Vantage Equity 4000
Individual and Family Plan Summary of Benefits
HIOS Product ID: 20507VA1210005

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 Coverage Policy, the provisions of that document will prevail for all benefits, conditions, limitations and exclusions. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Evidence of Coverage document carefully. Except for Emergency Services You must use In-Network Plan Providers for Your Covered Services.

Deductible[3]

$4,000 per Person per Calendar Year
$8,000 per Family per Calendar Year

Maximum Out of Pocket Limit[4]

$6,250 per Person Per Calendar Year
$12,500 per Family Per Calendar Year

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 Habilitative and rehabilitative therapy and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery[5]**.

	In-Network Benefits Copayments/%Coinsurance[1, 2]
Primary Care Physician (PCP) Office Visit Also includes Virtual Consults when provided by an Optima Health approved provider.	After Deductible You pay 20%
Specialist Office Visit	After Deductible You pay 20%

Preventive Care[9]

	In-Network Benefits Copayments/%Coinsurance[1, 2]
Routine Annual Physical Exam **Well Baby and Child Exams** **Annual Gynecological Exams and Pap Smears [10]** **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** **Women's Preventive Services**	Covered at 100% You pay no charges

Outpatient Rehabilitative and Habilitative Therapy and Services

You Pay a Copayment or Coinsurance amount for services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility. Visit limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice or Early Intervention benefit. When you get physical, occupational, speech therapy in the home, the Home Health Visit limit will apply instead of the Therapy Services limits listed below.

Therapy Services[6]	**In-Network Benefits Copayments/%Coinsurance[1, 2]**
Physical Therapy **Occupational Therapy** **Pre-Authorization is required.[5]** Services are limited to a maximum combined benefit of 30 visits per calendar year.[6] **Benefit visit limits are shared between rehabilitative and Habilitative services.**	After Deductible You pay 20%
Speech Therapy **Pre-Authorization is required.[5]** Services are limited to a maximum benefit of 30 visits per calendar year.[6] **Benefit visit limits are shared between rehabilitative and Habilitative services**	After Deductible You pay 20%

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Other Rehabilitative and Habilitative Services and Therapies[6]	In-Network Benefits Copayments/%Coinsurance[1, 2]
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.[5]**	After Deductible You pay 20%
Private Duty Nursing[6] **Pre-Authorization is required.[5]** Includes services provided by an RN or LPN in the home limited to 16 hours per calendar year.[6] **Benefit visit limits are shared between rehabilitative and Habilitative services**	After Deductible You pay 20%
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy** **Pre-Authorization is required.[5]**	After Deductible You pay 20%
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require prior-authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.	After Deductible You pay 20%
Outpatient Dialysis Services	
	In-Network Benefits Copayments/%Coinsurance[1, 2]
Dialysis Services Copayment or Coinsurance applies at any place of service. Coverage also includes home dialysis equipment and supplies.	After Deductible You pay 20%
Outpatient Surgery	
	In-Network Benefits Copayments/%Coinsurance[1, 2]
Outpatient Surgery **Pre-Authorization is required.[5]** Copayment or Coinsurance applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible You pay 20%
Outpatient Lab, Diagnostic, Imaging and Testing Procedures	
Copayment or Coinsurance will apply when a procedure is done in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.	
Outpatient Diagnostic Procedures	**In-Network Benefits Copayments/%Coinsurance[1, 2]**
Diagnostic Procedures	After Deductible You pay 20%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You pay 20%
Lab Work	After Deductible You pay 20%

