

Optima Foursight 30/750-B Individual PPO Plan Summary of Benefits

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the Plan Evidence of Coverage or Certificate of Insurance, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions.

It is the Member's responsibility to determine, based on his/her choice of providers, if this health care coverage is under the In-Network level or under the Out-of-Network level of benefits and to be familiar with his/her Coverage. Covered Services received from Non-Plan Providers, including but not limited to Physicians, facilities, and laboratories will be covered under Out-of-network benefits. It is the Member's responsibility to make sure the Pre-Authorization process is initiated and completed for those benefits requiring Pre-Authorization, regardless of the coverage chosen.

The following pages provide an overview of Copayments or Coinsurances you will be responsible for when using your Coverage.

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|--|--|
| Maximum Benefit | \$3,000,000 Combined In- and Out-of-Network | |
| Deductibles Per Calendar Year² | \$750 per Member \$1,500 per Family | \$1,500 per Member \$3,000 per Family |
| Maximum Out-of-Pocket Amount Per Calendar Year | \$2,250 per Member ³ \$4,500 per Family ³ | \$4,500 per Member ⁴ \$8,000 per Family ⁴ |

PHYSICIAN OFFICE VISITS

Includes office consult only.

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|--|---|
| Visits 1-4 per Member per Calendar year Copayment applies to first 4 visits per Member per calendar year received in or out of network. The Plan's Deductible does not apply. | \$30 Copayment then Covered at 100% ⁸ | \$30 Copayment then Covered at 50% ^{AC} |
| All visits after the first four per Member per Calendar year Copayment and Coinsurance apply to all visits after the first 4 visits per Member per calendar year received in or out of network. | \$30 Copayment then Covered at 80% ⁸ after Deductible | \$30 Copayment then Covered at 50% ^{AC} after Deductible |

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|---|--|
| Routine Annual Physical Exams Child Health Exams Annual Gyn Exams and Pap Smears PSA Tests Colorectal Cancer Tests Routine Immunizations Colonoscopy Mammograms The Plan's Deductible does not apply to the first \$250 per Member per calendar year of covered services received in or out-of-network. | Covered at 100% ⁸ up to a combined maximum with Out-of-Network benefits of \$250 per Member per calendar year. All services after the first \$250 covered at 80% ⁸ after deductible. | Covered at 100% ⁸ up to a combined maximum with In-Network benefits of \$250 per Member per calendar year. All services after the first \$250 covered at 50% ^{AC} after deductible. |
| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
| Childhood immunizations For each covered dependent child from birth to thirty-six months of age, diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, and rubella. The Plan's Deductible does not apply to services received in or out-of-network. | \$30 Copayment then Covered at 100% ⁸ | Covered at 50% ^{AC} |
| OUTPATIENT THERAPY, REHABILITATION AND DIALYSIS SERVICES^{5,6} | | |
| Coinsurance applies to services provided in a free-standing outpatient facility, hospital outpatient facility, or in the physician's office. | | |
| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
| Outpatient Physical, Occupational, and Speech Therapy Services Maximum combined benefit for services received in or out-of-network of \$1,000 per Member per calendar year. ⁶ | Covered at 80% ⁸ after deductible. | Covered at 50% ^{AC} after deductible |
| Outpatient Rehabilitation Services Includes cardiac, pulmonary, vascular, and other rehabilitation services authorized by the Plan. Maximum combined benefit for services received in or out-of-network of \$1,000 per Member per calendar year. ⁶ | Covered at 80% ⁸ after deductible. | Covered at 50% ^{AC} after deductible |
| Outpatient Chemotherapy, Radiation Therapy, IV Therapy, and Inhalation Therapy Pre-Authorization is required for IV Therapy with medications and inhalation therapy. | Covered at 80% ⁸ after deductible. | Covered at 50% ^{AC} after deductible |
| Outpatient Dialysis Services | Covered at 80% ⁸ after deductible. | Covered at 50% ^{AC} after deductible |

OUTPATIENT SURGERY⁵

Coinsurance applies to services provided in a freestanding ambulatory surgery center or Hospital outpatient surgical facility.

