OPTIMA POS
POINT OF SERVICE PLAN SUMMARY OF BENEFITS

City of Portsmouth 2020

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 employer group plan Summary Plan Description (SPD), the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. There are two benefit columns. One column lists Your Copayment or the percent Coinsurance You will pay for In Network benefits from Plan Providers. The other column lists Your Copayment or the percent Coinsurance You will pay for Out of Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Summary Plan Description document carefully.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT

	In-Network Benefits	Out-of-Network Benefits
Deductibles per Calendar Year[3]	$1,000 per Person $2,000 per Family	$2,000 per Person $4,000 per Family
Maximum Out-of-Pocket Limit per Calendar Year	$4,000 per Person[4] $8,000 per Family[4]	$7,000 per Person[5] $10,000 per Family[5]

PHYSICIAN SERVICES

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery[6]**.

Physician Office Visits	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Primary Care Physician (PCP) Office Visit	You Pay $35	After Deductible You Pay 30%
MDLIVE Services Contact MDLIVE at 1-866-648-3638 or mdlive.com/optimahealth	You Pay $35	Virtual Consults are not Covered Out-of-Network
Specialist Office Visit	You Pay $35	After Deductible You Pay 30%
Preventive Care [10,11]	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Routine Annual Physical Exams **Well Baby Exams** **Annual GYN Exams and Pap Smears [11]** **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** **Women's Preventive Services**	Covered at 100%	After Deductible You Pay 30%

OUTPATIENT THERAPY AND REHABILITATION SERVICES

You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation 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.

Short Term Therapy Services[7]	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Physical Therapy **Occupational Therapy** **Speech Therapy** **Pre-Authorization is required.[6]** Services are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 10% per visit	After Deductible You Pay 30% per visit

Short Term Rehabilitation Services[7]	In-Network Benefits Copayments/Coinsurance[2]	Out-of-Network Benefits Copayments/Coinsurances[2]
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.[6]** Services are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 10% per visit	After Deductible You Pay 30% per visit
Other Outpatient Treatments	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	After Deductible You Pay 10% per visit	After Deductible You Pay 30% per visit
OUTPATIENT DIALYSIS SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Dialysis Services Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 10% per visit	After Deductible You Pay 30% per visit
OUTPATIENT SURGERY		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Outpatient Surgery **Pre-Authorization is required.[6]** Coinsurance or Copayment applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible You Pay $165 and You Pay 10%	After Deductible You Pay 30% per visit
OUTPATIENT DIAGNOSTIC PROCEDURES		
Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Diagnostic Procedures	After Deductible You Pay 10%	After Deductible You Pay 30%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 10%	After Deductible You Pay 30%
Lab Work	After Deductible You Pay 10%	After Deductible You Pay 30%

OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[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** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Pre-Authorization is required for all procedures except MRS, SPECT and Nuclear Cardiology.[6]** 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 $165 and You Pay 10%	After Deductible You Pay 30%
MATERNITY CARE		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Maternity Care [8, 10,11] **Pre-Authorization is required for prenatal services.[6]** Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	You Pay $35 for initial visit, then You Pay 10%	After Deductible You Pay 30%
INPATIENT SERVICES		
Inpatient Services	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Hospital Services **Pre-Authorization is required.[6]**	After Deductible You Pay $400 and You Pay 10%	After Deductible You Pay $400 and You Pay 30%
Transplants **Pre-Authorization is required.[6]**	After Deductible You Pay $400 and You Pay 10%	After Deductible You Pay $400 and You Pay 30%
Skilled Nursing Facilities/Services[7] **Pre-Authorization is required.[6]** Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined with In-Network and Out-of-Network benefits per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services.[7]	After Deductible You Pay 10%	After Deductible You Pay 30%
AMBULANCE SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Ambulance Services[9] **Pre-Authorization is required for non-emergent transportation only.**[6] 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 10%	After Deductible You Pay 10%

EMERGENCY SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Emergency Services [2, 9] **Pre-Authorization is <u>not</u> required.** Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.	After Deductible You Pay $300	After Deductible You Pay $300
URGENT CARE CENTER SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Urgent Care Services[9] **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.	You Pay $65	After Deductible You Pay 30%
MENTAL/BEHAVIORAL HEALTH & 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), electro-convulsive therapy, and Transcranial Magnetic Stimulation (TMS).[6]**		
Mental/Behavioral Health/Substance Use Disorder	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Services **Pre-Authorization is required[6]**	After Deductible You Pay $400 and You Pay 10%	After Deductible You Pay $400 and You Pay 30%
Outpatient Office Visits	You Pay 10%	After Deductible You Pay 30%
Other Outpatient Visits **(Includes Hospital Outpatient and Freestanding Outpatient Centers)**	After Deductible You Pay 10%	After Deductible You Pay 30%
DIABETES TREATMENT		
Coverage includes benefits for equipment, supplies and 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. Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating Eye Med Provider at the applicable office visit Copayment or Coinsurance amount.		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Insulin Pumps **Pre-Authorization is required.[6]**	Covered at 100%	After Deductible You Pay 30%
Pump Infusion Sets and Supplies **Pre-Authorization is required.[6]**	After Deductible You Pay 20%	After Deductible You Pay 30%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution.	After Deductible You Pay 20%	After Deductible You Pay 30%
Insulin, Needles, and Syringes	Covered under the Prescription Drug Benefit.	Covered under the Prescription Drug Benefit.
Outpatient Self-Management Training and Education and Nutritional Therapy	Covered at 100%	After Deductible You Pay 30%