Outpatient Advanced Imaging and Testing Procedures	
	In-Network Benefits Copayments/%Coinsurance[1, 2]
Magnetic Resonance Imaging (MRI) **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)** **Sleep Studies** **Pre-Authorization is required.[5]** Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	After Deductible You pay 20%
Maternity Care	
	In-Network Benefits Copayments/%Coinsurance[1, 2]
Maternity Care[7, 10] **Pre-Authorization is required for prenatal services.[5]** Includes prenatal, delivery, postpartum services, and home health visits. You must also pay Your inpatient hospital Copayment or Coinsurance.	After Deductible You pay 20%
Inpatient Services	
Inpatient Services	**In-Network Benefits Copayments/%Coinsurance[1, 2]**
Inpatient Hospital Services **Pre-Authorization is required.[5]**	After Deductible You pay 20%
Transplant Surgery **Pre-Authorization is required.[5]** Covered at contracted facilities only.	After Deductible You pay 20%
Skilled Nursing Facilities/Services[6] **Pre-Authorization is required.[5]** Following inpatient hospital care or in lieu of hospitalization when, in the Plan's judgment, skilled services are required. Services include up to 100 days per stay [6].	After Deductible You pay 20%
Ambulance Services	
	In-Network Benefits Copayments/%Coinsurance[1, 2]
Ambulance Services[8] **Pre-Authorization is required for non-emergent transportation only.[5]** Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	After Deductible You pay 20%
Emergency Services	
	In-Network Benefits Copayments/%Coinsurance[1, 2]
Emergency Services[2,8] Pre-Authorization is <u>not</u> required. Includes Emergency Services, Physician, and ancillary services provided in an emergency department in-network or out-of-network.	After Deductible You pay 20%
Urgent Care Center Services	
	In-Network Benefits Copayments/%Coinsurance[1, 2]
Urgent Care Center Services[8] Pre-Authorization is <u>not</u> required. 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 an Emergency Services Copayment or Coinsurance.	After Deductible You pay 20%

Mental/Behavioral Health Care	
Includes inpatient and outpatient services for the treatment of mental substance use disorder.	
Mental/Behavioral Health Care	**In-Network Benefits Copayments/%Coinsurance[1, 2]**
Inpatient Services **Pre-Authorization is required for all inpatient services, and partial hospitalization services.[5]**	After Deductible You pay 20%
Outpatient Services **Pre-Authorization is required for intensive outpatient Program (IOP), and electro-convulsive therapy.[5]**	After Deductible You pay 20%
Other Covered Services	
Other Services	**In-Network Benefits Copayments/%Coinsurance[1, 2]**
Prosthetic Devices and Components **Pre-Authorization is required.[5]** Services include Medically Necessary Prosthetic devices including repair, fitting, replacement, and components **Component** means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. **"Limb"** means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. **"Prosthetic device"** means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.	After Deductible You pay 20%
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. **Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment or Coinsurance per 31 day supply**. An annual diabetic eye exam is covered from an Optima Plan Provider or a participating EyeMed Provider at the applicable office visit Copayment or Coinsurance amount.	After Deductible covered at 20% for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, insulin pump infusion sets, insulin pumps, outpatient self-management training and education, including medical nutritional therapy.

Other Covered Services	
Other Services	**In-Network Benefits Copayments/%Coinsurance[1, 2]**
Durable Medical Equipment (DME) and Supplies[6] **Orthopedic Devices and Prosthetic Appliances[6]** **Rehabilitative /Habilitative Devices** **Pre-Authorization is required for single items over $750.[5]** **Pre-Authorization is required for all rental items.[5]** **Pre-Authorization is required for repair and replacement.[5]** Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement	After Deductible You pay 20%
Early Intervention Services **Pre-Authorization is required.[5]** Covered for Dependent children from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices. **No therapy visit maximum applies to occupational, physical or speech therapy under this benefit.**	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.
Home Health Care Skilled Services[6] **Pre-Authorization is required.[5]** Services are covered up to a maximum of 100 visits per calendar year for home bound Members [6] You will also pay a separate Copayment or Coinsurance amount for Habilitative and rehabilitative services and therapies received at home. Occupational, physical, and speech therapy under this benefit will count toward the home health maximum visit limit.	After Deductible You pay 20%
Hospice Care **Pre-Authorization is required.[5]** No therapy visit maximum applies to occupational, physical or speech therapy under this benefit.	After Deductible You pay 20%
Adult Preventive Vision Exams (age 19 and up)[6] Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 12 months when done by a participating EyeMed Provider.	Covered at 100% You pay no charges.
Pediatric Vision Care (Children up to Age 19) [6] Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one exam each year for glasses or contact lenses, and one pair of glasses, lenses and frames per year from a limited frame collection, or contact lenses from a limited selection instead of glasses. Exams and materials must be received from EyeMed participating providers.	Covered at 100% You pay no charges.
Pediatric Oral Care (Children up to Age 19) Optima Health contracts with Delta Dental to administer this benefit. **Pre-authorization is required by Delta Dental for all orthodontia services.** Services must be received from Delta Dental participating providers.	<u>After Deductible Covered at 100% for:</u> Diagnostic and Preventive Dental Procedures <u>After Deductible You pay 20%:</u> Simple Restorative Dental Procedures Major Restorative Dental Periodontic Dental Procedures Endodontic Dental Procedures Oral Surgery Dental Procedures Prosthetic/Prosthodontic/Implant Dental Procedures Orthodontic Dental Procedures All Other Dental Procedures