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|--|---|---|
| Outpatient Surgery Pre-Authorization is required. | Covered at 80% ⁸ after deductible. | Covered at 50% ^{AC} after deductible |

OUTPATIENT DIAGNOSTIC SERVICES⁵

Includes lab work, X-ray, and other diagnostic services; Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET) Scans, Computerized Axial Tomography (CT) Scans and Computerized Axial Tomography Angiogram (CTA) Scans. Coinsurance applies to services provided in a physician's office, freestanding ambulatory surgery center or Hospital outpatient surgical facility.

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|--|--|--|
| Outpatient Diagnostic Services Pre-Authorization is required for diagnostic procedures, and MRI, MRA, PET, CT, and CTA scans.⁵ | Covered at 100% ⁸ up to \$500 maximum, combined benefit with Out-of-Network, per Member per calendar year for services done in the physician's office, urgent care center, outpatient department of the hospital or other outpatient facility. All services after \$500 maximum covered at 80% ⁸ after deductible | Covered at 100% ⁸ up to \$500 maximum, combined benefit with In-Network, per Member per calendar year for services done in the physician's office, urgent care center, outpatient department of the hospital or other outpatient facility. All services after \$500 maximum covered at 50% ^{AC} after deductible. |

INPATIENT SERVICES^{5,6}

Includes Inpatient hospital services and Skilled Nursing Facility services following inpatient hospital care or in lieu of hospital care. Skilled Nursing Facility coverage is limited to a maximum combined benefit for services received in or out of network benefits of 60 days per illness or condition per calendar year.^{4,6} Transplants are covered at contracted facilities only, and are limited to transplants of the cornea, kidney, and dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for the treatment of breast cancer.

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|---|---|
| Inpatient Services Pre-Authorization is required.⁵ | Covered at 80% ⁸ after deductible. | Covered at 50% ^{AC} after deductible |
| Skilled Nursing Facilities/Services Pre-Authorization is required.⁵ | Covered at 80% ⁸ after deductible | Covered at 50% ^{AC} after deductible |

AMBULANCE SERVICES⁹

For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan.

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|---|---|
| <p>Ambulance Services</p> <p>Pre-Authorization is required for use other than for emergency services.</p> <p>Maximum combined benefit for services received in or out-of-network of \$1,000 per Member per calendar year.⁶</p> | Covered at 80% ⁸ after deductible. | Covered at 50% ^{AC} after deductible |

EMERGENCY ROOM SERVICES⁹

Includes those emergency room facility, physician, and ancillary services that are rendered during an emergency room visit. If the Member requires inpatient hospital admission the Member will be responsible for the applicable inpatient hospital admission Coinsurance.

| | | |
|--|--|---|
| <p>Emergency Room Services</p> <p>A referral is <u>not</u> required.</p> <p>Pre-Authorization is <u>not</u> required.</p> | Covered at 80% ⁸ after deductible | Covered at 50% ^{AC} after deductible |
|--|--|---|

URGENT CARE CENTER SERVICES⁹

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|--|---|---|
| <p>Urgent Care Center Services</p> <p>A referral is <u>not</u> required.</p> <p>Pre-Authorization is <u>not</u> required.</p> <p>Includes urgent care center services, physician services, and other ancillary services received at an Urgent Care center.</p> <p>If you are transferred to an emergency room from an urgent care center, you will be responsible for any applicable emergency room Copayment or Coinsurance.</p> | Covered at 80% ⁸ after deductible. | Covered at 50% ^{AC} after deductible |

MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES

Administered by Sentara Behavioral Health Services. **Pre-Authorization by Sentara Behavioral Health Services is required.**

