six years prior to your request. The accounting of disclosures you receive will not include disclosures made for treatment, payment, or healthcare operations activities of Sentara Health Plans. Additionally, it will not include disclosures made to you. To request an accounting of disclosures, we require that you submit your request in writing to the Sentara Health Plans Privacy Officer (contact information below). You must state the time period for which you want to receive the accounting, which may not be longer than six years and which may not date back more than six years from the date of your request. You must indicate whether you wish to receive the list of disclosures electronically or on paper.

The first accounting of disclosures you receive in a 12-month period will be free. We may charge you for responding to additional requests in that same period. We will inform you of the costs involved before any costs are incurred. You may choose to withdraw or modify your request at that time.

Right to Request Restrictions: You have the right to request a restriction, or limitation, on the protected health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request. If we agree to your request, we will comply with your request unless the protected health information is needed to provide you with emergency treatment, or we are required by law to not disclose it.

To request a restriction, you must make your request in writing to the Sentara Health Plans Privacy Officer (contact information provided below) and 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 (for example, disclosures to your spouse). We are allowed to end the restriction by providing you notice. If we end the restriction, it will only affect the medical information that was created or received after we notify you.

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. Copies of this Notice are available by contacting the Sentara Health Plans Privacy Officer (contact information below). This notice is posted on our website and can be downloaded at: sentarahealthplans.com.

Right to Receive Notification of a Breach: You have the right to receive written notification of any breach of your unsecured protected health information.

Changes to This Notice: We reserve the right to change this Notice from time to time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any medical information we receive about you in the future. We will post a copy of the current notice on the Sentara Health Plans website at sentarahealthplans.com and provide the revised notice, or information about the material change and how to obtain the revised notice in our next annual mailing to members then covered by the plan. Please review the Notice from time to time to ensure you are familiar with our HIPAA privacy practices.

Questions, Requests, or Complaints: If you have questions or believe that your privacy rights have been violated, you may file a complaint with Sentara Health Plans or with the Secretary of the Department of Health and Human Services. To file a complaint with Sentara Health Plans, contact the Sentara Health Plans Privacy Officer. ***You will not be penalized or retaliated against for filing a complaint.***

Sentara Health Plans
Attn: Privacy Officer
1300 Sentara Park
Virginia Beach, VA 23464

757-552-7485
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Sentara HealthCare Integrated Notice of Privacy Practices

This Notice is effective 01/01/2022 and replaces all earlier versions.

Sentara HealthCare Integrated Notice of Privacy Practices

APPENDIX A

AFFILIATES

This Notice of Privacy Practices covers an Affiliated Covered Entity or "ACE". When this Notice refers to the Sentara Healthcare ACE, it is referring to Sentara Healthcare and each of the following subsidiaries and affiliates:

Sentara Health Insurance Company
Sentara Health Plan
Sentara Health Plans, Inc.
Sentara Behavioral Health Services, Inc.
Sentara Health Group, Inc.
Virginia Premier Health Plan, Inc.

Notice of Protection Provided By Virginia Life, Accident and Sickness Insurance Guaranty Association

This notice provides **a brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 In cash surrender and withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 In other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts. is $350,000, except for health benefit plans, for which the limit is Increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance

Notice of Protection Provided By Virginia Life, Accident and Sickness Insurance Guaranty Association

P.0. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945 http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia

Notice of Insurance Information Practices And Financial Information Practices

Our Privacy Policy

The Plan takes our responsibility to protect the privacy and confidentiality of Your Personal, Privileged, Medical Record, and Financial information very seriously. Our commitment to protecting Your privacy is not new. We have specific policies in place to safeguard information about You and Your family.

We are providing this notice to You to help You understand how we may collect information about You, the type of information that may be collected, and what information may be disclosed about You to the Plan's affiliates and to non-affiliated third parties.

What We Mean By Personal, Privileged, Medical Record, And Financial Information

"Personal Information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical-record information, but does not include (i) privileged information or (ii) any information that is publicly available.

"Privileged Information " means any individually identifiable information that (i) relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual, and (ii) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual.

"Medical-record Information " means personal information that:

1. Relates to an individual's physical or mental condition, medical history, or medical treatment; and
2. Is obtained from a medical professional or medical-care institution, from the individual or from the individual's spouse, parent, or legal guardian.

"Financial Information" means personal information other than medical record information or records of payment for the provision of health care to an individual.

How We Protect Your Information

We treat Your information in a confidential manner. We restrict access to nonpublic personal and financial information about You to those employees and other persons hired by us who need to know the information to provide services to You. Our employees are required to protect the confidentiality of Your information. We maintain physical, electronic and procedural safeguards that comply with applicable laws and regulations to store and secure information about You from unauthorized access, alteration and destruction.

We may enter into agreements with other companies to provide services to us to make services available to You. Under these agreements, the companies must safeguard

information about You and they may not use it for purposes other than helping us to improve our service to You.

Why We Collect Information About You

Your Plan needs to know general information about You, such as Your name and the names of Your dependents, Your address, Your age, Your marital status, and other more specific medical information for business purposes, including, but not limited to, processing claims, evaluating eligibility for covered services, administering health benefit plans, educational programs, disease management programs, and other transactions related to Your health care services.

We may collect and use certain financial information about You such as name, birth date, mailing address, employment, social security number, marital status, and checking account information. We need this type of information to administer Your health benefits, process claims and/or premium payments and collections, market products, and/or as part of our enrollment process.

We get most of this information directly from You on Your Application or other forms. When You completed and signed Your Application for coverage, You authorized Your physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of Your health or Your dependents' health to give to the Plan any such personal medical information for the purpose of underwriting and claims payment.