Other Covered Services	
Other Services	**In-Network Benefits Copayments/%Coinsurance[1, 2]**
Chiropractic Care (Spinal Manipulation)[6] Optima Health contracts with American Specialty Health Networks (ASHN) to administer this benefit. **Pre-authorization is required by ASHN for all services.** Services include spinal manipulation or other manual medical interventions for illness or injury for musculoskeletal conditions only. Maximum number of visits 30 per calendar year. Services must be received from ASHN participating providers.	After Deductible You pay 20%
Reconstructive Breast Surgery **Pre-Authorization is required.**[5] For Members who have had a mastectomy services include surgery and reconstruction, prostheses and physical complications of all stages of mastectomy, including lymphedema.	After Deductible You pay 20%
Infertility Services.[6] Includes the following services to diagnose and treat 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) **Excluded are AI, IVF and all other types of artificial or surgical means of conception and drugs used in connection with these procedures.**	After Deductible You pay 20%
Elective Termination of Pregnancy **Pre-Authorization is required.**[5]	After Deductible You pay 20%
Clinical Trials **Pre-Authorization is required.**[5] Coverage includes "routine patient costs" for 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	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.
Allergy Care, Testing, and Serum	After Deductible You pay 20%

Outpatient Prescription Drugs	
	Copayments/%Coinsurance[1, 2]
This Plan has a closed formulary and covers a specific list of drugs and medications. If Your drug is not on our formulary we have a process in place to request coverage. You will pay your Copayment or Coinsurance amount based on the Tier Your drug is in. For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug at a retail pharmacy. 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 You or Your prescribing Physician requests the brand-name drug or a higher costing generic, You must pay the difference between the cost of the dispensed drug and the generic product level in addition to Your Copayment or Coinsurance amount. • **Tier 1 Preferred Drugs** include the majority of commonly prescribed and widely available generic drugs. Preferred drugs are covered at the lowest Copayment level. Some brand-name drugs may be included in this category if the Plan recognizes they show documented long-term decreases in Illness and death. Large published peer-reviewed clinical trials are used to make this determination. • **Tier 2 Standard Drugs** include brand-name drugs that are considered by the Plan to be standard therapy; and generic drugs with significantly higher costs than the average Preferred (Tier 1) generic drugs that are considered by the plan to be standard therapy. • **Tier 3 Premium Drugs** include those generic and brand name drugs not included by the Plan on another tier. These may include single source brand name drugs that do not have a generic equivalent or therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers. **Specialty Drugs** Your Copayment or Coinsurance amount for up to a 31 day supply will depend on which Tier Your drug is in. After the first prescription is filled at a retail pharmacy Specialty Drugs will be delivered to Your home address from our specialty mail order drug pharmacy. If you have a question or need to find out if your drug is considered a Specialty Drug please call Member Services at the number on Your Optima ID Card . You can also log onto www.optimahealth.com for a list of Specialty Drugs.	**Preferred Drugs (Tier 1)** After Deductible You pay 50% **Standard Drugs (Tier 2)** After Deductible You pay 50% **Premium Drugs (Tier 3)** After Deductible You pay 50%

Notes

All benefits are subject to the terms and conditions in the *Evidence of Coverage* (EOC). Words that are capitalized are defined terms listed in the Definitions section of the EOC.

