Optima Vantage Gold 500/25/20% Rx Ded Direct
HIOS Product ID#: 20507VA1250010-00 Off HIX
Plan Effective Date: Beginning on or after 01/01/2022
Optima Health Plan
Small Group Plan Benefit Summary

This Benefit Summary is not a contract or health plan policy from Optima Health. If there are any differences between this Benefit Summary and the Optima Health coverage documents issued when You are enrolled, the provisions of the coverage documents will prevail for all benefits, conditions, cost-sharing, and limitations and exclusions.

This policy does not provide the ACA-required minimum essential pediatric oral health benefits. Stand-alone dental coverage that includes such benefits must be available to you for purchase separately from a qualified stand-alone dental plan.

This document is an overview of Your Covered Services and Your out-of-pocket cost-sharing amounts including any Deductibles, Copayment and Coinsurance. This Plan has tiered Copayment or Coinsurance amounts listed for In-Network benefits. For some services You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals, or other Facilities or providers. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

Details about Covered Services are in the section "What is Covered". Details about services and treatments that are not covered are in the section "What is Not Covered".

Some benefits require Pre-Authorization before You receive them. These services are marked with an * in this document.

Some Covered Services may have visit limits. Once a visit limit is reached, no additional services are covered under the benefit. If a service is shown as covered under Out-of-Network benefits visit limits are combined with In-Network and Out-of-Network benefits unless otherwise stated.

Services or treatment You receive Out-of-Network or from Non-Plan Providers will not be covered under Your Plan unless:

1. The Covered Service is an Emergency Service;
2. During treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

If Your Plan has a Deductible, that is the dollar amount that must be paid out of pocket by a Member for Covered Services each year before the Plan begins to pay for benefits.

Copayments and Coinsurances listed in this document are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan's Allowable Charge for Your Covered Service. You will pay a Copayment or a Coinsurance, but not both, for a Covered Service. For some benefits You may see the statement, "Cost-sharing determined by the type and place of service." For these services, Your cost-sharing will be based on where You receive a service, for example in a physician office or inpatient setting, and/or the type of service.

Your Plan's Maximum Out-of-Pocket Amount means the total dollar amount Members pay, or that are paid on their behalf, out-of-pocket for most Covered Services during a year. Deductibles, Copayments, and Coinsurance for most Covered Services count toward the maximum amount.

Deductible and Maximum Out-of-Pocket Amount (MOOP)			
	In-Network Tier 1	**In-Network Tier 2**	**Out-of-Network**
Deductible Plan Year	$500/Individual; $1,000/Family		Not Covered

The Plan has one combined Deductible for Tier 1 and Tier 2 In-Network Covered Services. Most amounts You Pay for Tier 1 and Tier 2 In-Network Covered Services will count toward meeting the In-Network Deductible. The Deductible applies to all Covered Services except for:

- In-Network Preventive Care Services required by law;
- Other services in this document shown as covered without a Deductible.

If You are the Subscriber, and the only Member covered under Your Plan, the Individual Deductible amount applies. If You have other Family Members on Your Plan the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one Family Member meets the Individual Deductible, his or her benefits will begin. Once the total Family coverage Deductible is met, benefits are available for all Family Members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a Member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible.

Any amounts applied to the Plan Deductible(s) during the last three months of the Plan Year can be carried forward to the next year.

	In-Network Tier 1	**In-Network Tier 2**	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$6,500/Individual; $13,000/Family		Not Covered

The Plan has one combined Maximum Out-of-Pocket Amount for Tier 1 and Tier 2 In-Network Covered Services. Most amounts You pay, or that are paid on Your behalf, for Tier 1 and Tier 2 In-Network Covered Services will count toward meeting the In-Network Maximum.
The following will not count toward any Plan Maximum Amount:

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic is available;
- Other services in this document that are shown as excluded from the Maximum Amount.

