Optima Vantage Equity 2800/30%
30110VA000100100
Plan Effective Date: 01/01/2021
Administered by Sentara Health Plan
BusinessEdge Self Funded Benefit Summary

This Benefit Summary is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. 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 the Benefit Summary.

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 Benefit Summary 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 out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the maximum amount.

Effective Period: From 01/01/2021 through 12/31/2021		
Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Contract year	$2,800/Individual; $5,600/Family	Not Covered

Amounts You pay, or that are paid on their behalf, for 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 Benefit Summary 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.

	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Contract year	$5,500/Individual; $11,000/Family	Not Covered

Amounts You Pay for most In-Network Covered Services will count toward meeting the In-Network Maximum.
The following will not count toward the Plan maximum amount: (s):

- 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 drug is available;
- Other services in this Benefit Summary 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	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	After Deductible You Pay 30%	Not Covered
Virtual Consult	After Deductible You Pay 30%	Not Covered
Specialist Visit	After Deductible You Pay 30%	Not Covered
Vaccines and Immunotherapeutic Agents This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 30%	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: https://www.healthcare.gov/what-are-my-preventive-care-benefits/		
Recommended exams, screenings, tests, immunizations, and other services	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 a treatment plan for Autism Spectrum Disorder.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Contract year.	After Deductible You Pay 30%	Not Covered
Speech Therapy* Services limited to 30 visits per Contract year.	After Deductible You Pay 30%	Not Covered
Cardiac Rehabilitation* Services limited to 30 visits per Contract year.	After Deductible You Pay 30%	Not Covered
Pulmonary Rehabilitation* Services limited to 30 visits per Contract year.	After Deductible You Pay 30%	Not Covered
Vascular Rehabilitation* Services limited to 30 visits per Contract year.	After Deductible You Pay 30%	Not Covered
Vestibular Rehabilitation* Services limited to 30 visits per Contract year.	After Deductible You Pay 30%	Not Covered

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

Benefit	In-Network	Out-of-Network
IV Infusion Therapy	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	No Covered
Respiratory/Inhalation Therapy	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Radiation Therapy*	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	Not Covered
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 30%	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 30%	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 30%	Not Covered
Outpatient Lab, Diagnostic, Imaging and Testing		
Diagnostic Procedures	After Deductible You Pay 30%	Not Covered

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

Benefit	In-Network	Out-of-Network
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 30%	Not Covered
Lab Work	After Deductible You Pay 30%	Not Covered
Outpatient Advanced Imaging, Testing and Scans		
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 30%	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**	After Deductible You Pay 30%	Not Covered
Inpatient Services		
Inpatient Hospital Services*	After Deductible You Pay 30%	Not Covered
Transplants* Covered at contracted facilities only.	After Deductible You Pay 30%	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 100 days per Contract year.	After Deductible You Pay 30%	Not Covered
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 30%	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 In-Network or Out-of-Network. If You are admitted the Copayment will be waived, and You will pay the Inpatient Hospital Services Copayment or Coinsurance.		
Emergency Services	After Deductible You Pay 30%	After Deductible You Pay 30%

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

Benefit	In-Network	Out-of-Network
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	After Deductible You Pay 30%	Not Covered
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders.***Pre-Authorization is required for Inpatient Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.** Virtual Consults must be furnished by approved Optima Health providers.		
Inpatient Services*	After Deductible You Pay 30%	Not Covered
Outpatient Office Visits	After Deductible You Pay 30%	Not Covered
Virtual Consults	After Deductible You Pay 30%	Not Covered
Other Outpatient Visits(Facility/Freestanding Centers)	After Deductible You Pay 30%	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*	After Deductible You Pay 30%	Not Covered
Pump Infusion Sets and Supplies*	After Deductible You Pay 30%	Not Covered
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution. ***Pre-Authorization is required for talking blood glucose monitors**	After Deductible You Pay 30%	Not Covered
Insulin, Needles, Syringes	Covered under the Plan's Prescription Drug Benefit	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	After Deductible You Pay 30%	Not Covered
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment*	After Deductible You Pay 30%	Not Covered
Autism Spectrum Disorder Includes diagnosis and treatment of Autism Spectrum Disorder.		
Autism Spectrum Disorder	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	Out-of-Network
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices [123*Pre-Authorization is required for items over [$750] *Pre-Authorization is required for repair, replacement and rental items.	After Deductible You Pay 30%	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.	Not Covered
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 Contract year.	After Deductible You Pay 30%	Not Covered
Hospice Care		
Hospice Care*	After Deductible You Pay 30%	Not Covered
Vision Care Optima Health contracts with EyeMed Vision Services to administer this benefit. Services must be received from EyeMed providers.		
Vision Exams Limited to one exam every 12 months from an EyeMed provider.	No Charge	Members will be reimbursed up to $30 for an eye examination
Chiropractic Services Optima Health Contracts with American Specialty Health Group (ASH) to administer this benefit.		
Chiropractic Services *Pre-Authorization is required by ASH for all Chiropractic services.	After Deductible You Pay 30%	Not Covered
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* Prostheses* Physical Complications Lymphedema*	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.	Not Covered

