Optima POS 15/35
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Large Group 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 Benefit Summary is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. There are two benefit columns. One column lists cost sharing amounts You will pay for In-Network benefits from Plan Providers. The other column lists cost sharing amounts You will pay for Out-of-Network benefits from Non-Plan 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 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 be covered under the Plan's Out-of-Network benefits 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. Your Plan may have separate Deductibles for In-Network and Out-of-Network 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. You may also have to pay for balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers.

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. Your Plan may have separate maximum amounts for In-Network and Out-of-Network benefits.

York County School Division Effective Period: From 01/01/2022 through 12/31/2022		
Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Plan Year	Your Plan Does Not Have a Deductible	$400/Individual; $800/Family
	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$3,500/Individual; $7,000/Family	$4,500/Individual; $9,000/Family

The In-Network and the Out-of-Network Maximum Out-of-Pocket Amounts are separate. Most amounts You pay, or that are paid on Your behalf, for In-Network Covered Services will count toward meeting the In-Network Maximum. Most amounts You pay, or that are paid on Your behalf, for Covered Services Out-of-Network will count toward meeting the Out-of-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;
- 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.

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	You Pay $15	After Deductible You Pay 30%
Virtual Consult	You Pay $10	Not Covered
Specialist Visit	You Pay $35	After Deductible You Pay 30%
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. **This does not include routine immunizations covered under Preventive Care.**	You Pay 50%	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
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. 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	After Deductible You Pay 30%
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 Plan year combined for rehabilitative and habilitative services.	You Pay $25	After Deductible You Pay 30%
Speech Therapy* Services limited to 30 visits per Plan year combined for rehabilitative and habilitative services.	You Pay $25	After Deductible You Pay 30%
Cardiac Rehabilitation*	You Pay $25	After Deductible You Pay 30%
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	You Pay $25	After Deductible You Pay 30%
Vascular Rehabilitation* Services limited to 30 visits per Plan year.	You Pay $25	After Deductible You Pay 30%
Vestibular Rehabilitation* Services limited to 30 visits per Plan year.	You Pay $25	After Deductible You Pay 30%
IV Infusion Therapy	No Charge	After Deductible You Pay 30%
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $15 **Specialist Office Visit** You Pay $35 **Outpatient Facility** No Charge	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** You Pay $15 **Specialist Office Visit** You Pay $35 **Outpatient Facility** No Charge	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** 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
Radiation Therapy*	**PCP Office Visit** You Pay $15 **Specialist Office Visit** You Pay $35 **Outpatient Facility** No Charge	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%
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	No Charge	After Deductible You Pay 30%
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	You Pay $25	After Deductible You Pay 30%
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*	You Pay $150	After Deductible You Pay 30%
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	No Charge	After Deductible You Pay 30%
X-Ray **Ultrasound** **Doppler Studies**	No Charge	After Deductible You Pay 30%
Lab Work	No Charge	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
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***	You Pay 20%	After Deductible You Pay 30%
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 No Charge for Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 30%
Inpatient Services		
Inpatient Hospital Services*	You Pay $200 per day up to a $1,000 maximum Copayment per Admission	After Deductible You Pay 30%
Transplants*	You Pay $200 per day up to a $1,000 maximum Copayment per Admission	After Deductible You Pay 30%
Skilled Nursing Facility Services* Limited to a maximum of 100 days per Plan year.	No Charge	After Deductible You Pay 30%
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.**	No Charge	No Charge
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.		
Emergency Services	You Pay $200	You Pay $200

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	You Pay $35	After Deductible You Pay 30%
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*	You Pay $200 per day up to a $1,000 maximum Copayment per Admission	After Deductible You Pay 30%
Outpatient Office Visits	You Pay $15	After Deductible You Pay 30%
Virtual Consults	You Pay $10	Not Covered
Other Outpatient Visits (Facility/Freestanding Centers)	No Charge	After Deductible You Pay 30%
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	After Deductible You Pay 30%
Pump Infusion Sets and Supplies*	You Pay 20%	After Deductible You Pay 30%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution. ***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
Insulin, Needles, Syringes	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	After Deductible You Pay 30%
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	You Pay 20%	After Deductible You Pay 30%
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.

Benefit	In-Network	Out-of-Network
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.**	You Pay 20%	After Deductible You Pay 30%
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.
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 Plan year.	You Pay 20%	After Deductible You Pay 30%
Private Duty Nursing* Covered in the home limited to 16 hours per calendar year	You Pay 20%	After Deductible You Pay 30%
Hospice Care		
Hospice Care*	No Charge	After Deductible You Pay 30%
Vision Care Optima Health contracts with EyeMed Vision Services to administer this benefit. Services must be received from EyeMed providers.		
Includes a routine eye examination, refraction, and materials including lenses or contact lenses once every 12 months from a Participating EyeMed Provider. Frames are covered once every 24 months.	**Examinations** You Pay $15 Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost. **Materials** Lenses (single, vision, bifocal, trifocal) covered in full. Frames covered in full up to $130 retail. Contact lenses (in lieu of glasses) covered in full up to $130 retail.	Members will be reimbursed up to $30 for an eye examination