If You are the Subscriber, and the only Member covered under Your Plan, the Individual Maximum applies. If You have other Family Members on Your Plan the Family Maximum applies. Under Family coverage, the Individual Maximum applies separately to each covered Family Member. Once the total Family coverage Maximum is met, the Family Maximum Amount is satisfied. No one Member can contribute more than their Individual Maximum Amount to the Family limit.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Optima Health approved providers. ***Pre-Authorization is required for in-office surgery.**			
Primary Care Visit	You Pay $25	You Pay $50	Not Covered
Virtual Consult	You Pay $10	You Pay $10	Not Covered
Specialist Visit	You Pay $50	You Pay $100	Not Covered
Preventive Care Recommended Preventive Care Services are covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits/.			
Recommended exams, screenings, tests, immunizations, and other services	No Charge	No Charge	Not Covered
Outpatient Therapies and Services You pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient facility, a Hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of the Hospice or Early Intervention benefit, or as part of a treatment plan for Autism Spectrum Disorder. When You get physical, occupational, speech therapy in the home, the Home Health Visit limit will apply instead of the Therapy Services limits listed below.			
Occupational and Physical Therapy* Rehabilitative Services limited to 30 combined visits per Plan year. Habilitative Services limited to 30 combined visits per Plan year.	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered
Speech Therapy* Rehabilitative Services limited to 30 combined visits per Plan year for Tier 1 and Tier 2 providers. Habilitative Services limited to 30 combined visits per Plan year for Tier 1 and Tier 2 providers.	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered
Cardiac Rehabilitation*	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered
Pulmonary Rehabilitation*	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered
Vascular Rehabilitation*	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered
Vestibular Rehabilitation*	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
IV Infusion Therapy	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 20%	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $100 **Outpatient Facility** After Deductible You Pay 40%	Not Covered
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 20%	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $100 **Outpatient Facility** After Deductible You Pay 40%	Not Covered
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 20%	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $100 **Outpatient Facility** After Deductible You Pay 40%	Not Covered
Radiation Therapy*	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 20%	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $100 **Outpatient Facility** After Deductible You Pay 40%	Not Covered
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Outpatient Dialysis You pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.			
Dialysis Services	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.			
Surgery Services*	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient facility or lab or a Hospital outpatient facility or lab.			
Diagnostic Procedures	You Pay $50	You Pay $100	Not Covered
X-Ray **Ultrasound** **Doppler Studies**	You Pay $50	You Pay $100	Not Covered
Lab Work	You Pay $50	You Pay $100	Not Covered
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a free-standing outpatient facility, or a Hospital outpatient facility or lab.			
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.			
Maternity Care ***Pre-Authorization is required for prenatal services**	You Pay $450 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	You Pay $600 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
Inpatient Services			
Inpatient Hospital Services*	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered
Transplants* Covered at contracted facilities only.	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 100 days per stay.	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Ambulance Services Includes Emergency transportation, or non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way.			
Air, Water, Ground Services ***Pre-Authorization is required for non-emergency transportation.**	After Deductible You Pay $100	After Deductible You Pay $100	Not Covered except for Emergency Services
Emergency Services Includes Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services, and medical supplies provided in an Emergency Department, including an independent freestanding Emergency Department, In-Network or Out-of-Network.			
Emergency Services	After Deductible You Pay 30%	After Deductible You Pay 30%	After Deductible You Pay 30%
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance.			
Urgent Care Services	You Pay $50	You Pay $50	Not Covered
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Optima Health providers. ***Pre-Authorization is required for Inpatient Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**			
Inpatient Services*	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Outpatient Office Visits	You Pay $25	You Pay $25	Not Covered
Virtual Consults	You Pay $10	You Pay $10	Not Covered
Other Outpatient Visits(Facility/Freestanding Centers)	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Employee Assistance Visits Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174.	No Charge for up to 3 visits from Optima Health Employee Assistance providers per presenting issue as determined by treatment protocols.		
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is covered from an In-Network Plan Provider or a participating EyeMed Vision Services provider at the office visit Copayment or Coinsurance amount.			
Insulin Pumps*	No Charge	No Charge	Not Covered
Pump Infusion Sets and Supplies*	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution; and continuous glucose monitors, sensors and supplies. ***Pre-Authorization is required for talking blood glucose monitors**	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit	Not Covered
Insulin, and Needles, and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	No Charge	Not Covered
Prosthetic Limb Replacement			
Prosthetic Devices and Components, repair, fitting, replacement, adjustment*	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Durable Medical Equipment (DME) and Supplies			
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement, and rental items.**	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Wigs* Limited to one wig per Plan year following cancer treatment.	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Early Intervention Services For Dependent children from birth to age three.			
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home.			
Home Health Care* Limited to a maximum of 100 visits per Member per Plan year. This limit does not apply to home dialysis or home infusion therapy. Occupational, physical, and speech therapy, and cardiac rehabilitation under this benefit will count toward the home health maximum visit limit.	You Pay $25	You Pay $25	Not Covered
Private-Duty Nursing			
Private-Duty Nursing* Includes services provided by an RN or LPN in the home. Limited to 16 hours per Plan year.	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Hospice Care			
Hospice Care* Therapy visit limits do not apply to occupational, physical or speech therapy under this benefit.	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered
Vision Care Optima Health contracts with EyeMed Vision Services to administer this benefit. Services must be received from EyeMed providers.			
Adult Preventive Vision Exams (age 19 and up) Limited to one exam every 12 months from an EyeMed provider.	No Charge	No Charge	Members will be reimbursed up to $30 for an eye examination
Pediatric Vision Care (Children up to the end of the month the child turns 19) Limited to one exam each Plan year for glasses or contact lenses, and one pair of glasses, lenses and frames per Plan year from a limited frame collection, or contact lenses from a limited selection instead of glasses. Low vision exams are limited to one every 5 years.	**Vision Exam:** No Charge **Vision Materials:** No Charge	**Vision Exam:** No Charge **Vision Materials:** No Charge	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.			
Surgery and Reconstruction* **Prostheses*** **Physical Complications Lymphedema***	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered
Infertility Services Includes limited services, for Members only, to diagnose and treat underlying medical conditions resulting in Infertility.			
Endometrial biopsies (Limited to 2 per lifetime) **Semen analysis** (Limited to 2 per lifetime) **Hysterosalpingography** (Limited to 2 per lifetime) **Sims-Huhner test (smear)** (Limited to 4 per lifetime) **Diagnostic laparoscopy** (Limited to 1 per lifetime)	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Clinical Trials Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.			
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Allergy Care			
Allergy Care, Testing, and Serum	After Deductible You Pay 20%	After Deductible You Pay 40%	Not Covered
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.			
Telemedicine Services ***Pre-Authorization is required except for emergency services.**	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered
Chiropractic Services Optima Health Contracts with American Specialty Health Group (ASH) to administer this benefit. Services include therapy to treat problems of the bones, joints, and back.			
Chiropractic Services ***Pre-Authorization is required by ASH for all Chiropractic services.** Limited to 30 visits per Plan year for Rehabilitative services and 30 visits per Plan year for Habilitative services.	After Deductible You Pay 20%	After Deductible You Pay 20%	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Autism Spectrum Disorder Includes diagnosis and treatment of Autism Spectrum Disorder.			
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Prescription Drugs

