Optima Plus 25/500
Individual PPO Plan
Summary of Benefits

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the Plan Evidence of Coverage or Certificate of Insurance, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions.

This Summary of Benefits lists Copayments, Coinsurances, and Deductibles that will apply when using your benefits. Covered Services received from Non-Plan Providers, including but not limited to Physicians, facilities, and laboratories will be covered under Out-of-network benefits. It is Your responsibility to make sure all Pre-Authorization requirements in the Policy are completed.

	In-Network Coverage	*Out-of-Network Coverage*
Maximum Benefit[1]	None	
Deductibles Per Calendar Year[2]	$500 per Member $1,000 per Family	$1,000 per Member $2,000 per Family
Maximum Out-of-Pocket Amount Per Calendar Year	$1,500 per Member[3] $3,000 per Family[3]	$2,500 per Member[4] $5,000 per Family[4]

PHYSICIAN SERVICES

Includes Covered Services performed in the Physician's office during the Physician office visit. Includes, but is not limited to Office consults, in-office surgery, lab, X-ray, injections, diagnostic and treatment services. **Pre-Authorization is required for in-office surgery.**

	In-Network Coverage	*Out-of-Network Coverage*
Primary Care Physician (PCP) Office Visit	$25 Copayment per office visit then Covered at 100%[8] Not subject to the Plan's Deductible	After Deductible Covered at 60%
Specialist Office Visit	$40 Copayment per office visit then Covered at 100%[8] Not subject to the Plan's Deductible	After Deductible Covered at 60%
Routine Annual Physical Exams **Child Health Exams** **Annual Gyn Exams and Pap Smears** **PSA Tests** **Colorectal Cancer Tests** **Routine Immunizations** Maximum benefit for services received Out-of-Network of $250 per Member per calendar year.[6]	Covered at 100%[8]	After Deductible Covered at 60%
Colonoscopy **Mammograms**	Covered at 100%[8]	After Deductible Covered at 60%
Childhood Immunizations For each child from birth to thirty-six months of age, diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella.	Covered at 100%[8]	After Deductible Covered at 60%

OUTPATIENT THERAPY, REHABILITATION AND DIALYSIS [5, 6]

Coinsurance applies to services provided in a free-standing outpatient facility, hospital outpatient facility, or in the physician's office.

	In-Network Coverage	*Out-of-Network Coverage*
Outpatient Therapy Services Includes physical, occupational, and speech therapy services. Maximum combined benefit for services received In-Network or Out of Network of $1,000 per Member per calendar year.[6]	After Deductible Covered at 80%[8]	After Deductible Covered at 60%
Outpatient Rehabilitation Services Includes cardiac, pulmonary, vascular, and other rehabilitation services authorized by the Plan. Maximum combined benefit for services received In-Network or Out of Network of $1,000 per Member per calendar year.[6]	After Deductible Covered at 80%[8]	After Deductible Covered at 60%
Outpatient Chemotherapy, Radiation Therapy, IV Therapy, and Inhalation Therapy Pre-Authorization is required for IV Therapy with medications and inhalation therapy**.**	After Deductible Covered at 80%[8]	After Deductible Covered at 60%
Outpatient Dialysis Services	After Deductible Covered at 80%[8]	After Deductible Covered at 60%

OUTPATIENT SURGERY [5]

Coinsurance applies to services provided in a freestanding ambulatory surgery center or Hospital outpatient surgical facility.

	In-Network Coverage	*Out-of-Network Coverage*
Outpatient Surgery **Pre-Authorization is required.**	After Deductible Covered at 80%[8]	After Deductible Covered at 60%

OUTPATIENT DIAGNOSTIC PROCEDURES [5]

Coinsurance will apply when the diagnostic procedure is performed outside the Physician's office

	In-Network Coverage	*Out-of-Network Coverage*
Diagnostic Procedures **Pre-Authorization is required.**[5]	After Deductible Covered at 80%[8]	After Deductible Covered at 60%
Routine Radiological Exams Includes X-ray, Ultrasound, and Doppler studies.	After Deductible Covered at 80%[8]	After Deductible Covered at 60%
Outpatient Lab Work	After Deductible Covered at 80%[8]	After Deductible Covered at 60%
Diagnostic Imaging Procedures **Pre-Authorization is required.**[5] Includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET) Scans, Computerized Axial Tomography (CT) Scans, and Computerized Axial Tomography Angiogram (CTA) Scans.	After Deductible Covered at 80%[8]	After Deductible Covered at 60%

INPATIENT SERVICES [5,6]