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

Benefit	In-Network	Out-of-Network
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing is determined by the type and place of service.	Cost sharing is determined by the type and place of service.
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 is determined by the type and place of service.	Cost sharing is determined by the type and place of service.
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 is determined by the type and place of service.	Cost sharing is determined by the type and place of service.
Allergy Care		
Allergy Care, Testing, and Serum	Cost sharing is determined by the type and place of service.	After Deductible You Pay 30%
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	Cost sharing is determined by the type and place of service.	Cost sharing is determined by the type and place of service.
Chiropractic Care Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit.		
Chiropractic Care Rider **Pre-Authorization is required by ASH for all Chiropractic services.** Maximum number of visits 30 per Calendar year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Calendar year when medically necessary.	You Pay $25	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
Wigs Reimbursement for wigs in conjunction with chemotherapy. Coverage is limited to 3 units per Calendar year.	You Pay 20%	After Deductible You Pay 30%

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of year 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.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-229-1199 or visit optimahealth.com and sign into the Member Portal. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-229-1199 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	**$0**/Individual or **$0**/family In-Network **$400**/Individual or **$800**/family Out-of-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-carebenefits/.
Are there other deductible for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network **$3,500** person / **$7,000** family and out-of-network-providers **$4,500** person / **$9,000** 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 limit 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 health care this plan doesn't 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 http://www.optimahealth.com or call 1-800-229-1199.	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 you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment	30% coinsurance	None
	Specialist visit	$35 copayment	30% coinsurance	None
	Preventive care/ screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at optumrx.com	Generic Drugs (Tier 1)	$15 copayment 30-day retail $45 copayment 90-day retail $15 copayment mail order	Not covered retail Not covered mail order	Prescription drug coverage is provided by OptumRx. Please contact OptumRx Member Services at 1-844-265-1719 or their Pharmacy Help Desk at 1-844-368-8731.
	Brand Drugs (Tier 2)	$40 copayment 30-day retail $90 copayment 90-day retail $80 copayment mail order	Not covered retail Not covered mail order	
	Non-Preferred Drugs (Tier 3)	$75 copayment 30-day retail $180 copayment 90-day retail $150 copayment mail order	Not covered retail Not covered mail order	
	Specialty drugs (Tier 4)	$200 copayment 30-day retail Not covered 90-day retail Not covered mail order	Not covered retail Not covered mail order	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copayment	30% coinsurance	Pre-authorization required.
	Physician/surgeon fees	No charge	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 copayment	$200 copayment, deductible does not apply	None
	Emergency medical transportation	No charge	No charge; deductible does not apply	None
	Urgent care	$35 copayment	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment/Day	30% coinsurance	Pre-authorization required. $1,000 maximum Copayment per Admission.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copayment office visits No charge other visits	30% coinsurance	Pre-authorization required for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy, and Transcranial Magnetic Stimulation.
	Inpatient services	$200 copayment/Day	30% coinsurance	Pre-authorization required for all inpatient services. $1,000 maximum Copayment per Admission.
If you are pregnant	Office visits	No charge	30% coinsurance	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). $1,000 maximum Copayment per Admission.
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	$200 copayment/Day	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Pre-authorization required. 100 visits/plan year.
	Rehabilitation services	PT/OT: $25 copayment Speech Therapy: $25 copayment	PT/OT: 30% coinsurance Speech Therapy: 30% coinsurance	Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST. Combined Rehabilitation and Habilitation services
	Habilitation services			
	Skilled nursing care	No charge	30% coinsurance	Pre-authorization required. 100 days/plan year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
	Durable medical equipment	20% coinsurance	30% coinsurance	Pre-authorization required for single items over $750, all rental items, and repair and replacement.
	Hospice services	No charge	30% coinsurance	Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	$15 copayment/standard, deductible does not apply	$30 Reimbursement, deductible does not apply	Coverage limited to one exam/plan year from participating EyeMed providers.
	Children's glasses	No charge contact lenses when medically necessary, deductible does not apply $130 allowance/frames and contact lenses, deductible does not apply No charge/single, bifocal, trifocal, lenticular lenses, deductible does not apply	Not covered	Contact lenses are in lieu of frames. Coverage limited to one/plan year for lenses and contact lenses and one/24 months for frames from participating EyeMed providers. Additional charge may apply for additional lens options.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Pediatric)
- Hearing Aids
- Long-term Care
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Infertility Treatment
- Non-emergency care when traveling outside the U.S. (under out-of-network benefit)
- Private-duty Nursing
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-800-229-1199. 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 orwww.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.. 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 plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for Minimum Essential Coverage, you may not be eligible for the premium tax credit..

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-687-6260.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-687-6260.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-687-6260.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-687-6260.

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) copayment	$200
Other copayment	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$270**

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$200
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$200
Other copayment	$25

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$570**

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