



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit optimahealth.com or call 1-866-846-2682. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the glossary at healthcare.gov/sbc-glossary/ or call 1-866-846-2682 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall deductible ? | \$150/Individual or \$300/family In- Network | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Prescription drugs ; most services that require a copayment ; and preventive care , vision, and materials are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. \$50 Person / \$150 Family for Dental Care (Adult). There are no other specific deductibles . | You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan ? | For In- Network \$1,500 person / \$3,000 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance-billed charges, and healthcare this plan does not cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.optimahealth.com or call 1-866-846-2682. | 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. |
| Do I need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$5 Copayment Tier 1; deductible does not apply \$25 Copayment Tier 2; deductible does not apply | Not Covered | None |
| | Specialist visit | \$10 Copayment Tier 1; deductible does not apply \$40 Copayment Tier 2; 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) | 20% Coinsurance | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% 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 . | Generic drugs (Tier 1) | \$15 Copayment retail/\$30 Copayment mail order | \$15 Copayment retail/Mail Order Not Covered | Coverage is limited to FDA-approved prescription drugs . For non-selected brand and specialty drugs , the out-of-pocket amount is limited to \$250 Copayment per retail prescription. If brand drugs are used when a generic is available, you must pay the difference in cost plus the Copayment or Coinsurance amount. Covers up to a 31-day supply (retail); 31- to 90-day supply (mail order). Not all drugs are available through a mail order program. |
| | Preferred brand drugs (Tier 2) | \$30 Copayment retail/\$60 Copayment mail order | \$30 Copayment retail/Mail Order Not Covered | |
| | Non-preferred brand drugs (Tier 3) | \$45 Copayment retail/\$90 Copayment mail order | \$45 Copayment retail/Mail Order Not Covered | |
| | Specialty drugs (Tier 4) | \$55 Copayment retail | \$55 Copayment retail | |

*For more information about limitations and exceptions, see the plan or policy document at https://www.optimahealth.com/eccoidoc/Vant_LG_HMO_202001.pdf

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|---|--|--|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$125 Copayment per visit; deductible does not apply | Not Covered | Pre-authorization required. |
| | Physician/ surgeon fees | No Charge ; deductible does not apply | Not Covered | None |
| If you need immediate medical attention | Emergency room care | \$150 Copayment per visit; deductible does not apply | \$150 Copayment per visit | None |
| | Emergency medical transportation | 20% Coinsurance | Not Covered | None |
| | Urgent care | \$40 Copayment per visit; deductible does not apply | \$40 Copayment for emergent services only. Not covered for non-emergent services | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$300 Copayment per admission; deductible does not apply | Not Covered | Pre-authorization required. |
| | Physician/surgeon fees | No Charge ; deductible does not apply | Not Covered | None |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services | Mental Health Outpatient: \$10 Copayment office visits; deductible does not apply \$125 Copayment other visits; deductible does not apply EAV: No Charge ; deductible does not apply | Mental Health Outpatient: Not Covered EAV: Not Covered | Pre-authorization required for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy, and Transcranial Magnetic Stimulation. EAV: 4 visits/presenting issue by Optima EAV providers only |
| | Inpatient services | \$300 Copayment per admission; deductible does not apply | Not Covered | Pre-authorization required for all inpatient services. |
| If you are pregnant | Office visits | \$150 Copayment Global; 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). |
| | Childbirth/delivery professional services | No Charge ; deductible does not apply | Not Covered | |
| | Childbirth/delivery facility services | \$300 Copayment per admission; deductible does not apply | Not Covered | |
| | Home health care | No Charge ; deductible does not apply | Not Covered | Pre-authorization required. 100 visits/ plan year |
| | | Physical and Occupational Therapy: \$25 Copayment per visit; deductible does not apply | Physical and Occupational Therapy: Not Covered | Pre-authorization required. 30 |

*For more information about limitations and exceptions, see the plan or policy document at https://www.optimahealth.com/eccoidoc/Vant_LG_HMO_202001.pdf