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|---|--|
| <p>Inpatient Services^{5, 6, 7}</p> <p>Maximum combined benefit for services received in or out of network of 20 days per adult age 19 and above per calendar year.</p> <p>Maximum combined benefit for services received in or out of network of 25 days per child or adolescent under age 19 per calendar year</p> <p>For services received in or out of network up to ten (10) inpatient days may be converted to a partial hospitalization benefit at the exchange of 1.5 days of partial hospitalization coverage for each inpatient day.⁶</p> | <p>Covered at 80%⁸ after deductible.</p> | <p>Covered at 50%^{AC} after deductible</p> |
| <p>Outpatient Services</p> <p>Maximum combined benefit for services received in or out of network of 20 visits per adult, child or adolescent per calendar year.⁶</p> | <p>\$30 Copayment then Covered at 100%⁸ per outpatient visit for visits 1-5;</p> <p>Visits 6-20 Covered at 50%⁸ after deductible.</p> | <p>\$30 Copayment then Covered at 50%^{AC} per outpatient visit for visits 1-5;</p> <p>Visits 6-20 Covered at 50%^{AC} after deductible.</p> |

EARLY INTERVENTION SERVICES

Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for covered Dependent children from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|--|---|--|
| <p>Early Intervention Services</p> <p>Coverage is limited to a maximum combined benefit for services received in or out of network of \$5,000 per Member per calendar year.⁶</p> | <p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.</p> | <p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service</p> |

HOSPICE SERVICES

Hospice services include a coordinated program of home and inpatient care provided directly or under the direction of a licensed hospice; and will include palliative and supportive physical, psychological, psychosocial and other health services to Members with a terminal illness.

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|---|---|
| <p>Hospice Care</p> <p>Pre-Authorization is required.⁵</p> | <p>Covered at 80%⁸ after deductible.</p> | <p>Covered at 50%^{AC} after deductible</p> |

DURABLE MEDICAL EQUIPMENT

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|---|---|
| <p>Durable Medical Equipment ^{5, 6}</p> <p>Pre-Authorization required for single items over \$250.</p> <p>Pre-Authorization required for all rental items.</p> <p>Covered Services also include colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters.</p> <p>Coverage is limited to a maximum combined benefit for services received in or out of network of \$1,000 per Member per calendar year.</p> <p>Repair and Replacement</p> <p>Pre-Authorization is required.⁵</p> <p>Repair and replacement is limited to a maximum combined benefit for services received in or out of network of \$500 per Member per calendar year. ⁶</p> | <p>Covered at 80%⁸ after deductible.</p> | <p>Covered at 50%^{AC} after deductible</p> |

DIABETIC SUPPLIES AND EQUIPMENT

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|--|--|
| <p>Diabetic Supplies and Equipment</p> <p>Includes FDA-approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy.</p> <p>Note: Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment per 31-day supply.</p> | <p>Covered at 80%⁸ after deductible for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets.</p> <p>Covered at 80%⁸ after deductible for insulin pumps.</p> <p>Covered at 80%⁸ after deductible for outpatient self-management training and education, including medical nutritional therapy.</p> | <p>Covered at 50%^{AC} after deductible for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets.</p> <p>Covered at 50%^{AC} after deductible after deductible for insulin pumps.</p> <p>Covered at 50%^{AC} after deductible for outpatient self-management training and education, including medical nutritional therapy.</p> |

PREVENTIVE VISION SERVICES

Vision Services are administered by EyeMed Vision Services.

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|--|---|
| <p>Preventive Vision Services</p> <p>Covered Services include one examination every 24 months</p> <p>Not subject to the Plan's Deductible.</p> | <p>\$25 Copayment per eye examination performed by a Participating EyeMed provider.</p> <p>Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost</p> | <p>\$30 reimbursement for exam only</p> |

ALLERGY CARE AND SERVICES

| | <i>In-Network Coverage</i> | <i>Out-of-Network Coverage</i> |
|---|---|---|
| <p>Allergy Care</p> <p>Cover services include allergy testing, injections, and serum.</p> <p>Coverage is limited to a combined maximum benefit for services received in or out of network of \$250 per Member per calendar year.⁶</p> | <p>Covered at 80%⁸ after deductible.</p> | <p>Covered at 50%^{AC} after deductible</p> |

