This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at optimahealth.com or by calling 1-800-741-9910.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, healthcare this plan does not cover, and pre-authorization penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Does this plan use a network of providers?	Yes. For a list of participating providers, see **optimahealth.com** or call **1-800-741-9910.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed after page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Copayment/visit	Not covered	--none--
	Specialist visit	$25 Copayment/visit	Not covered	--none--
	Other practitioner office visit	Not covered	Not covered	--none--
	Preventive care/ screening/immunization	No charge	Not covered	--none--
If you have a test	Diagnostic test (x-ray, blood work)	$25 Copayment/visit	Not covered	--none--
	Imaging (CT/PET scans, MRIs)	$150 Copayment/visit	Not covered	Benefits may be denied or reduced without pre-authorization
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at optimahealth.com	Selected generic drugs	$10 Copayment for retail prescription/ $20 Copayment mail order prescription	$10 Copayment for retail prescription/ $20 Copayment mail order prescription	Coverage is limited to FDA-approved prescription drugs. For 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. One Copayment or Coinsurance amount covers up to a 31-day supply retail, and a 90-day supply
	Select brand and other generic drugs	$20 Copayment for retail prescription/ $40 Copayment mail order prescription	$20 Copayment for retail prescription/ $40 Copayment mail order prescription	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Non-selected brand drugs	$40 Copayment for retail prescription/ $80 Copayment mail order prescription	$40 Copayment for retail prescription/ $80 Copayment mail order prescription	mail order. Not all drugs are available through a mail order program.
	Specialty drugs	20% Coinsurance for retail prescription	20% Coinsurance for retail prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copayment/ admission	Not covered	Benefits may be denied or reduced without pre-authorization
	Physician/surgeon fees	No charge	Not covered	--none--
If you need immediate medical attention	Emergency room services	$200 Copayment/visit	$200 Copayment/visit	--none--
	Emergency medical transportation	$100 Copayment/trip	Not covered	--none--
	Urgent care	$25 Copayment/visit	Not covered	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copayment/day	Not covered	Benefits may be denied or reduced without pre-authorization. $500 maximum Copayment per admission
	Physician/surgeon fee	No charge	Not covered	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 Copayment/visit	Not covered	Benefits may be denied or reduced without pre-authorization for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy.
	Mental/Behavioral health inpatient services	$100 Copayment/day	Not covered	Benefits may be denied or reduced without pre-authorization for all inpatient services. $500 maximum Copayment per admission
	Substance use disorder outpatient services	$10 Copayment/visit	Not covered	Benefits may be denied or reduced without pre-authorization for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	$100 Copayment/day	Not covered	Benefits may be denied or reduced without pre-authorization for all inpatient services. $500 maximum Copayment per admission
If you are pregnant	Prenatal and postnatal care	$100 Global Copayment	Not covered	Benefits may be denied or reduced without pre-authorization for prenatal services
	Delivery and all inpatient services	$100 Copayment/day	Not covered	$500 maximum Copayment per admission
If you need help recovering or have other special health needs	Home health care	$10 Copayment/visit	Not covered	Benefits may be denied or reduced without pre-authorization. Coverage is limited to 100 visits per person per plan year.
	Rehabilitation services	$25 Copayment/visit	Not covered	Benefits may be denied or reduced without pre-authorization. Coverage is limited to 30 combined visits for PT and OT; 30 visits for cardiac, pulmonary, vascular, and vestibular therapies; and 30 visits for ST, per person per plan year.
	Habilitation services	Not covered	Not covered	--none--
	Skilled nursing care	No charge after Inpatient Copayment	Not covered	Benefits may be denied or reduced without pre-authorization. Coverage is limited to 100 days per person per stay.
	Durable medical equipment	No charge	Not covered	Benefits may be denied or reduced without pre-authorization for single items over $750, all rental items, and repair and replacement.
	Hospice service	No charge	Not covered	Benefits may be denied or reduced without pre-authorization
If your child needs dental or eye care	Eye exam	No charge	$30 Reimbursement	Coverage is limited to one exam every 12 months from participating EyeMed providers. Additional cost may apply for contact lens exam.
	Glasses	$100 allowance	Not covered	--none--
	Dental check-up	Not covered	Not covered	--none--

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation Services
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Private-duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-741-9910. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

For group health coverage subject to ERISA, you may 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 (Toll Free), or bureauofinsurance@scc.virginia.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact Member Services at the number on the back of your member ID card, 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 (Toll Free), 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 http://www.scc.virginia.gov/boibureauofinsurance@scc.virginia.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-741-9910.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-741-9910.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-741-9910.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-741-9910.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,860
- **Patient pays** $680

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$680
Coinsurance	$0
Limits or exclusions	$0
Total	**$680**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,760
- **Patient pays** $640

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$640
Coinsurance	$0
Limits or exclusions	$0
Total	**$640**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.