Children are covered up to the end of the month in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have annual or lifetime dollar limits on Your benefits. You must pay Your total premium amount on time each month.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your EOC for details about how to file a complaint or an appeal.

Under certain circumstances Your coverage can be terminated. However, Your Coverage can only be rescinded for fraud or intentional misrepresentation of material fact. Please look in Your EOC in the section on When Your Coverage will end.

For Optima Health plans that require that You choose a primary care provider (PCP) You have the right to choose any PCP who participates in our network and who is available to accept You or Your family members. For children, You may choose a pediatrician as the PCP.

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.

2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's **Allowable Charge** for the Covered Service You receive.

   Allowable Charge is the amount Optima determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers Allowable Charge is the Provider's contracted rate with Optima or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.

   Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be covered under Your In-Network benefits. All other services You receive from Non-Plan Providers will not be Covered; and You will be responsible for payment of all charges to the Non-Plan Provider.

   Emergency Care You get Out of Network from a Non-Plan Provider will be covered as an In-Network benefit. However, You may have to pay the difference between what the Non-Plan Provider's charges and the Plan's maximum allowable amount or Allowable Charge in addition to Your Emergency Care Copayment , Coinsurance and Deductible amounts.

   The maximum allowable amount or Allowable Charge for Emergency Care from an Out-of-Network Non-Plan Provider will be the greatest of the following:
   i. The amount negotiated with In-Network Providers for the Emergency service;
   ii. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost sharing for the Out-of-Network cost-sharing; or
   iii. The amount that would be paid under Medicare for the Emergency service.

3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. If You have individual coverage You must satisfy the per person coverage deductible before coverage begins. If You have family coverage You and Your family must satisfy the entire family deductible before anyone in Your family is covered. Deductibles will not be reimbursed under the Plan. The Deductible does not apply to Preventive Care Visits and Screenings. Amounts applied to an in-network deductible will apply toward the Plan's in-network Maximum Out of Pocket Limit.

4. **Maximum Out of Pocket Limit** means the total dollar amount You pay out of pocket for most Covered Services during a calendar year. Copayments and Coinsurance amounts that You pay for most Covered Services will count toward Your Maximum Out of Pocket Limit. Your Deductible will apply toward Your Maximum Out of Pocket Limit. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met.**

Copayments or Coinsurances or any other charges for the following will not count toward Your Maximum Out of Pocket Limit:

1. Amounts You pay for services not covered under Your Plan;
2. Balance billing amounts from Non-Plan Providers;
3. Premium amounts;
4. Amounts You pay as a penalty for failure to comply with the Plan's Pre-authorization procedures;

5. This benefit requires Pre Authorization by the provider before You receive services. Your benefits for Covered Services may be reduced or denied if You do not comply with the Plan's Pre-Authorization requirements.

6. Coverage for this benefit or service has a visit, day, hour or other stated limit. The Plan will not cover any additional services after the limits have been reached. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are excluded from Coverage and will not count toward Your Maximum Out of Pocket Maximum Limit.

7. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.

8. All Emergency, Urgent Care, Ambulance, and Emergency Mental/Behavioral 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 Service, the Plan will have no responsibility for the cost of the treatment and You will be solely responsible for payment. 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 You received care from a Plan Provider.

9. Preventive Care includes the services listed below. You may be responsible for an office visit copayment or coinsurance when you receive preventive care. Some services may be administered under Your prescription drug benefit under the Plan.

1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:

- **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
- **Contraceptive Methods and Counseling including:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
- **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
- **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
- **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
- **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
- **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
- **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.

10. You do not need prior authorization from Optima Health or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan. Look in Your EOC in the Utilization Management Section for more information on pre-authorization.