NOTES

The Covered Services herein are subject to the terms and conditions set forth in the Optima Health Individual Coverage Policy form number OHIC.IND.POLICY.09

1. Maximum benefits payable under the Plan.
 2. 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. Any part of the calendar year deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year. The Deductible does not apply to Physician office visits and the Member is required to pay applicable office visit Copayment only. Amounts applied to an in-network deductible will apply toward the Plan's in-network out of pocket maximum amount. Amounts applied to an out-of-network deductible will apply toward the Plan's out of network out of pocket maximum amount.
 3. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered In-Network Services. The In-Network Deductible will apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for outpatient mental health care, vision care, outpatient prescription drugs, or amounts which a covered person is required to pay for to failure to comply with the Plan's Pre-Authorization and Referral procedures do not count toward the In-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The Out-Of-Network Deductible does not apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for Out-Of-Network Covered Services do not count toward the In-Network Out-Of-Pocket Maximum.
 4. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered Out-of-Network Services. The Out-Of-Network Deductible will apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for outpatient mental health care, vision care, outpatient prescription drugs, amounts which a covered person is required to pay for failure to comply with the Plan's Pre-Authorization and Referral procedures, or amounts which are in excess of the Plan's Allowable Charge do not count toward the Out-Of-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The In-Network Deductible does not apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for In-Network Covered Services do not count toward the Out-Of-Network Out-Of-Pocket Maximum.
 5. Pre-Authorization is required. A Member's benefits under the policy will be reduced, after any deductible amount, if he/she does not comply with the Plan's referral and pre-authorization procedures. Details concerning the Plan's referral and pre-authorization procedures, including possible benefit reductions for not following the requirements, are provided under Section III in the Certificate of Insurance.
 6. Maximum amounts are combined maximums of both In-Network and Out-Of Network Covered Services unless otherwise indicated. Amounts in excess of a benefit dollar limit and/or visit limit as stated in the Schedule of Benefits or added by a Plan rider are excluded from Coverage.
 7. Mental Health and Substance Abuse services are provided through Sentara Behavioral Health Services, and all Mental Health pre-authorization services are administered by Sentara Behavioral Health Services.
 8. Benefits are payable at the percent specified of the Plan's fee schedule.
 9. All Emergency, Urgent Care, Ambulance and Emergency Mental Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an emergency, the benefit will be reduced as specified on the Schedule of Benefits. Members who receive Emergency services from Non-Plan Providers may be responsible for charges in excess of what would have been paid had the emergency care been received from Plan Providers. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the member received care from a Plan Provider.
- AC Benefits for Covered Services performed by any provider who is not a Plan Provider will be based on either a negotiated or agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the Plan's in-network fee schedule for the same service performed by the same type of provider. The Member will be responsible for payment of all charges in excess of the Plan's allowable charge in addition to any copayment and coinsurance amounts he/she is required to pay. Charges from non-Plan providers will generally exceed the Plan's allowable charge.

Optima Individual Product Foursight B Prescription Drug Rider

Your policy covers outpatient prescription drugs. Costs for this rider are included in your monthly premium payments for your policy.

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

Tier Definitions

- **Tier 1 - Select Generic Drugs include:** The majority of commonly prescribed and widely available generic drugs.
- **Tier 2 - Standard Generics Drugs include:** Newly FDA-approved generic drugs and those generic drugs with significantly higher costs than the average Select Generic (Tier 1) drugs.
- **Tier 3 - Select Brand Drugs include:** Select brand name drugs that do not have a generic equivalent or a generic alternative to treat life-threatening chronic illnesses.

Your Maximum Benefit

Maximum Benefit of \$5,000 per Covered Person per calendar year. The maximum benefit does not apply to Physician prescribed diabetic supplies covered under the prescription drug benefit.

Your Deductible, Copayments and Coinsurances

Deductible: \$250 per Covered Person per calendar year.

