



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, visit optimahealth.com or call 1-800-206-1060. 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 healthcare.gov/sbc-glossary or call 1-800-206-1060 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$2,000/Self Only \$4,000/ Self Plus One or Self and Family in-network	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For in-network providers \$6,000 Self Only/\$12,000 Self Plus One or Self and Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , <u>balance-billed charges</u> , and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.optimahealth.com/federal or call 1-800-206-1060 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose for covered services 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	Not covered	--none--
	<u>Specialist</u> visit	20% <u>coinsurance</u>	Not covered	--none--
	<u>Preventive care/screening/immunization</u>	No charge Deductible does not apply	Not covered	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	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	--none--
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	Pre-authorization required
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.optimahealth.com/federal	Generic drugs	\$15 <u>copayment</u> retail/\$30 <u>copayment</u> mail order	\$15 <u>copayment</u> retail/\$30 <u>Copayment</u> mail order	The medical <u>deductible</u> applies except to <u>prescription</u> drugs considered by the plan to be for <u>preventive care</u> . Coverage is limited to FDA-approved prescription drugs. If brand drugs are used when a generic is available, you must pay the difference in cost plus the <u>copayment</u> or <u>coinsurance</u> amount. Covers up to a 30-day supply (retail); 30-to 90-day supply (mail order). Not all drugs are available through a mail order program.
	Preferred brand drugs	\$50 <u>copayment</u> retail/\$100 <u>copayment</u> mail order	\$50 <u>copayment</u> retail/\$100 <u>copayment</u> mail order	
	Non-preferred brand drugs	20% not to exceed \$85 <u>copayment</u> retail /20% not to exceed \$170 <u>copayment</u> mail order	20% not to exceed \$85 <u>copayment</u> retail /20% not to exceed \$170 <u>copayment</u> mail order	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> retail	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Pre-authorization required
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	--none--
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	--none--
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Not covered	--none--
	<u>Urgent care</u>	20% <u>coinsurance</u>	Not covered	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	Pre-authorization required
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	--none--

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Not covered	Pre-authorization required for intensive outpatient program, partial hospitalization services, electroconvulsive therapy, and Transcranial Magnetic Stimulation
	Inpatient services	20% <u>coinsurance</u>	Not covered	Pre-authorization required for all inpatient services
If you are pregnant	Office visits	20% <u>coinsurance</u>	Not covered	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).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	Coverage limited to care ordered by a plan physician and provided by a R.N, L.P.N., L.V.N., or home health aide. Therapy applicable to applicable <u>copayments</u> and limits.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not covered	Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	Pre-authorization required. 100 days/plan year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Pre-authorization required
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	Pre-authorization required
If your child needs dental or eye care	Children's eye exam	No charge <u>Deductible</u> does not apply	Not covered	One exam/plan year from participating EyeMed providers only
	Children's glasses	\$200 allowance/glasses or contact lenses for ocular injury or intraocular surgery Not covered/all other	Not covered	One pair/plan year from participating EyeMed providers only
	Children's dental check-up	Not covered	Not covered	--none--

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Private-duty nursing
- Weight loss programs

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

- Routine eye care (Adult)
- Routine foot care when under active treatment for metabolic disease

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 or www.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.

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.

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 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 certain types of 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, kwijjigo holne' 1-855-687-6260.

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

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 \$2,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,170

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

- The plan's overall deductible \$2,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$200
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,300

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

- The plan's overall deductible \$2,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200