OPTIMA POS 500/15/20%

POINT OF SERVICE PLAN SUMMARY OF BENEFITS

James City County
Effective July 1, 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 document, 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 document (SPD) carefully.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT		
	In-Network Benefits	**Out-of-Network Benefits**
Deductibles per Contract Year[3]	$500 per Person $1,000 per Family	$800 per Person $1,600 per Family
Maximum Out-of-Pocket Limit per Contract Year	$3,750 per Person[4] $7,500 per Family[4]	$4,750 per Person[5] $9,500 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 $15	After Deductible You Pay 30%
Virtual Consults Must be furnished by approved Optima Health providers.	You Pay $15	Virtual Consults are not Covered Out-of-Network
Specialist Office Visit	You Pay $35	After Deductible You Pay 30%
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 50%	After Deductible You Pay 50%
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**	No Charge	After Deductible You Pay 30%

OUTPATIENT THERAPY AND REHABILITATION SERVICES		
You Pay a Copayment or Coinsurance amount for each visit 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** **Pre-Authorization is required.[6]** Physical and Occupational Therapy 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 contract year.[7]	You Pay $25	After Deductible You Pay 30%
Speech Therapy **Pre-Authorization is required.[6]** Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per contract year.[7]	You Pay $25	After Deductible You Pay 30%
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 36 visits per contract year.[7]	You Pay $25	After Deductible You Pay 30%
Other Outpatient Therapy Services	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
IV Infusion Therapy **Respiratory/Inhalation Therapy**	You Pay $15 per PCP office visit You Pay $35 per Specialist office visit After Deductible You Pay 20% per outpatient facility visit	After Deductible You Pay 30%
Chemotherapy and Chemotherapy Drugs **Radiation Therapy** **Pre-Authorization is required for Chemotherapy and Chemotherapy Drugs, Radiation Therapy.[6]**	You Pay $15 per PCP office visit You Pay $35 per Specialist office visit After Deductible You Pay 20% per outpatient facility visit	After Deductible You Pay 30%
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-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. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 20%	After Deductible You Pay 30%
OUTPATIENT DIALYSIS SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Dialysis Services	After Deductible You Pay 20%	After Deductible You Pay 30%

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 20%	After Deductible You Pay 30%
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 20%	After Deductible You Pay 30%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 20%	After Deductible You Pay 30%
Lab Work	After Deductible You Pay 20%	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 20%	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.	After Deductible You Pay 20%	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 20%	After Deductible You Pay 30%
Transplants **Pre-Authorization is required.[6]**	After Deductible You Pay 20%	After Deductible 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 contract year that in the Plan's judgment requires Skilled Nursing Facility Services.[7]	After Deductible You Pay 20%	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 20%	After Deductible You Pay 20%
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 20%	After Deductible You Pay 20%
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 $35	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 20%	After Deductible You Pay 30%
Outpatient Office Visits	You Pay $15	After Deductible You Pay 30%
Virtual Consults Must be furnished by approved Optima Health providers.	You Pay $15	Virtual Consults are not Covered Out-of-Network
Other Outpatient Visits **(Includes Hospital Outpatient and Freestanding Outpatient Centers)**	After Deductible You Pay 20%	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 EyeMed 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]	No Charge	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.	Covered under the Plan's Prescription Drug Benefit.	Covered under the Plan's Prescription Drug Benefit.
Insulin, Needles, and Syringes	Covered under the Plan's Prescription Drug Benefit.	Covered under the Plan's Prescription Drug Benefit.
Outpatient Self-Management Training and Education and Nutritional Therapy	No Charge	After Deductible You Pay 30%
OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Allergy Care	You Pay $15 per PCP office visit You Pay $35 per Specialist office visit	After Deductible You Pay 30%
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,	After Deductible You Pay 20%	After Deductible You Pay 30%

misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.		
Autism Spectrum Disorder **Pre-Authorization is required.[6]** Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder. "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) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) **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.
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.

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
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, ileostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.	After Deductible You Pay 20%	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.
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 contract 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 20%	After Deductible You Pay 30%
Hospice Care **Pre-Authorization is required.[6]**	After Deductible You Pay 20%	After Deductible You Pay 30%

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Preventive Vision Services[7] 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. To contact EyeMed about participating Providers call 1-888-610-2268.	No Charge 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 $45 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.
Infertility Services[7] Includes the following services, for Covered Persons only, to diagnose and treat underlying medical 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 Artificial Insemination (AI), In-Vitro Fertilization (IVF) and all other types of artificial or surgical means of conception and drugs used in connection with these procedures.**	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.

Rider	In-Network Benefits Copayments/Coinsurance[2]	Out-of-Network Benefits Copayments/Coinsurances[2]
Chiropractic Care Rider [7] **Pre-Authorization is required by ASH for all Chiropractic services.** Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit. Pre-Authorization is required by ASH for all chiropractic care services To use this benefit call ASH's Member Services at 1-800-678-9133. Representatives are available 8:00 AM to 9:00 PM Monday-Friday. Coverage is limited to a combined maximum benefit with In-and Out-of-Network benefits of 30 visits per contract year. This benefit also includes coverage of Chiropractic appliances up to a combined maximum benefit with In-and Out-of-Network benefits of 1 appliance per Person per contract year when medically necessary. For providers not in the ASH network the Member will be responsible for payment of all charges in excess of ASH's allowable charge in addition to any Coinsurance amount. Allowable charge is the lesser of the provider's actual charge or ASH's In-Network fee schedule for the same services.	You Pay $25	After Deductible You Pay 30%

NOTES

All benefits are subject to the terms and conditions in the Summary plan document (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.

