




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, call 1-866-514-5916 or visit optimahealth.com and sign into the Member Portal. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-866-514-5916 to request a copy.

| Important Questions | Answers | Why This Matters |
|--|---|---|
| <p>What is the overall deductible?</p> | <p>\$2,000/Individual or \$4,000/family In-Network</p> | <p>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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Most preventive care services and screenings are covered before you meet your deductible.</p> | <p>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-carebenefits/.</p> |
| <p>Are there other deductible for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>For In-Network \$8,700 person / \$17,400 family</p> | <p>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, the overall family out-of-pocket limit must be met.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, balance-billed charges, and health care this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. See http://www.optimahealth.com or call 1-866-514-5916.</p> | <p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>No.</p> | <p>You can see the specialist you choose without a referral.</p> |

 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 (You will pay the least) | Out-of-Network (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 /Visit, deductible does not apply | Not covered | None. |
| | Specialist visit | \$60 copayment /Visit, deductible does not apply | 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) | 25% coinsurance | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | 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 . | Preferred generic drugs (Tier 1) | \$15 copayment, deductible does not apply retail \$45 copayment, deductible does not apply mail order | Not covered retail Not covered mail order | Coverage is limited to FDA-approved prescription drugs . One copayment or coinsurance amount covers up to a 30-day supply; two copayment or coinsurance amounts cover up to a 31- to 60-day supply; and three copayment or coinsurance amounts cover up to a 61- to 90-day supply (retail). Some outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available in a 90-day supply through mail order. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy and are limited to a 30-day supply (retail and mail order). |
| | Preferred brand & other generic drugs (Tier 2) | \$30 copayment, deductible does not apply retail \$90 copayment, deductible does not apply mail order | Not covered retail Not covered mail order | |
| | Non-Preferred brand drugs (Tier 3) | \$60 copayment, deductible does not apply retail \$180 copayment, deductible does not apply mail order | Not covered retail Not covered mail order | |
| | Specialty drugs (Tier 4) | \$250 copayment, deductible does not apply retail | Not covered retail | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | Not covered | Pre-authorization required. |

* For more information about limitations and exceptions, see the plan or policy document at https://apps.optimahealth.com/Public/OHBRFileManager/DownloadFile.aspx?filePath=%2Fpresales%2F2023%2FECCOI-For-SBC%2F2023_IP_20507VA141006801.pdf

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| | Physician/surgeon fees | 25% coinsurance | Not covered | None. |
| If you need immediate medical attention | Emergency room care | 25% coinsurance | 25% coinsurance | None. |
| | Emergency medical transportation | Non-emergency services: 25% coinsurance Emergency services: 25% coinsurance | Non-emergency services: Not covered Emergency services: 25% coinsurance | Pre-authorization required for non-emergent transport. |
| | Urgent care | \$45 copayment /Visit, deductible does not apply | Not covered | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% coinsurance | Not covered | Pre-authorization required. |
| | Physician/surgeon fees | 25% coinsurance | Not covered | None. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office visits: \$30 copayment /Visit, deductible does not apply Other visits: 25% coinsurance | Office visits: Not covered Other visits: Not covered | Pre-authorization required for partial hospitalization, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation. |
| | Inpatient services | 25% coinsurance | Not covered | Pre-authorization required for all inpatient services. |
| If you are pregnant | Office visits | 25% coinsurance | 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 | 25% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 25% coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 25% coinsurance | Not covered | Pre-authorization required. 100 visits/year. |
| | Rehabilitation services | Rehabilitative PT/OT: \$30 copayment /Visit, deductible does not apply | Rehabilitative PT/OT: Not covered Rehabilitative Speech | Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|--|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| | | Rehabilitative Speech Therapy: \$30 copayment /Visit, deductible does not apply Other Services: 25% coinsurance | Therapy: Not covered Other Services: Not covered | |
| | Habilitation services | Habilitative PT/OT: \$30 copayment /Visit, deductible does not apply Habilitative Speech Therapy: \$30 copayment /Visit, deductible does not apply Other Services: 25% coinsurance | Habilitative PT/OT: Not covered Habilitative Speech Therapy: Not covered Other Services: Not covered | Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST. |
| | Skilled nursing care | 25% coinsurance | Not covered | Pre-authorization required. 100 days/stay. |
| | Durable medical equipment | 25% coinsurance | Not covered | Pre-authorization required for single items over \$750, all rental items, and repair and replacement. |
| | Hospice services | 25% 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 VSP providers . |
| | Children's glasses | No charge, deductible does not apply | Not covered | Coverage limited to one pair/ plan year from participating VSP providers . |
| | Children's dental check-up | Not covered | Not covered | None. |

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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 .) | | |
|---|---|---|
| <ul style="list-style-type: none">• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)• Acupuncture• Bariatric Surgery• Cosmetic Surgery | <ul style="list-style-type: none">• Dental Care (Adult)• Dental Care (Pediatric)• Hearing aids• Long-term care | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Routine eye care (Adult)• Routine foot care unless medically necessary• Weight Loss Programs |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none">• Chiropractic Care | <ul style="list-style-type: none">• Infertility Treatment | <ul style="list-style-type: none">• Private-duty nursing |

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 plan provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? **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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-687-6260.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-687-6260.

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Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-687-6260.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-687-6260.

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

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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 plan's overall deductible | \$2,000 | ■ The plan's overall deductible | \$2,000 | ■ The plan's overall deductible | \$2,000 |
| ■ Specialist coinsurance | 25% | ■ Specialist copayment | \$30 | ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 25% | ■ Hospital (facility) coinsurance | 25% | ■ Hospital (facility) coinsurance | 25% |
| ■ Other coinsurance | 25% | ■ Other coinsurance | 25% | ■ Other copayment | \$30 |
| This EXAMPLE event includes services like: 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>) | | This EXAMPLE event includes services like: 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>) | | This EXAMPLE event includes services like: 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>) | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <i>Cost Sharing</i> | | <i>Cost Sharing</i> | | <i>Cost Sharing</i> | |
| Deductibles | \$2,000 | Deductibles | \$100 | Deductibles | \$2,000 |
| Copayments | \$70 | Copayments | \$800 | Copayments | \$200 |
| Coinsurance | \$2,600 | Coinsurance | \$0 | Coinsurance | \$90 |
| <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 |
| The total Peg would pay is | \$4,670 | The total Joe would pay is | \$900 | The total Mia would pay is | \$2,290 |