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Prosthetics and Components **Pre-Authorization is required.[6]** Services include coverage for medically necessary prosthetic devices. This also includes 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 10%	After Deductible You Pay 30%
Allergy Care and Testing	You Pay $35 per PCP office visit You Pay $35 per Specialist office visit Allergy serum Covered at 100%	After Deductible You Pay 30%
Autism Spectrum Disorder **Pre-Authorization is required.[6]** Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder in children from age two through ten. "Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of Autism Spectrum Disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder. "Treatment for Autism Spectrum Disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) psychiatric care, (iii) psychological care, (iv) therapeutic care, and (v) **Applied Behavioral Analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.** "Applied Behavioral Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. **Coverage for Applied Behavioral Analysis under this benefit is limited to an annual maximum benefit of $35,000.[6]**	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Clinical Trials **Pre-Authorization is required.[6]** Coverage of routine patient costs for phase I, II and 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.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.
Durable Medical Equipment (DME) and Supplies Orthopedic Devices and Prosthetic Appliances **Pre-Authorization is required for single items over $750.[6]** **Pre-Authorization is required for all rental items.[6]** **Pre-Authorization is required for repair and replacement.[6]** 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 10%	After Deductible You Pay 30%
Early Intervention Services **Pre-Authorization is required.[6]** Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.	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.
Hearing Aid Rider[7] **Pre-Authorization is required.[6]** The following services are covered up to a maximum combined benefit with In-Network and Out-of-Network benefits of $2,000: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 36 months from date of acquisition. Batteries are not covered. Supplies are not covered.	Covered at 100% Cost sharing amounts You pay for this rider will not count toward Your Maximum Out of Pocket Limit.	After Deductible You Pay 30% Cost sharing amounts You pay for this rider will not count toward Your Maximum Out of Pocket Limit.
Home Health Care Skilled Services[7] **Pre-Authorization is required.[6]** Services are covered up to a maximum combined benefit with In-Network and Out-of-Network benefits of 100 visits per calendar year for Members who are home bound, and in the Plan's judgment require Home Health Skilled Services.[7] You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.	After Deductible You Pay 10%	After Deductible You Pay 30%

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Hospice Care **Pre-Authorization is required.[6]**	After Deductible You Pay 10%	After Deductible You Pay 30%
Infertility Treatment Rider[7] **Pre-Authorization is required.[6]** 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) Artificial insemination (Limited to 6 per lifetime) Diagnostic laparoscopy (Limited to 1 per lifetime) **Covered Services do not include IVF and all other types of artificial or surgical means of conception and drugs used in connection with these procedures.**	After Deductible You Pay 50% of fee schedule or allowable charge	After Deductible You Pay 50% Cost sharing amounts You pay for this rider will not count toward Your Maximum Out of Pocket Limit.
Preventive Vision Services[7] Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 24 months when done by a participating EyeMed Provider. To contact EyeMed about participating Providers call 1-888-610-2268.	You Pay $15 Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit unless services are considered an Essential Health Benefit (EHB) for children.	For eye examinations from Out-of-Network Non-Plan Providers, Members will be reimbursed up to $30 for an eye examination only. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit.
Telemedicine Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. 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.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. 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.

NOTES

All benefits are subject to the terms and conditions in the *Summary Plan Description* (SPD). Words that are capitalized are defined terms listed in the Definitions section of the SPD.

Children are covered up to the end of the year in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your 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.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your SPD 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 SPD 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 Health's **Allowable Charge** for the Covered Service You receive.

   Allowable Charge is the amount Optima Health 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 Health or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.

   Covered Services You receive from Non-Plan Providers will be administered under Your Out-of-Network benefits with the following exceptions:

   - If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits.

   - Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket amounts.

   When You use Out-of-Network benefits from Non-Plan Providers Allowable Charge may be a negotiated rate; or if there is no negotiated rate Allowable Charge is Optima Health's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full. Except in an Emergency if You use a Non-Plan Provider who charges more than our allowable amount the Provider may balance bill You for the difference. You will have to pay the difference to the Provider in addition to Your Copayment or Coinsurance amount. Charges from Non-Plan Providers will be higher than the Plan's Allowable Charge so You will usually pay more out of pocket when You use Out-of-Network benefits.