For a single Copayment or Coinsurance charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug at a retail pharmacy.

- After Deductible \$15.00 Copayment Tier 1 prescription drugs
- After Deductible \$30.00 Copayment or 40% * Coinsurance, whichever is greater for Tier 2 prescription drugs
- After Deductible \$50.00 Copayment or 50% * Coinsurance, whichever is greater for Tier 3 prescription drugs.

*Benefits are payable at the percent specified of the Plan's fee schedule

Optima Individual Product Foursight B Prescription Drug Rider

Some drugs are covered only at a generic level. If you or your doctor asks for a brand-name or a higher costing generic you must pay the difference between the cost of that drug and the generic drug plus the Copayment charge.

All drugs must be approved by the U.S Food and Drug Administration.

Optima may limit the amount of some drugs you receive.

All drugs require a prescription by state or federal law.

All compounded prescriptions require prior authorization. They must contain at least one prescription ingredient.

Some drugs require your doctor to get Pre-Authorization from the Plan before you receive them.

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.

Prescription contraceptive drugs and devices are covered. Depo-Provera and Lunelle injections, Intrauterine devices (IUDs), and cervical caps and insertion are covered under medical benefits.

Some over the counter drugs may be covered. You must have a doctor's prescription for the drug. The drug must be listed on the formulary.

Prescription Drug Rider Exclusions.

The following are not covered under this Rider:

1. Disposable medical supplies such as bandages, cotton swabs, hypodermic needles are not covered. Durable medical equipment not listed as covered are excluded from Coverage.
2. Diabetic supplies and equipment, in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes not listed as covered under this rider are covered under Your medical benefit.
3. Appetite suppressants and any other drugs for weight loss are not covered.
4. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are not covered.
5. Immunization agents, biological sera, blood or blood products are not covered.
6. Infertility drugs are not covered.
7. Injectables (other than those self-administered and insulin) are not covered.
8. Medication taken or administered in the Doctor's office is not covered.
9. Medication taken or administered in a licensed Hospital, rest home, sanatorium, extended care facility, convalescent Hospital, nursing home, or similar institution is not covered .
10. Investigational or experimental drugs are not covered.
11. Drugs for cosmetic purposes only, such as Retin-A for aging, are not covered.

Optima Individual Product Foursight B Prescription Drug Rider

12. Medications for smoking cessation such as Nicorette gum, nicotine patches, nicotine spray are not covered.
13. Medications for experimental indications are not covered. Dosage regimens determined by the Plan to be experimental are not covered.
14. Medications with no approved FDA indications are not covered.
15. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law are not covered. OTC medications are not covered unless they are listed on the Plan's Preferred or Standard drug list.
16. Replacement prescriptions from loss, theft or breakage are not covered.
17. Therapeutic devices or appliances, such as support stockings and other medical/non-medical items or substances, regardless of their intended use are not covered.
18. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are not covered.
19. Any prescription drugs, over the counter drugs, or devices that are not included on the Formulary are not covered.

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

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

OPTIMA HEALTH INSURANCE COMPANY

Individual Policy Exclusions and Limitations

The following is a general list of services, supplies, equipment and benefits that are limited in or excluded from Coverage under Optima Health Individual Plan policies. Once enrolled Optima Members should always refer to their individual coverage policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the member's policy will govern.

PRE-EXISTING CONDITIONS

A Pre-existing Condition means a condition that, during the 12 month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received within 12 months immediately preceding the effective date of coverage. Benefits for pre-existing conditions are not payable until the covered person's coverage has been in force for 12 consecutive months with Optima Health unless the member can demonstrate prior creditable coverage.

A

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

Acupuncture - is excluded from Coverage.

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

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

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

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

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

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

Aromatherapy - is excluded from Coverage.

Artificial Limbs – are excluded from Coverage.

Autopsies - are excluded from Coverage.