Includes Inpatient hospital services and Skilled Nursing Facility services following inpatient hospital care or in lieu of hospital care. Transplants are covered at contracted facilities only**.** The Plan only covers transplants of the kidney , cornea, and dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for the treatment of breast cancer

	In-Network Coverage	*Out-of-Network Coverage*
Inpatient Hospital Services **Pre-Authorization is required.**[5]	After Deductible Covered at 80%[8]	After Deductible Covered at 60%
Skilled Nursing Facilities/Services **Pre-Authorization is required.**[5] Skilled Nursing Facility coverage is limited to a maximum combined benefit for services received In-Network or Out of Network benefits of 60 days per illness or condition per calendar year.[4, 6]	After Deductible Covered at 80%[8]	After Deductible Covered at 60%

AMBULANCE SERVICES [9]

For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan.

	In-Network Coverage	*Out-of-Network Coverage*
Ambulance Services **Pre-Authorization is required for use other than for emergency services.**	After Deductible Covered at 80%[8]	After Deductible Covered at 60%

EMERGENCY DEPARTMENT SERVICES [9]

Includes those emergency department facility, physician, and ancillary services that are rendered during an emergency visit. If the Member requires inpatient hospital admission the Member will be responsible for the applicable inpatient hospital admission Coinsurance.

Emergency Department Services **Pre-Authorization is <u>not</u> required.**	After Deductible Covered at 80%[8]	After Deductible Covered at 80%[8]

URGENT CARE CENTER SERVICES [9]

	In-Network Coverage	*Out-of-Network Coverage*
Urgent Care Center Services **Pre-Authorization is <u>not</u> required.** Includes urgent care center services, physician services, and other ancillary services received at an Urgent Care center. If you are transferred to an emergency room from an urgent care center, you will be responsible for any applicable emergency room Copayment or Coinsurance.	After Deductible Covered at 80%[8]	After Deductible Covered at 50%

MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES

Administered by Sentara Behavioral Health Services. **Pre-Authorization by Sentara Behavioral Health Services is required.**

	In-Network Coverage	*Out-of-Network Coverage*
Inpatient Services[5, 6, 7] Maximum combined benefit for services received In-Network or Out of Network of 20 days per adult age 19 and above per calendar year. Maximum combined benefit for services received In-Network or Out of Network of 25 days per child or adolescent under age 19 per calendar year. For services received in or out of network up to ten (10) inpatient days may be converted to a partial hospitalization benefit at the exchange of 1.5 days of partial hospitalization coverage for each inpatient day.[6]	After Deductible Covered at 80%[8]	After Deductible Covered at 60%
Outpatient Services Maximum combined benefit for services received In-Network or Out of Network of 20 visits per adult, child or adolescent per calendar year.[6]	Visits 1-5: $40 Copayment per outpatient visit then Covered at 100%[8] Visits 6-20: Covered at 50%[8] Not subject to the Plan's deductible.	Visits 1-5: After Deductible Covered at 60% per outpatient visit Visits 6-20: After Deductible Covered at 50%

EARLY INTERVENTION SERVICES

Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for covered Dependent children from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

	In-Network Coverage	*Out-of-Network Coverage*
Early Intervention Services. Coverage is limited to a maximum combined benefit for services received In-Network or Out of Network of $5,000 per Member per calendar year.[6]	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service

HOSPICE SERVICES

Hospice services include a coordinated program of home and inpatient care provided directly or under the direction of a licensed hospice; and will include palliative and supportive physical, psychological, psychosocial and other health services to Members with a terminal illness.

	In-Network Coverage	*Out-of-Network Coverage*
Hospice Care **Pre-Authorization is required.**[5]	After Deductible Covered at 80%[8]	After Deductible Covered at 60%

DURABLE MEDICAL EQUIPMENT

	In-Network Coverage	*Out-of-Network Coverage*
Durable Medical Equipment [5, 6] **Pre-Authorization required for single items over $250.** **Pre-Authorization required for all rental items.** Covered Services also include colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters. **Coverage is limited to a maximum combined benefit for services received In-Network or Out of Network of $1,000 per Member per calendar year.**	After Deductible Covered at 80%[8]	After Deductible Covered at 60%
Repair and Replacement **Pre-Authorization is required.**[5] **Repair and replacement is limited to a maximum combined benefit for services received In-Network or Out of Network of $500 per Member per calendar year.** [6]	After Deductible Covered at 80%[8]	After Deductible Covered at 60%

DIABETIC SUPPLIES AND EQUIPMENT

	In-Network Coverage	*Out-of-Network Coverage*
Diabetic Supplies and Equipment Includes FDA-approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. Note: Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment per 31-day supply.	After Deductible Covered at 80%[8] for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. After Deductible Covered at 80%[8] for insulin pumps. After Deductible Covered at 80%[8] for outpatient self-management training and education, including medical nutritional therapy.	After Deductible Covered at 60% for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets After Deductible Covered at 60% for insulin pumps. After Deductible Covered at 60% for outpatient self-management training and education, including medical nutritional therapy.