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Rehabilitation services | Speech Therapy: \$25 Copayment per visit; deductible does not apply | Speech Therapy: Not Covered | visits/ plan year for PT, OT. 30 visits/ plan year for ST |
| | Habilitation services | Not Covered | Not Covered | None |
| | Skilled nursing care | No Charge ; deductible does not apply | Not Covered | Pre-authorization required. 100 days/ plan year |
| | Durable medical equipment | 20% Coinsurance | Not Covered | Pre-authorization required for single items over \$750, all rental items, and repair and replacement. |
| | Hospice services | No Charge ; deductible does not apply | Not Covered | Pre-authorization required. |
| If your child needs dental or eye care | Children's eye exam | \$15 Copayment per exam; deductible does not apply | \$50 Reimbursement | Coverage limited to one exam/ plan year from participating EyeMed providers |
| | Children's glasses | \$20 Copayment lenses; deductible does not apply \$100 Allowance frames and contact lenses; deductible does not apply | Not Covered | None |
| | Children's dental check-up | No Charge diagnostic and preventive; deductible does not apply 20% Coinsurance restorative, oral surgery, endodontics, periodontics 50% Coinsurance crowns, implants , orthodontic | Not Covered | \$2,000 annual benefit max/person. \$2,000 lifetime orthodontic benefit max/person. |

*For more information about limitations and exceptions, see the plan or policy document at https://www.optimahealth.com/eccoidoc/Vant_LG_HMO_202001.pdf

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Cosmetic Surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Routine eye care (Adult)

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the [plan](#) at 1-866-846-2682. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, at 1-877-310-6560 or bureauofinsurance@scc.virginia.gov; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 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.

Does this Coverage Provide [Minimum Essential Coverage](#)? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium](#) tax credit to help you pay for a [plan](#) through the [Marketplace](#).

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery) | | 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 | \$150 | ■ The plan's overall deductible | \$150 | ■ The plan's overall deductible | \$150 |
| ■ Specialist copayment | \$150 | ■ Specialist copayment | \$10 | ■ Specialist copayment | \$10 |
| ■ Hospital (facility) copayment | \$300 | ■ Hospital (facility) copayment | \$300 | ■ Hospital (facility) copayment | \$150 |
| ■ Other coinsurance | 20% | ■ Other coinsurance | 20% | ■ Other copayment | \$25 |
| 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 | \$12,800 | Total Example Cost | \$7,400 | Total Example Cost | \$1,900 |
| 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 | \$200 | Deductibles | \$100 | Deductibles | \$200 |
| Copayments | \$700 | Copayments | \$600 | Copayments | \$400 |
| Coinsurance | \$200 | Coinsurance | \$0 | Coinsurance | \$100 |
| <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 |
| Total Peg would pay is | \$1,100 | Total Joe would pay is | \$700 | Total Mia would pay is | \$700 |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-846-2682.

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

Optima Health Alternative Language Options for Notices and other Written Information

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

Amharic:

ማሳሰቢያ:

አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260።

Arabic:

تنبيه:

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

Bengali/Bangla:

লক্ষ্য করবেন: যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন- 1-855-687-6260।

Chinese (Mandarin):

注意: 如果您讲中文普通话, 可以免费获得语言协助服务。请拨打电话 1-855-687-6260。

French:

ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260.

German:

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 zur Verfügung.

Gujarati:

ધ્યાન આપો : જો તમે ગુજરાતી બોલી છે તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કોલ કરો.

Hindi:

ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 पर कॉल करें।

Hmong:

CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260.

Igbo:

GEE NT I: ọbụrụ na i na-asụ Igbo, i ga-enweta enyemaka n'efu site n'aka ndi ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

Japanese:

重要: 日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260までお電話ください。

Korean:

주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260번으로 전화해 주십시오.

Kru/Bassa:

YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha I nyuu hola we. Sebel: 1-855- 687-6260.

Laotian:

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

Mon-Khmer, Cambodian:

កំណត់សំគាល់: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260។

Navajo:

SHOOH: Diné Bizaad bee yánítti'go doo báháh ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'á. Kojí' hólne' 1-855-687-6260.

Persian/Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 تماس بگیرید.

Portuguese:

ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260.

Russian:

ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260, и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:

ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260.

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260.

Turkish:

DİKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz. 1-855-687-6260 numaralı telefonu arayın.

Urdu:

توجه دیں: اگر آپ اردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 کال کریں۔

Vietnamese:

CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260.

Yoruba:**KÉÉRE:**

Ti o bá n sọ èdè Yorùbá, isẹ ìrànlọwọ èdè wà fún ọ lófẹẹ. Pe 1-855-687-6260