Equity Vantage 2700/90%
Optima Health Plan

Coverage Period: Beginning on or after 01/01/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family| **Plan Type:** HMO

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 1-800-275-3755.

Important Questions	Answers	Why this Matters
What is the overall deductible?	**$2,700** person / **$5,400** family In-Network Does not apply to preventive care.	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 1st). 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 services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$4,000** person / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a policy 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 **1-800-275-3755**.	If you use a participating provider 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 3. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-275-3755** or visit us at **optimahealth.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call **1-800-275-3755** to request a copy.

- **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		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% Coinsurance[AD]	Not Covered	AD denotes After Deductible.
	Specialist visit	10% Coinsurance[AD]	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)	10% Coinsurance[AD]	Not Covered	--none--
	Imaging (CT/PET scans, MRIs)	10% Coinsurance[AD]	Not Covered	Pre-Authorization required
		$10 Copayment[AD] for retail	$10 Copayment[AD] for retail	

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 need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at optimahealth.com.	Selected Generic drugs	prescription/ $30 Copayment[AD] mail order prescription	prescription/ $30 Copayment[AD] mail order prescription	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. One 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.
	Selected brand and other generic drugs	$40 Copayment[AD] for retail prescription/ $120 Copayment[AD] mail order prescription	$40 Copayment[AD] for retail prescription/ $120 Copayment[AD] mail order prescription	
	Non-selected brand drugs	Greater of $60 Copayment[AD] for retail prescription/ $180 Copayment [AD] mail order prescription or 20% Coinsurance[AD]	Greater of $60 Copayment[AD] for retail prescription/ $180 Copayment [AD] mail order prescription or 20% Coinsurance[AD]	
	Specialty drugs	20% Coinsurance[AD] for retail prescription	20% Coinsurance[AD] for retail prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance[AD]	Not Covered	Pre-Authorization required
	Physician/ surgeon fees	10% Coinsurance[AD]	Not Covered	--none--
If you need immediate medical attention	Emergency room services	10% Coinsurance[AD]	10% Coinsurance[AD]	--none--
	Emergency medical transportation	10% Coinsurance[AD]	Not Covered	--none--
	Urgent care	10% Coinsurance[AD]	Not Covered	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance[AD]	Not Covered	Pre-Authorization required
	Physician/surgeon fee	10% Coinsurance[AD]	Not Covered	--none--
	Mental/Behavioral health outpatient services	Mental Health Outpatient: 10% Coinsurance[AD] EAP: No Charge	Mental Health Outpatient: Not Covered EAP: Not Covered	Benefits may be denied or reduced without pre-authorization for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy. EAP coverage is limited to a 3-visit maximum combined benefit per presenting issue by Optima EAP

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
				providers only.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	10% Coinsurance[AD]	Not Covered	Benefits may be denied or reduced without pre-authorization for all inpatient services.
	Substance use disorder outpatient services	Mental Health Outpatient: 10% Coinsurance[AD] EAP: No Charge	Mental Health Outpatient: Not Covered EAP: Not Covered	Benefits may be denied or reduced without pre-authorization for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy. EAP coverage is limited to a 3-visit maximum combined benefit per presenting issue by Optima EAP providers only.
	Substance use disorder inpatient services	10% Coinsurance[AD]	Not Covered	Benefits may be denied or reduced without pre-authorization for all inpatient services.
If you are pregnant	Prenatal and postnatal care	10% Coinsurance[AD]	Not Covered	Pre-Authorization required for prenatal services.
	Delivery and all inpatient services	10% Coinsurance[AD]	Not Covered	--none--
If you need help recovering or have other special health needs	Home health care	10% Coinsurance[AD]	Not Covered	Pre-Authorization required. Coverage is limited to 100 visits per person per plan year.
	Rehabilitation services	Physical and Occupational Therapy: 10% Coinsurance[AD] Speech Therapy: 10% Coinsurance[AD]	Physical and Occupational Therapy: Not Covered Speech Therapy: 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 ST; and 30 combined visits for cardiac, pulmonary, vascular, and vestibular therapies, per person per plan year.
	Habilitation services	Not Covered	Not Covered	--none--
	Skilled nursing care	10% Coinsurance[AD]	Not Covered	Pre-Authorization required. Coverage is limited to 90 days per person per stay.

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
	Durable medical equipment	10% Coinsurance[AD]	Not Covered	Pre-Authorization required for single items over $750, all rental items, and repair and replacement.
	Hospice service	10% Coinsurance[AD]	Not Covered	Pre-Authorization required
If your child needs dental or eye care	Eye exam	No Charge	$30 Reimbursement	Coverage is limited to one exam every 24 months from participating EyeMed providers. Additional cost may apply for contact lens exam.
	Glasses	Not Covered	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)
- Glasses
- Habilitative Services
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric Dental Check-ups
- 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 1-800-275-3755. 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 1-800-275-3755.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-275-3755.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-275-3755.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'1-800-275-3755.

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 cost 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: $4,420**
- **Patient pays: $3,120**

Sample care cost:

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	$2,700
Copays	$20
Coinsurance	$400
Limits or exclusions	$0
Total	$3,120

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

- **Amount owed to providers: $5,400**
- **Plan pays: $2,490**
- **Patient pays: $2,910**

Sample care cost:

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	$2,700
Copays	$200
Coinsurance	$10
Limits or exclusions	$0
Total	$2,910

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.