**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 |
|---|---|---|
| **What is the overall deductible?** | **$0** | 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?** | No. | This plan covers items and services even if you haven't yet met the deductible amount. |
| **Are there other deductible for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Not Applicable. | This plan does not have an out-of-pocket limit. |
| **What is not included in the out-of-pocket limit?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Yes. See http://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 you 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 Tier 1 (You will pay the least) | In-Network Tier 2 (You will pay less) | 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 | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Specialist visit | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Preventive care/ screening/ immunization | No charge, deductible does not apply | 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) | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Imaging (CT/PET scans, MRIs) | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Pre-authorization required. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| **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) | No charge, deductible does not apply retail No charge mail order | No charge, deductible does not apply retail No charge mail order | Not covered retail Not covered mail order | 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 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) | No charge, deductible does not apply retail No charge mail order | No charge, deductible does not apply retail No charge mail order | Not covered retail Not covered mail order | |
| | Non-Preferred Brand Drugs (Tier 3) | No charge, deductible does not apply retail | No charge, deductible does not apply retail | Not covered retail Not covered mail order | |

* For more information about limitations and exceptions, see the plan or policy document at https://apps.optimahealth.com/Public/OHBRFileManager/DownloadFile.aspx?filePath=%2Fpresales%2F2022%2FEOCCOI-For-SBC%2F2022_IP_20507VA141001902.pdf

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network Tier 1 (You will pay the least) | In-Network Tier 2 (You will pay less) | Out-of-Network (You will pay the most) | |
| | | No charge mail order | No charge mail order | | |
| | Specialty drugs (Tier 4) | No charge, deductible does not apply retail | No charge, deductible does not apply retail | Not covered retail | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Pre-authorization required. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Physician/surgeon fees | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| **If you need immediate medical attention** | Emergency room care | No charge, deductible does not apply | No charge, deductible does not apply | No charge, deductible does not apply | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Emergency medical transportation | No charge, deductible does not apply | No charge, deductible does not apply | No charge, deductible does not apply /Emergency services<br><br>Not covered/all other | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Urgent care | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Pre-authorization required. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Physician/surgeon fees | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |

* For more information about limitations and exceptions, see the plan or policy document at https://apps.optimahealth.com/Public/OHBRFileManager/DownloadFile.aspx?filePath=%2Fpresales%2F2022%2FEOCCOI-For-SBC%2F2022_IP_20507VA141001902.pdf

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network Tier 1 (You will pay the least) | In-Network Tier 2 (You will pay less) | Out-of-Network (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge, deductible does not apply office visits<br>No charge, deductible does not apply other visits | No charge, deductible does not apply office visits<br>No charge, deductible does not apply other visits | Not covered | Pre-authorization required for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy, and Transcranial Magnetic Stimulation. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Inpatient services | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Pre-authorization required for all inpatient services. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| **If you are pregnant** | Office visits | No charge, deductible does not apply | No charge, deductible does not apply | 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).If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Childbirth/delivery professional services | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | |
| | Childbirth/delivery facility services | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Pre-authorization required. 100 visits/year. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Rehabilitation services | Rehabilitative PT/OT: No charge, deductible does not apply Rehabilitative Speech Therapy: | Rehabilitative PT/OT: No charge, deductible does not apply Rehabilitative Speech Therapy: | Rehabilitative PT/OT: Not covered Rehabilitative Speech Therapy: Not covered | Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network Tier 1 (You will pay the least) | In-Network Tier 2 (You will pay less) | Out-of-Network (You will pay the most) | |
| | | No charge, deductible does not apply | No charge, deductible does not apply | | |
| | Habilitation services | Habilitative PT/OT: No charge, deductible does not apply Habilitative Speech Therapy: No charge, deductible does not apply | Habilitative PT/OT: No charge, deductible does not apply Habilitative Speech Therapy: No charge, deductible does not apply | Habilitative PT/OT: Not covered Habilitative Speech Therapy: Not covered | Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Skilled nursing care | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Pre-authorization required. 100 days/stay. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Durable medical equipment | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Pre-authorization required for single items over $750, all rental items, and repair and replacement. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Hospice services | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Pre-authorization required. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| **If your child needs dental or eye care** | Children's eye exam | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Coverage limited to one exam/plan year from participating EyeMed providers. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |
| | Children's glasses | No charge, deductible does not apply | No charge, deductible does not apply | Not covered | Coverage limited to one pair/plan year from participating EyeMed providers. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance-billing). |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network Tier 1 (You will pay the least) | In-Network Tier 2 (You will pay less) | Out-of-Network (You will pay the most) | |
| | Children's dental check-up | Not covered | 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.)**

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Pediatric)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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.)**

- Chiropractic Care
- Infertility Treatment
- 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.

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**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.

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, kwiijigo holne' 1-855-687-6260.

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

* For more information about limitations and exceptions, see the plan or policy document at https://apps.optimahealth.com/Public/OHBRFileManager/DownloadFile.aspx?filePath=%2Fpresales%2F2022%2FEOCCOI-For-SBC%2F2022_IP_20507VA141001902.pdf

## 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 | $0 |
| Specialist copayment | $0 |
| Hospital (facility) copayment | $0 |
| Other copayment | $0 |

**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** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$0** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $0 |
| Hospital (facility) copayment | $0 |
| Other copayment | $0 |

**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** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$0** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $0 |
| Hospital (facility) copayment | $0 |
| Other copayment | $0 |

**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** | **$2,800** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

The plan would be responsible for the other costs of these EXAMPLE covered services.