This document describes Your Plan's outpatient prescription drug coverage. All drugs must be United States Food and Drug Administration (FDA) approved, and You must have a prescription. You will need to pay Your Copayment or Coinsurance when You fill your prescription at the pharmacy. If Your Plan has a Deductible, You must meet that amount before Your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited.

Details about Covered Services are in the section "What is Covered". Details about services and treatments that are not covered are in the section "What is Not Covered".

Prescriptions may be filled at a participating, in-network Plan pharmacy or at a non-participating pharmacy or its intermediary if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan or its Pharmacy Benefit Manager, including any Copayment or Coinsurance consistently imposed by the Plan or its Pharmacy Benefit Manager, at the same level as the Plan or its Pharmacy Benefit Manager gives to participating pharmacies.

Our formulary is a list of FDA-approved medications that we cover. Prescription drugs are reviewed by the Plan's Pharmacy and Therapeutics Committee for placement onto the formulary. For a single Copayment or Coinsurance charge, You may receive up to a consecutive 30-day supply of a covered drug at a retail pharmacy. Some drugs may be available under the Plan's mail-order pharmacy. Specialty Drugs are available up to a 30-day supply and can be delivered to Your home address from Optima Health's specialty mail-order drug pharmacy.

This formulary is organized into the following tiers, which will determine what You pay out of pocket to fill a prescription:

Preferred Generic Drugs (Tier 1) includes commonly prescribed Generic Drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.

Preferred Brand & Other Generic Drugs (Tier 2) includes brand-name drugs and some Generic Drugs with higher costs than Tier 1 Generic Drugs that are considered by the Plan to be standard therapy.

Non-Preferred Brand Drugs (Tier 3) includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a Generic Product Level equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers.

