



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [optimahealth.com](http://optimahealth.com) or call 1-866-514-5916. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the glossary at [healthcare.gov/sbc-glossary/](http://healthcare.gov/sbc-glossary/) or call 1-866-514-5916 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	\$6,500/Individual or \$13,000/family In- <a href="#">Network</a>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Most <a href="#">preventive care</a> services and <a href="#">screenings</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For In- <a href="#">Network</a> \$7,900 person / \$15,800 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , balance-billed charges, and healthcare this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.optimahealth.com">www.optimahealth.com</a> or call 1-866-514-5916.	You pay the least if you use a <a href="#">provider</a> in Tier 1. You pay more if you use a <a href="#">provider</a> in Tier 2. You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do I need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$35 <a href="#">Copayment</a> Tier 1 visits 1-3; <a href="#">deductible</a> does not apply 40% <a href="#">Coinsurance</a> Tier 1 visits after 3 \$70 <a href="#">Copayment</a> visits 1-3; <a href="#">deductible</a> does not apply 50% <a href="#">Coinsurance</a> visits after 3	Not Covered	None
	<a href="#">Specialist</a> visit	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge ; <a href="#">deductible</a> does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	Pre-Authorization required
<b>If you need drugs to treat your illness or condition.</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.optimahealth.com">optimahealth.com</a> .	Generic drugs (Tier 1)	\$25 <a href="#">Copayment</a> retail	\$25 <a href="#">Copayment</a> retail	Medical <a href="#">deductible</a> applies except to Tier 1 <a href="#">prescription drugs</a> . Coverage is limited to FDA-approved <a href="#">prescription drugs</a> . If brand drugs are used when a generic is available, you must pay the difference in cost plus the <a href="#">Copayment</a> or <a href="#">Coinsurance</a> amount. One <a href="#">Copayment</a> or <a href="#">Coinsurance</a> amount covers up to a 31-day supply (retail). All <a href="#">specialty drugs</a> are filled and delivered only by home delivery.
	Preferred brand drugs (Tier 2)	40% <a href="#">Coinsurance</a> retail	40% <a href="#">Coinsurance</a> retail	
	Non-preferred brand drugs (Tier 3)	40% <a href="#">Coinsurance</a> retail	40% <a href="#">Coinsurance</a> retail	
	<a href="#">Specialty drugs</a> (Tier 4)	40% <a href="#">Coinsurance</a> retail	40% <a href="#">Coinsurance</a> retail	

\*For more information about limitations and exceptions, see the plan or policy document at [https://www.optimahealth.com/eoccoidoc/20507VA142001400\\_20190101.pdf](https://www.optimahealth.com/eoccoidoc/20507VA142001400_20190101.pdf)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	Pre-Authorization required
	Physician/ surgeon fees	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	50% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	40% <a href="#">Coinsurance</a>	Not Covered	None
	<a href="#">Urgent care</a>	40% <a href="#">Coinsurance</a>	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	Pre-Authorization required.
	Physician/surgeon fees	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	None
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">Coinsurance</a> Tier 1 office visits; <a href="#">deductible</a> does not apply 50% <a href="#">Coinsurance</a> Tier 2 office visits; <a href="#">deductible</a> does not apply 40% <a href="#">Coinsurance</a> Tier 1 other visits 50% <a href="#">Coinsurance</a> Tier 2 other visits	Not Covered	Pre-Authorization required for partial <a href="#">hospitalization</a> services, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation.
	Inpatient services	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	Pre-Authorization required for all inpatient services.
If you are pregnant	Office visits	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	Pre-Authorization required for prenatal services. <a href="#">Cost sharing</a> does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	
	Childbirth/delivery facility services	40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Not Covered	
	<a href="#">Home health care</a>	40% <a href="#">Coinsurance</a>	Not Covered	Pre-Authorization required. 100 visits/ <a href="#">plan</a> year
	<a href="#">Rehabilitation services</a>	Rehabilitative PT/OT: 40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2  Rehabilitative ST: 40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Rehabilitative PT/OT: Not Covered  Rehabilitative ST: Not Covered	Pre-Authorization required. 30 visits/ <a href="#">plan</a> year for PT, OT. 30 visits/ <a href="#">plan</a> year for ST