We may also receive information about You from Your employer, from Your or Your employer's insurance broker, or, if You receive insurance coverage through a governmental program, from local, state or federal agencies or their representatives. In some instances, we may receive coverage information about You from another insurance carrier with which You have insurance (this is done to coordinate payment of Your medical bills.)

Medical Record information and financial information about You in our files is private. We will not give this data or privileged or personal information about You collected or received in connection with an insurance transaction unless You have provided written authorization or as permitted by law.

How We Disclose Personal, Privileged, Medical And Financial Information

To administer Your health coverage we may need to disclose information about You. According to law we may disclose information about an individual collected or received in connection with an insurance transaction, without written authorization, if the disclosure is:

1. To insurers, agents, or insurance support organizations. Data must be reasonably needed for them or us: (a) to detect or prevent a crime, fraud or material misrepresentation or nondisclosure; or (b) to perform our or their function relating to Your insurance such as determining an individual's eligibility for benefits or payment of claims.

2. To a medical care institution or medical professional for the purpose of: (a) verifying insurance coverage or benefits; or (b) informing You of a medical problem of which You may not be aware; or (c) conducting an operations or services audit.
3. To a state or federal insurance regulatory authority.
4. To a law enforcement authority or other government authority to prevent or prosecute fraud or other unlawful activities.
5. In response to facially valid administrative or judicial order, including a search warrant or subpoena.
6. To those engaged in actuarial or research studies, provided: (a) no names will be used in their report; (b) all data is destroyed or returned to us after use; and (c) no data will be disclosed unless it is authorized by law.
7. To a nonaffiliated third party whose only use of such information will be in connection with the marketing of a nonfinancial product or service, provided: (a) no medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from the information is disclosed (b) the individual has been given the opportunity to indicate that he or she does not want financial information disclosed for marketing purposes and has given no indication that he does not want the information disclosed and (c) the nonaffiliated third party receiving the information agrees not to use it except in connection with the marketing of the product or service.
8. To a group policyholder for reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit.
9. To a government authority in order to determine eligibility for health benefits for which it may be liable.
10. To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction.
11. Pursuant to any federal Health Insurance Portability and Accountability Act privacy rules promulgated by the United States Department of Health and Human Services.
12. To others as permitted or required by law.

Your Right Of Access To Information

1. You have the right to request access to data about You in our files. Your request must: (a) be sent to us or our agent; (b) be in writing; (c) clearly describe the data You want; (d) clearly describe the purpose for which You want the data; and (e) be for data which we or our agent can reasonably locate and retrieve.
2. We will respond to Your request within 30 business days from the date Your request is received. Our response will: (a) inform You of the nature and substance of the recorded personal information in writing, by telephone, or by other oral communication; (b) permit You the right to see and copy, in person, the recorded personal information pertaining to You or to obtain a copy of the recorded personal information by mail, whichever You prefer, unless the recorded personal information is in coded form, in which case an accurate translation in plain language will be provided in writing; and (c) disclose the identity, if recorded, of those persons to whom we have disclosed the personal information within two years prior to the request, and if the identity is not recorded, the names of those insurance institutions, agents, insurance-support organizations or other persons to whom

such information is normally disclosed; (d) give You the rights, as described below, regarding correction, amendment, or deletion of recorded personal information.

3. Medical Record Information supplied by a medical care institution or medical professional and requested by You, together with the identity of the medical professional or medical care institution that provided the information, will be provided to the medical professional designated by You and licensed to provide medical care with respect to the condition to which the information relates. We will notify You, at the time of disclosure, that we have provided the information to the medical professional.
4. We may charge a reasonable fee for providing copies of data in our files.

Your Rights Regarding Correction, Amendment Or Deletion Of Information

1. If You feel data about You in our files is wrong, you can request correction, amendment or deletion. You must make Your request in writing.
2. We will have 30 business days from receipt of Your request to respond. Our response will either: (a) confirm that we have made the changes You asked for; or (b) inform You of our refusal to change our records.
3. If we correct, amend or delete recorded personal information about You we will notify You in writing and furnish the corrections, amendment, or fact of deletion to: (a) any person specifically designated by You who, within the preceding two years, may have received the recorded personal information; (b) any insurance-support organization whose primary source of personal information is insurance institutions if the insurance-support organization has systematically received the recorded personal information from the insurance institution within the preceding seven years. The correction, amendment, or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and (c) any insurance-support organization that furnished the personal information that has been corrected, amended or deleted.
4. If we refuse to change our records, You can send us a written statement for our files. In it, You can state: (a) what You think is the correct, relevant or fair information; and/or (b) why You disagree with our refusal. If You send us such a statement, we will (a) keep it with Your file so that it will be seen by

any-one reviewing the file; (b) include it with any data sent to others about You; and (c) send it to anyone described in subsection 3, above.

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

Whom You Should Contact If You Have Additional Questions About This Notice

If You have any questions or comments concerning this Privacy Statement, please contact us by mail at:

Sentara Member Services
1300 Sentara Park
Virginia Beach, VA 23464

Balance Billing Protection

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services at the same facility that you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network facility

When you get services from an in-network facility, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, laboratory, surgeon and assistant surgeon services, and professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers **can't** balance bill you and **can't** ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

Balance Billing Protection

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you believe you've been wrongly billed, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**.

Visit cms.gov/no surprises for more information about your rights under federal law.

Consumers covered under (i) a fully insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance- Billing-Protection for more information about your rights under Virginia law.

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