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

Benefit	In-Network	Out-of-Network
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.	Not Covered
Out of Area Dependent Program Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits when Covered Services are received from Optima Health providers that participate in the Out of Area Program. The Plan will require eligible out of area Dependents to complete an annual certification form prior to being eligible for the program. Except for Emergency Services any Covered Services received outside of the service area from Out of Network Non-Plan Providers that are not included in the Out of Area Dependent Program will not be covered.		
Out of Area Program Services	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service

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

Prescription Drugs
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This Benefit Summary describes Your Plan's outpatient prescription drug coverage. All drugs must be United States Food 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 Plan pharmacy or at a non-participating pharmacy if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies.

Prescription drugs are placed into Tiers by the Plan's Pharmacy and Therapeutics Committee. For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug at a retail pharmacy or Optima's Specialty Pharmacy. Specialty Drugs will be delivered to Your home address from Our specialty mail order drug pharmacy.

Selected 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.

Selected 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-Selected 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. Tier 4 also includes compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. 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. 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 the Optima Health specialty mail order pharmacy. Proprium Pharmacy at 1-855-553-3568. Specialty Drugs will 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.

Deductible and Maximum Out-of-Pocket Amount (MOOP), and Benefits	
Deductibles	You must meet the medical Deductible listed on Your Plan's Benefit Summary before coverage for Tier 1, Tier 2, Tier 3 and Tier 4 drugs begin.
Maximum Out-of-Pocket Amount	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Medical Maximum Out-of-Pocket Amount . Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available are not Covered, do not count toward the Plan's Maximum Out-of-Pocket Amount and must continue to be paid after the Maximum Out-of-Pocket Amount has been met.
Insulin, syringes, and needles	Covered at the cost sharing listed 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.
Formulary	This Plan has an open formulary. Please use the following link to see a list of drugs on the open formulary: www.optimahealth.com Certain prescription drugs will be covered at a Generic Product Level established by the Plan. If a Generic Product Level has been established for a drug and You or Your prescribing Physician requests the brand-name drug or a higher costing Generic Drug, You must pay the difference between the cost of the dispensed drug and the Generic Product Level in addition to the Copayment or Coinsurance charge.

Copayments and Coinsurance Retail Pharmacy or Optima Specialty Pharmacy for up to a 31 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: https://www.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.
Selected Generic Drugs (Tier 1)	After Deductible You Pay $10
Selected Brand & Other Generic Drugs (Tier 2)	After Deductible You Pay $40
Non-Selected Brand Drugs (Tier 3)	After Deductible You Pay $60 Copayment or 20% Coinsurance, whichever is greater up to a maximum Copayment of $250.
Specialty Drugs (Tier 4)	After Deductible You Pay 20% up to a maximum Copayment of $250.

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 the Plan's Specialty Pharmacy Proprium Pharmacy and are limited to a 31 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: https://www.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.
Selected Generic Drugs (Tier 1)	After Deductible You Pay $25
Selected Brand & Other Generic Drugs (Tier 2)	After Deductible You Pay $100
Non-Selected Brand Drugs (Tier 3)	After Deductible You Pay $180 Copayment or 20% Coinsurance, whichever is greater up to a maximum Copayment of $750.
Specialty Drugs (Tier 4)	After Deductible You Pay 20% up to a maximum Copayment of $250.

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

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