\*For more information about limitations and exceptions, see the plan or policy document at [https://www.optimahealth.com/eoccoidoc/20507VA142001400\\_20190101.pdf](https://www.optimahealth.com/eoccoidoc/20507VA142001400_20190101.pdf)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Habilitation services</a>	Habilitative PT/OT: 40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2  Habilitative ST: 40% <a href="#">Coinsurance</a> Tier 1 50% <a href="#">Coinsurance</a> Tier 2	Habilitative PT/OT: Not Covered  Habilitative ST: Not Covered	Pre-Authorization required. 30 visits/ <a href="#">plan</a> year for PT, OT. 30 visits/ <a href="#">plan</a> year for ST
	<a href="#">Skilled nursing care</a>	40% <a href="#">Coinsurance</a>	Not Covered	Pre-Authorization required. 100 days/stay
	<a href="#">Durable medical equipment</a>	40% <a href="#">Coinsurance</a>	Not Covered	Pre-Authorization required for single items over \$750, all rental items, and repair and replacement.
	<a href="#">Hospice services</a>	40% <a href="#">Coinsurance</a>	Not Covered	Pre-Authorization required
	Children's eye exam	No Charge ; <a href="#">deductible</a> does not apply	Not Covered	Coverage limited to one exam/ <a href="#">plan</a> year from participating EyeMed <a href="#">providers</a>
If your child needs dental or eye care	Children's glasses	No Charge ; <a href="#">deductible</a> does not apply	Not Covered	Coverage limited to one pair of glasses/ <a href="#">plan</a> year from participating EyeMed <a href="#">providers</a>
	Children's dental check-up	Not Covered	Not Covered	None

\*For more information about limitations and exceptions, see the plan or policy document at [https://www.optimahealth.com/eoccoidoc/20507VA142001400\\_20190101.pdf](https://www.optimahealth.com/eoccoidoc/20507VA142001400_20190101.pdf)

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric Dental Check-ups
- Routine foot care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Abortion only if [medically necessary](#)
- Chiropractic Care
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)

## Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the [plan](#) at 1-866-514-5916. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: your state insurance department at Bureau of Insurance at 1-877-310-6560 or [bureauofinsurance@scc.virginia.gov](mailto:bureauofinsurance@scc.virginia.gov); or [www.HealthCare.gov](http://www.HealthCare.gov) at 1-800-318-2596

## Your [Grievance](#) and [Appeals](#) Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Member Services at the number on the back of your member ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or your state department of insurance at the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA, 23218, 1-877-310-6560 or [bureauofinsurance@scc.virginia.gov](mailto:bureauofinsurance@scc.virginia.gov).

Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA, 23218, 1-877-310-6560, or [bureauofinsurance@scc.virginia.gov](mailto:bureauofinsurance@scc.virginia.gov).

## Does this Coverage Provide [Minimum Essential Coverage](#)? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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**Does this Coverage Meet the Minimum Value Standard? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium](#) tax credit to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,500	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,500	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,500
■ <a href="#">Specialist coinsurance</a>	40%	■ <a href="#">Specialist coinsurance</a>	40%	■ <a href="#">Specialist coinsurance</a>	40%
■ Hospital (facility) <a href="#">coinsurance</a>	40%	■ Hospital (facility) <a href="#">coinsurance</a>	40%	■ Hospital (facility) <a href="#">coinsurance</a>	50%
■ Other <a href="#">coinsurance</a>	40%	■ Other <a href="#">coinsurance</a>	40%	■ Other <a href="#">coinsurance</a>	40%
<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$6,500	Deductibles	\$500	Deductibles	\$1,900
Copayments	\$30	Copayments	\$1,100	Copayments	\$0
Coinsurance	\$1,400	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
<b>Total Peg would pay is</b>	<b>\$7,930</b>	<b>Total Joe would pay is</b>	<b>\$1,600</b>	<b>Total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of the these EXAMPLE covered services.

## Optima Health Alternative Language Options for Notices and other Written Information

### English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

### Amharic:

ማሳሰቢያ:

አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260።

### Arabic:

تنبيه:

إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجاناً. اتصل بالرقم 1-855-687-6260.

### Bengali/Bangla:

লক্ষ্য করবেন: যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন- 1-855-687-6260।

### Chinese (Mandarin):

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

### French:

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

### German:

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

### Gujarati:

ધ્યાન આપો : જો તમે ગુજરાતી બોલી છે તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કોલ કરો.

### Hindi:

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

### Hmong:

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

### Igbo:

GEE NT I: ọbụrụ na i na-asụ Igbo, i ga-enweta enyemaka n’efu site n’aka ndi ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

### Japanese:

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

### Korean:

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

### Kru/Bassa:

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

### Laotian:

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

### Mon-Khmer, Cambodian:

កំណត់សំគាល់: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260។



**Navajo:**

SHOOH: Diné Bizaad bee yánítti'go doo báháh ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'á. Kojí' hólne' 1-855-687-6260.

**Persian/Farsi:**

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 تماس بگیرید.

**Portuguese:**

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

**Russian:**

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

**Spanish:**

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

**Tagalog:**

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

**Turkish:**

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

**Urdu:**

توجه دیں: اگر آپ اردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 کال کریں۔

**Vietnamese:**

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

**Yoruba:****KÉÉRE:**

Ti o bá n sọ èdè Yorùbá, isẹ̀ ìrànlọ́wọ́ èdè wà fún ọ lọfẹ́ẹ̀. Pe 1-855-687-6260