Specialty Drugs (Tier 4) includes those drugs classified by the Plan as Specialty Drugs. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs include the following:

1. Medications that treat certain patient populations including those with rare diseases;
2. Medications that require close medical and pharmacy management and monitoring;
3. Medications that require special handling and/or storage;
4. Medications derived from biotechnology and/or blood-derived drugs or small molecules;
5. Medications that can be delivered via injection, infusion, inhalation, or oral administration; and
6. Medications subject to restricted distribution by the U.S. Food and Drug Administration.

Specialty Drugs are only available through an Optima Health specialty mail-order pharmacy, including Proprium Pharmacy at 1-855-553-3568 and are limited to a 30-day supply. Specialty Drugs can be delivered to Your home address. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Pharmacy Member Services at the number on Your Optima Health ID Card. You can also log onto optimahealth.com for a list of Specialty Drugs and specialty pharmacies.

Tier 4 also includes compound prescription medications. A compound prescription medication is used to meet the needs of a specific individual and must have at least one ingredient requiring a Physician's authorization by State or Federal Law.

Refills

Your Plan has refill limitations. You must use most of Your medication or about 75% of Your medication based on the day supply of Your prescription before You can get a refill. There are several ways to refill Your prescription. In most cases contact the retail, mail order, or specialty pharmacy where You originally filled Your prescription and request a refill. Sometimes Your doctor will prescribe a set amount of refills for Your prescription. If You have run out of refills You will need a new prescription from Your doctor. In some cases, Your pharmacist may be able to call Your doctor to get more refills for You.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Deductibles, Maximum Out-of-Pocket Amount (MOOP), and Benefits	
Deductibles	Your Plan has the following separate Pharmacy Deductible that must be met before Coverage for Prescription drugs begins: $100 per Person per Plan year.
Maximum Out-of-Pocket Amount	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance or amounts You pay, or that are paid on Your behalf, apply to the Plan's Maximum Medical Out-of-Pocket Limit unless otherwise noted.
Insulin, and Needles and Syringes for Injection	Covered at the cost-sharing listed below for the applicable Tier. A Member's cost-sharing payment for a covered insulin drug will not exceed $50 per 30-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. Deductible does not apply.
Diabetic Testing Supplies including blood glucose monitors, test strips, lancets, lancet devices, and control solution	No Charge Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. *Pre-Authorization is required for talking blood glucose meters.
Continuous Glucose Monitors, Sensors, and Supplies	You pay the cost sharing for the applicable Tier.
Formulary	This Plan has a closed formulary and covers a specific list of drugs and medications. If Your drug is not on Our formulary, We have a process in place to request coverage. Please use the following link to see a list of drugs on the Plan's formulary:optimahealth.com/documents/drug-lists/2022-formulary-small-group-plans.pdf

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Retail Pharmacy Cost Sharing When You pick up Your drug at a retail pharmacy You will pay the Copayment (one Copayment for each 30-day supply) or the Coinsurance amount listed under the applicable Tier for Your drug: • You pay one Copayment or the Coinsurance for up to a 30-day supply • You pay two Copayments or the Coinsurance for a 31 to 60-day supply • You pay three Copayments or the Coinsurance for a 61 to 90-day supply **Tier 4 Specialty Drugs are only available from an Optima Health Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.**	
ACA Preventive Drugs ACA preventive prescription drugs and over-the-counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs (Tier 1)	You Pay $15
Preferred Brand & Other Generic Drugs (Tier 2)	After Deductible You Pay $50
Non-Preferred Brand Drugs (Tier 3)	After Deductible You Pay 20%
Specialty Drugs (Tier 4)	After Deductible You Pay 20% up to a maximum Copayment of $350.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Copayment and Coinsurance Mail Order (If Your Drug is available) for up to a 90-day supply Some Outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available from the Plan's Mail Order Pharmacy OptumRx Home Delivery. You may call OptumRx Home Delivery at 1-866-244-9113 to find out if Your drug is available. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy, including Proprium Pharmacy and are limited to a 30-day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over-the-counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs (Tier 1)	You Pay $38
Preferred Brand & Other Generic Drugs (Tier 2)	After Deductible You Pay $125
Non-Preferred Brand Drugs (Tier 3)	After Deductible You Pay 20% up to a maximum Copayment of $400.
Specialty Drugs (Tier 4)	Tier 4 Specialty Drugs are only available from an Optima Health Specialty pharmacy including Proprium Pharmacy and are limited to a 30-day supply.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of month they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health Benefits.

This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.