B

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

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

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

Underwritten by Optima Health Insurance Company

OPTIMA HEALTH INSURANCE COMPANY

Individual Policy Exclusions and Limitations

Blood and Blood Products – except as listed as covered under the Plan's benefits for Hemophilia and Congenital Bleeding Disorders in Section 8 are excluded from Coverage. The cost of securing the services of blood donors are excluded from Coverage. The cost of transportation and storage of blood if used in or outside the Plan's Service Area is excluded from Coverage.

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

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

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

Breast Ductal Lavage - is excluded from Coverage.

C

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

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

Cold Therapy Machine - is excluded from Coverage.

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

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

- Any cosmetic surgery and any hospital, physician, or other health service related thereto, except to the extent Medically Necessary to restore function.
- Treatment or services resulting from complications due to cosmetic and/or experimental procedures.
- Breast Augmentation/ /Mastopexy procedures requested for the purpose of correction of cosmetic physical imperfections, except as required by State or Federal law regarding breast reconstruction and symmetry following mastectomy.
- Tattoo removal.
- Keloid treatment as a result of the piercing of any body part.
- Consultations and/or office visits for the purpose of obtaining cosmetic and/or experimental procedures.
- Penile Implants.
- Vitaligo

Covered Services by Another Payor - the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws, are excluded from Coverage. Should a Member have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of covered services in those cases where the Member received services in accordance with the Plan's referral procedures. The Plan will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

Crime/Illegal Occupation - Expenses incurred for an illness or injury suffered in connection with the commitment of or intent to commit a felony.

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

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Individual Policy Exclusions and Limitations

D

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

1. **Dentistry**

- Restorative services and supplies necessary to repair or replace sound natural teeth even if loss is due to an injury or accident excluded from Coverage.
- Services to restore appearance or for cosmetic purposes are excluded from Coverage.
- Dental implants and any preparation work for implants or dentures are excluded from Coverage.
- Dental services performed in a hospital or any outpatient facility except as described in the Member's Covered Services under "Hospitalization and Anesthesia for Dental procedures" are excluded from Coverage.

2. **Oral Surgery**

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

3. **Dental Care**

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

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

Driver Training - is excluded from Coverage.

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

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

E

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

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

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

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

- The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or

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

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

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

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

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

F

Food Allergy Testing - is excluded from Coverage.

Foot Care -

- Routine foot care such as the removal of corns or calluses and the trimming of nails is excluded from Coverage, except for an operation which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions, or as approved by the Plan for Members with diabetes.
- Treatment and services related to flat-feet, fallen arches, routine bunionectomy or chronic foot strain are excluded from Coverage.
- Foot Orthotics - of any kind are excluded from Coverage, including but not limited to, customized or non-customized shoes, boots, and inserts.

G

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

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

Growth Hormones - are covered only under the Plan's Outpatient Prescription Drug Rider.

H

Hearing Aids - are excluded from Coverage, including but not limited to, fittings, molds and/or supplies, such as batteries.

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

Home Births – are excluded from Coverage.

Home Health - Home Health Care Services are excluded from Coverage.

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Individual Policy Exclusions and Limitations

Hypnotherapy - is excluded from Coverage.

I

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

Illegal Occupation/Crime - Expenses incurred for an illness or injury suffered in connection with the commitment of or intent to commit a felony.

Immunizations –

- Immunizations for foreign travel and/or employment are excluded from Coverage.
- Immunizations not specifically listed as covered are excluded from Coverage.

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

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

- In-Vitro Fertilization programs, Artificial insemination or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- GIFT programs;
- Reproductive material storage;
- Treatment related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage, or sperm washing;
- Infertility Services needed due to a reversal of sterilization;
- Services to reverse voluntary sterilization;
- Semen analysis;
- Sims-Huhner test (smear);
- Drugs used to treat infertility.

Influenza Vaccines - Preservative free influenza vaccines and flu-mist vaccines are excluded from Coverage unless authorized by the Plan.

Intoxicants and Narcotics - The Plan is not liable for any loss resulting from the insured being drunk, or under the influence of any narcotic unless taken on the advice of a physician.