PREVENTIVE VISION SERVICES

Vision Services are administered by EyeMed Vision Services.

	In-Network Coverage	*Out-of-Network Coverage*
Preventive Vision Services Covered Services include one examination every 24 months Not subject to the Plan's Deductible.	$0 Copayment per eye examination performed by a Participating EyeMed provider. Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost	$30 reimbursement for exam only

ALLERGY CARE AND SERVICES

	In-Network Coverage	*Out-of-Network Coverage*
Allergy Care Cover services include allergy testing, injections, and serum. Coverage is limited to a combined maximum benefit for services received in or out of network of $250 per Member per calendar year.[6]	After Deductible Covered at 80%[8]	After Deductible Covered at 60%

NOTES

The Covered Services herein are subject to the terms and conditions set forth in the Optima Health Individual Coverage Policy form number OHIC.IND.POLICY.08

1. Maximum benefits payable under the Plan.

2. Deductible means the dollar amount of covered medical expenses for which a Member is responsible to pay before benefits are payable under the Plan. Such amount will not be reimbursed under the Plan. Any part of the calendar year deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year. The Deductible does not apply to Physician office visits and the Member is required to pay applicable office visit Copayment only. Amounts applied to an in-network deductible will apply toward the Plan's in-network out of pocket maximum amount. Amounts applied to an out-of-network deductible will apply toward the Plan's out of network out of pocket maximum amount.

3. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered In-Network Services. The In-Network Deductible will apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for outpatient mental health care, vision care, outpatient prescription drugs, or amounts which a covered person is required to pay for to failure to comply with the Plan's Pre-Authorization and Referral procedures do not count toward the In-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The Out-Of-Network Deductible does not apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for Out-Of-Network Covered Services do not count toward the In-Network Out-Of-Pocket Maximum.

4. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered Out-of-Network Services. The Out-Of-Network Deductible will apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for outpatient mental health care, vision care, outpatient prescription drugs, amounts which a covered person is required to pay for failure to comply with the Plan's Pre-Authorization and Referral procedures, or amounts which are in excess of the Plan's Allowable Charge do not count toward the Out-Of-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The In-Network Deductible does not apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for In-Network Covered Services do not count toward the Out-Of-Network Out-Of-Pocket Maximum.

5. Pre-Authorization is required. A Member's benefits under the policy will be reduced, after any deductible amount, if he/she does not comply with the Plan's referral and pre-authorization procedures. Details concerning the Plan's referral and pre-authorization procedures, including possible benefit reductions for not following the requirements, are provided in the Individual Coverage Policy

6. Maximum amounts are combined maximums of both In-Network and Out-Of Network Covered Services unless otherwise indicated. Amounts in excess of a benefit dollar limit and/or visit limit as stated in the Schedule of Benefits or added by a Plan rider are excluded from Coverage.

7. Mental Health and Substance Abuse services are provided through Optima Behavioral Health Services, and all Mental Health pre-authorization services are administered by Optima Behavioral Health Services.

8. Benefits are payable at the percent specified of the Plan's fee schedule.

9. All Emergency, Urgent Care, Ambulance and Emergency Mental Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an emergency, the benefit will be reduced as specified on the Schedule of Benefits. Members who receive Emergency services from Non-Plan Providers may be responsible for charges in excess of what would have been paid had the emergency care been received from Plan Providers. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the member received care from a Plan Provider.

AC Benefits for Covered Services performed by any provider who is not a Plan Provider will be based on either a negotiated or agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the Plan's in-network fee schedule for the same service performed by the same type of provider. The Member will be responsible for payment of all charges in excess of the Plan's allowable charge in addition to any copayment and coinsurance amounts he/she is required to pay. Charges from non-Plan providers will generally exceed the Plan's allowable charge.

Optima Plus Individual Plan Prescription Drug Rider

Members are entitled to receive the following FDA-approved prescription drugs, when prescribed by a participating Physician, from a participating pharmacy or from a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan at the same level as the Plan gives to participating pharmacies.

