OptimaFit Silver 3500 30% Direct
Optima Health Plan

Coverage for: Individual/Family| **Plan Type:**HMO

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 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/ or call 1-866-514-5916 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,500**/Individual or **$7,000**/family In-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Most preventive care services and screenings are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network **$7,100** person / **$14,200** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.optimahealth.com or call 1-866-514-5916.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copayment Tier 1 visits 1-3; deductible does not apply 30% Coinsurance Tier 1 visits after 3 $60 Copayment Tier 2 visits 1-3; deductible does not apply 50% Coinsurance Tier 2 visits after 3	Not Covered	None
	Specialist visit	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	None
	Preventive care/screening/immunization	No Charge ; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	Pre-Authorization required
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at optimahealth.com.	Generic drugs (Tier 1)	$30 Copayment retail	$30 Copayment retail	Medical deductible applies except to Tier 1 prescription drugs. Coverage is limited to FDA-approved prescription drugs. If brand drugs are used when a generic is available, you must pay the difference in cost plus the Copayment or Coinsurance amount. One Copayment or Coinsurance amount covers up to a 31-day supply (retail). All specialty drugs are filled and delivered only by home delivery.
	Preferred brand drugs (Tier 2)	$55 Copayment retail	$55 Copayment retail	
	Non-preferred brand drugs (Tier 3)	40% Coinsurance retail	40% Coinsurance retail	
	Specialty drugs (Tier 4)	40% Coinsurance retail	40% Coinsurance retail	

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)	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	Pre-Authorization required
	Physician/ surgeon fees	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	None
If you need immediate medical attention	Emergency room care	50% Coinsurance	50% Coinsurance	None
	Emergency medical transportation	30% Coinsurance	Not Covered	None
	Urgent care	30% Coinsurance	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	Pre-Authorization required.
	Physician/surgeon fees	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	None
If you have mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance Tier 1 office visits; deductible does not apply 50% Coinsurance Tier 2 office visits; deductible does not apply 30% Coinsurance Tier 1 other visits 50% Coinsurance Tier 2 other visits	Not Covered	Pre-Authorization required for partial hospitalization services, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation.
	Inpatient services	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	Pre-Authorization required for all inpatient services.
If you are pregnant	Office visits	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	Pre-Authorization required for prenatal services. Cost sharing 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	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	
	Childbirth/delivery facility services	30% Coinsurance Tier 1 50% Coinsurance Tier 2	Not Covered	
	Home health care	30% Coinsurance	Not Covered	Pre-Authorization required. 100 visits/plan year
	Rehabilitation services	Rehabilitative PT/OT: 30% Coinsurance Tier 1 50% Coinsurance Tier 2 Rehabilitative ST: 30% Coinsurance Tier 1 50% Coinsurance Tier 2	Rehabilitative PT/OT: Not Covered Rehabilitative ST: Not Covered	Pre-Authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST

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				
	Habilitation services	Habilitative PT/OT: 30% Coinsurance Tier 1 50% Coinsurance Tier 2 Habilitative ST: 30% Coinsurance Tier 1 50% Coinsurance Tier 2	Habilitative PT/OT: Not Covered Habilitative ST: Not Covered	Pre-Authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST
	Skilled nursing care	30% Coinsurance	Not Covered	Pre-Authorization required. 100 days/stay
	Durable medical equipment	30% Coinsurance	Not Covered	Pre-Authorization required for single items over $750, all rental items, and repair and replacement.
	Hospice services	30% Coinsurance	Not Covered	Pre-Authorization required
If your child needs dental or eye care	Children's eye exam	No Charge ; deductible does not apply	Not Covered	Coverage limited to one exam/plan year from participating EyeMed providers
	Children's glasses	No Charge ; deductible does not apply	Not Covered	Coverage limited to one pair of glasses/plan year from participating EyeMed providers
	Children's dental check-up	Not Covered	Not Covered	None

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; or 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; 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.

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.

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.

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)

The plan's overall deductible	**$3,500**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$30
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$0
Total Peg would pay is	**$6,230**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,500**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Joe would pay is	**$1,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,500**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Mia would pay is	**$1,900**

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 ነ ጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል፡፡ በዚህ ስልክ ይደው ሉ 1-855-687-6260፡፡

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

Bengali/Bangla:
লক্ষ্য করবেনঃ 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 છો તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કૉલ કરો.

Hindi:
ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 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 Ị: ọbụrụ na ị na-asụ Igbo, ị ga-enweta enyemaka n’efu site n’aka ndị ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

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, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນໍາໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

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

Navajo:
SHOOH: Diné Bizaad bee yáníłti'go doo bą́ąh ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'ą́. Kojį' 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:
توجہ دیں:
اگر آپ اُردو 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 ń sọ èdè Yorùbá, iṣẹ́ ìrànlọ́wọ́ èdè wà fún ọ lọ́fẹ̀ẹ́. Pe 1-855-687-6260