J

K

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

L

Laboratory Services - Laboratory services received from Non-Plan Providers or laboratories are covered under out-of-network benefits only.

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

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Individual Policy Exclusions and Limitations

M

Magnetic Resonance Spectroscopy - is excluded from Coverage.

Massage Therapy - is excluded from Coverage.

Maternity Services -

- Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post-partum care is excluded from Coverage unless covered under a Rider.
- Home Births are excluded from Coverage.

Maximum Benefit - Amounts in excess of a benefit limit as stated in the Schedule of Benefits of this Certificate of Insurance are excluded from Coverage.

Medically Necessary Treatments - Any services, supplies, treatments or procedures not specifically listed as a Covered Service and any other services, supplies, or treatments or procedures determined not to be Medically Necessary are excluded from Coverage.

Medical Equipment and Supplies -

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

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

Mental Health and Substance Abuse Services - The following mental health and substance abuse services are excluded from Coverage:

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

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

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

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N

Narcotics and Intoxicants - The Plan is not liable for any loss resulting from the insured being drunk, or under the influence of any narcotic unless taken on the advice of a physician.

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

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

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

O

Obstetrical Care -

- Home births are excluded from Coverage.
- Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post-partum is excluded from Coverage unless covered under a Rider.

Oral Surgery

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

Orthopedic Devices— are excluded from Coverage.

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

Out Of Network Medical and Laboratory Services - any services other than Emergency Services received from Non-Plan Providers, whether referred or directed by a Plan Provider, will be processed under the Plan's out of network benefit unless Pre-authorized by the Plan.

P

Penile implants - are excluded from Coverage.

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

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

Physician Examinations -

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

OPTIMA HEALTH INSURANCE COMPANY

Individual Policy Exclusions and Limitations

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

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

Private Duty Nursing - is excluded from Coverage.

Prosthetic Appliances or Devices are excluded from Coverage.

Q

R

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

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

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

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

S

Saliva Tests - are excluded from Coverage.

Second Opinions – A second opinion is covered when authorized by the Plan.

Services – the following services are excluded from Coverage:

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

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

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

Spinal Manipulation – is excluded from Coverage. Spinal manipulation means the detection, treatment, and correction of structural imbalance, sUBLUXATION or misalignment of the vertebral column in the human body, for the purpose of alleviating pressure on the spinal nerves and its associated effects related to such structural imbalance, misalignment or distortion, by physical or mechanical means.

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Individual Policy Exclusions and Limitations

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

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

T

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

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

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

- Services received outside the Plan's Service Area unless Pre-authorized by the Plan;
- Services received from Non-Plan Providers unless Pre-authorized by the Plan;
- Services and supplies associated with screenings, searches and registries;
- Organ and tissue transplants that are considered experimental or investigative are excluded from Coverage;
- Organ and tissue transplants that are not medically necessary are excluded from Coverage.

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

Tubal Ligation – is excluded from Coverage.

U

Urea Breath Testing - is excluded from Coverage unless approved by the Plan.

V

Vaccines – Influenza preservative free and flu-mist vaccines are excluded from Coverage unless authorized by the Plan.

Vasectomy - is excluded from Coverage.

Virtual Colonoscopy - is excluded from Coverage.

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Individual Policy Exclusions and Limitations

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

W

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

Wisdom Teeth - extraction of wisdom teeth are excluded from Coverage.

X

Y

Z

Optima Health individual ppo policy form numbers:

**OHIC.IND.POLICY.08; OHIC.Ind.RX.08; OHIC.IND.FOUR.08; OHIC.INDHSA.PPO.08;
OHIC.IND.CHILD.08; OHIC.IND.RX.07; OHIC.INDCHOICE.PPO.08. OHIC.MO.07;OHIC.IFOURB.09;
OHIC.IPLUSB.09;OHIC.IPLUSB.RX.09; OHIC.IFOURBRX.09; OHIC.IPLUSB.MAT.09**

Optima Health enrollment applications: OHC.INDAPP.08;OHIC.1881.08