This Plan uses a closed formulary. Recommendations on drug coverage are made by the Pharmacy and Therapeutics Committee composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add a drug to, or remove a drug from the formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. Selected drugs may require your physician to obtain Pre-Authorization from the Plan in order to be covered. The Pharmacy and Therapeutics Committee may establish monthly quantity limits for selected medications. Members will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in. Covered prescription drugs are placed into Tiers according to the following:

- **Select Generic (Tier 1) include**: The majority of commonly prescribed and widely available generic drugs.
- **Standard Generics (Tier 2) include**: Newly FDA-approved generic drugs and those generic drugs with significantly higher costs than the average Select Generic (Tier 1) drugs.
- **Brand (Tier 3) include**: Select brand name drugs that do not have a generic equivalent or a generic alternative to treat life-threatening chronic illnesses.

Optima Plus Plan Outpatient Prescription Drug Coverage

Deductibles and Maximum Benefit

Outpatient Prescription Drug Deductible: $150 per Covered Person per calendar year.

Maximum Benefit of $5,000 per Covered Person per calendar year. The maximum benefit does not apply to Physician prescribed diabetic supplies covered under the prescription drug benefit.

Member Copayments and Coinsurances

For a single Copayment or Coinsurance charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug at a retail pharmacy.

- $15.00 Copayment after deductible for Select Generic (First) tier drugs.
- $30.00 Copayment **or** 40%* Coinsurance, whichever is greater, after deductible for Standard Generic (Second) tier drugs.
- $50.00 Copayment **or** 50%* Coinsurance, whichever is greater, after deductible for Brand (Third) tier drugs

*Benefits are payable at the percent specified of the Plan's fee schedule

Optima Plus Individual Plan Prescription Drug Rider

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 the Member or prescribing Physician requests the brand-name drug or a higher costing generic, the Member must pay the difference between the cost of the dispensed drug and the generic product level in addition to the tier Copayment or Coinsurance charge.

All covered outpatient prescription drugs have been approved by the Food and Drug Administration and require a prescription either by state or federal law.

All compounded prescriptions require prior authorization and must contain at least one prescription ingredient.

Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization.

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

The Pharmacy and Therapeutics Committee may establish monthly quantity limits for selected medications. Please call Member Services with any questions about what tier a particular prescription drug falls under and any applicable quantity limits. This information is also available at the Plan's website www.optimahealth.com.

For a single Copayment charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug.

Depo-Provera and Lunelle injections, Intrauterine devices (IUDs), and cervical caps and their insertion are covered under medical benefits. Please see Section IV Family Planning.

Limited over the counter drugs may be covered at quantities approved by the Plan. The Member must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs.

EXCLUSIONS. The following are excluded or limited under the Prescription Drug Rider:

1. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
2. Diabetic supplies and equipment, in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, other than those listed as covered under this prescription drug rider are covered under the Plan's medical benefit.
3. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
4. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from coverage.
5. Immunization agents, biological sera, blood or blood products are excluded from Coverage.

6. Infertility drugs are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage.
9. Medication taken or administered in whole or in part, while he/she is a patient in a licensed Hospital, rest home, sanatorium, extended care facility, convalescent Hospital, nursing home, or similar institution is excluded from Coverage .
10. Investigational or experimental medications are excluded from Coverage.
11. Medications for cosmetic purposes only, including but not limited to Retin-A for aging, are excluded from Coverage.
12. Medications for smoking cessation, including but not limited to Nicorette gum, nicotine patches, nicotine spray are excluded from Coverage.
13. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
14. Medications with no approved FDA indications are excluded from Coverage.
15. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage unless listed as covered on the Plan's Preferred or Standard drug list.
16. Replacement prescriptions resulting from loss, theft or breakage are excluded from Coverage.
17. Therapeutic devices or appliances, including but not limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
18. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
19. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are excluded from Coverage.

Requests for Coverage of Non-Formulary Outpatient Prescription Drugs.

You have the right to request a non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of covered drugs (formulary), or You have been receiving a specific nonformulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your physician must complete a medical necessity form and deliver it to the Optima Health pharmacy authorization department. After reasonable investigation and consultation with Your prescribing physician, Optima Health will make a determination. Optima Health will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.

This document contains a general summary description of benefits. Once enrolled Optima Members should always refer to their individual coverage policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the member's policy will govern. Optima Health individual PPO policy form numbers:
OHIC.IND.POLICY.08; OHIC.Ind.RX.08. Optima Health enrollment applications: OHC.INDAPP.08