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. Your Plan may have separate Deductible amounts You have to meet for In-Network Covered Services and for Out-of-Network Covered Services. Amounts applied to an In-Network Deductible will apply toward the Plan's In-Network Maximum Out of Pocket Limit. Amounts applied to an Out-of-Network Deductible will apply toward the Plan's Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage You must satisfy the individual member coverage Deductible before coverage begins. If You have family coverage You and Your family must satisfy the family coverage Deductible. This Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. Amounts You are required to pay for preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Preventive Care Visits and Screenings You receive from In-Network Plan Providers. Cost sharing amounts You pay for some Covered Services will not count toward any Deductible. Deductibles 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.

4. **Maximum Out of Pocket Limit for In-Network Benefits** means the total dollar amount You and Your family pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's Out-of-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out of Pocket Amount Optima Health will cover most In-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Plan In-Network benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out of Pocket Amount Optima Health will cover most In-Network benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **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 In-Network Maximum Out of Pocket Limit:

1. Amounts You pay for services or charges not covered under Your Plan;
2. Amounts You pay for services after a benefit limit has been reached;
3. Balance billing amounts from Non-Plan Providers;
4. Premium amounts;
5. Except for Emergency Services, amounts You pay for Out-of-Network Services;
6. Cost Sharing amounts including Copayments, Coinsurance, and Deductibles for the following:
    i. Amounts You pay for Vision care unless services are considered an Essential Health Benefit (EHB) for children;
    ii. Amounts You pay for any benefits covered under a plan rider for Hearing Aids.

5. **Maximum Out of Pocket Limit for Out-of-Network Benefits** means the total dollar amount You and Your family will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's In- Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage once You meet the per individual Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out-of-Pocket Amount Optima Health will cover most Out-of-Network Plan benefits with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **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. Deductibles, Copayments, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Amounts You pay for In- Network Benefits;
    4. Amounts You pay for Vision care;
    5. Amounts You pay for any benefits covered under a plan rider including riders for Infertility Treatment, Vision Care and Materials, Hearing Aids, Chiropractic Care, Oral Surgery/Wisdom Teeth Extraction
    6. Amounts applied to Your In-Network Deductible;
    7. Balance billing amounts that exceed the Plan's Allowable Charge for a Covered Service from a Non-Plan Provider;
    8. Premium amounts;
    9. Amounts You pay for transplant services from Non-Plan Providers

6. This benefit requires Pre Authorization before You receive services. We have instructions and procedures in place for providers to obtain Pre-Authorization through Case Management/Clinical Care Services. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.
7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. Unless otherwise noted benefit limits are combined for services received both In-Network and Out-of-Network and for all places of service. 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 not Covered Services and will not count toward Your In-Network or Out-of-Network Maximum Out of Pocket Maximum Limit.

8. 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.

9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital

emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. 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

10. 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. Where no frequency or limits are indicated the Plan will use it's normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

    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 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.

11. 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, or procedures for making referrals. Look in Your SPD in the Utilization Management Section for more information on Pre-Authorization.

Optima Health Alternative Language Options for Notices and other Written Information

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

Amharic:
ማሳሰቢያ፡
አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260።

Arabic:

تنبيه:
إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجانًا. اتصل بالرقم 1-855-687-6260.

Bengali/Bangla:
লক্ষ্য করবেনঃ যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন– 1-855-687-6260।

Chinese (Mandarin):
注意：如果您讲中文普通话，可以免费获得语言协助服务。请拨打电话 1-855-687-6260。

French:
ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260.

German:
ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 zur Verfügung.

Gujarati:
ધ્યાન આપો : જો તમે ગુજરાતી બોલી છો તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કૉલ કરો.

Hindi:
ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 पर कॉल करें।

Hmong:
CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260.

Igbo:
GEE NT Ị: ọbụrụ na ị na-asụ Igbo, ị ga-enweta enyemaka n'efu site n'aka ndị ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

Japanese:
重要：日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260までお電話ください。

Korean:
주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260번으로 전화해 주십시오.

Kru/Bassa:
YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha I nyuu hola we. Sebel: 1-855- 687-6260.

Laotian:
ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນໍາໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

Mon-Khmer, Cambodian:
កំណត់សំគាល់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260។

Navajo:
SHOOH: Diné Bizaad bee yáníłti'go doo bą́ą́h ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'ą́. Kojį' hólne' 1-855-687-6260.

Persian/Farsi:
توجه:
اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 تماس بگیرید.

Portuguese:
ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260.

Russian:
ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260, и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:
ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260.

Turkish:
DİKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz. 1-855-687-6260 numaralı telefonu arayın.

Urdu:
توجہ دیں:
اگر آپ اُردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 کال کریں۔

Vietnamese:
CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260.

Yoruba:
KÉÉRE:
Ti o bá ń sọ èdè Yorùbá, iṣẹ́ ìrànlọ́wọ́ èdè wà fún ọ lọ́fẹ̀ẹ́. Pe 1-855-687-6260