   Services or treatment You receive from Out-of-Network Non-Plan Providers will be Covered under Your POS Out-of-Network benefits except in the following situations:

   - 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.

3. **Deductible** means the dollar amount You must pay out of pocket each contract 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.

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 contract 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. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available;
6. Except for Emergency Services, amounts You pay for Out-of-Network Services;
7. 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 including riders for Vision Care and Materials unless services are considered an Essential Health Benefit (EHB) for children, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction unless services are considered an Essential Health Benefit (EHB) for children

5. **Maximum Out of Pocket Limit for Out-of-Network Benefits** means the total dollar amount You and Your family will pay during a contract 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. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available. Ancillary charges are not Covered Services;
    7. Amounts applied to Your In-Network Deductible;
    8. Balance billing amounts that exceed the Plan's Allowable Charge for a Covered Service from a Non-Plan Provider;
    9. Premium amounts;
    10. 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 Medical 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. Recommended Preventive Care listed below will be covered with no Member cost-sharing when received from In-Network Plan Providers. However, You may still have to pay Your office visit cost sharing including Copayments, Coinsurance, and Deductibles listed on the Face Sheet of Your Evidence of Coverage in certain circumstances:
    - You will pay office visit cost sharing if Your preventive care item or service is billed separately, or is tracked as individual encounter data separately from the office visit.
    - You should not pay office visit cost sharing if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit, and the primary purpose of the office visit is the delivery of the preventive item or service.
    - You will pay office visit cost sharing if an item or service is not billed separately, or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.
    - You will pay Out-of-Network Copayments, Coinsurance, and Deductibles for preventive care items and services and office visits you receive from Out-of-Network Non-Plan Providers.

    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. Some services may be administered under Your prescription drug benefit under the Plan. Services covered under the Plan's outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. **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 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.

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 POS $15/40/75/20%
Outpatient Prescription Drug Summary of Benefits

This Summary of Benefits describes Your outpatient prescription drug coverage. All drugs must be United States Food, Drug Administration (FDA) approved, and you must have a prescription. You will need to pay Your Copayment or Coinsurance when you fill your prescription at the pharmacy. If Your Plan has a Deductible, You must meet that amount before your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. Your drug coverage has specific Exclusions and Limitations listed in Your coverage documents. Optima Health's Pharmacy and Therapeutics Committee places covered drugs into the following Tiers. You will pay Your Copayment or Coinsurance depending on which Tier Your Drug is in.

- **Selected Generic (Tier 1)** includes commonly prescribed generic drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.

- **Selected Brand & Other Generic (Tier 2)** includes brand-name drugs, and some generic drugs with higher costs than Tier 1 generics, that are considered by the Plan to be standard therapy.

- **Non-Selected Brand (Tier 3)** includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a generic equivalent or a 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 (Tier 4)** includes those drugs classified by the Plan as Specialty Drugs. Tier 4 also includes covered compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or on-going medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional. Specialty Drugs include the following:

  - Medications that treat certain patient populations including those with rare diseases;
  - Medications that require close medical and pharmacy management and monitoring;
  - Medications that require special handling and/or storage;
  - Medications derived from biotechnology and/or blood derived drugs or small molecules; and
  - Medications that can be delivered via injection, infusion, inhalation, or oral administration.

  Specialty Drugs are only available through the Optima Health specialty mail order pharmacy. Proprium Pharmacy at 1-855-553-3568. Specialty Drugs will be delivered to Your home address from Our Specialty mail order pharmacy. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Pharmacy Member Services at the number on Your Optima Health ID Card. You can also log onto optimahealth.com for a list of Specialty Drugs.

  A compound prescription medication is used to meet the needs of a specific individual and must have at least one ingredient requiring a Physician's authorization by State or Federal Law. Compound prescriptions can usually be filled at Your local pharmacy.

Your Copayment, Coinsurance, and Deductible amounts for each Tier are listed below. Your Maximum Out-of-Pocket Limit is also listed below. If You need help please call Member Services or log on to optimahealth.com to find out which of the following Tiers Your drug is in.

Maximum Out-of-Pocket Limit	
Maximum Out-of-Pocket Limit	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Maximum Medical Out of Pocket Limit Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are not Covered, do not count toward the Plan's Maximum Out of Pocket Limit and must continue to be paid after the Maximum Out of Pocket Limit has been met.
Insulin, syringes, and needles	Covered at the cost sharing listed below for the applicable Tier.
Diabetic Testing Supplies covered including blood glucose monitors, test strips, lancets, lancet devices, and control solution	Covered at 100% Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. Pre-Authorization is required for talking blood glucose meters.
Copayments and Coinsurances.	
For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge. 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 the Copayment charge. ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider are covered with no Member cost sharing. **Please use the following link for a complete list of covered preventive care services:** **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**	
Selected Generic (Tier 1)	You Pay $15 Copayment
Selected Brand & Other Generic (Tier 2)	You Pay $40 Copayment
Non-Selected Brand (Tier 3)	You Pay $75 Copayment
Specialty Drugs (Tier 4)	You Pay 20% with a maximum Copayment of $200 per prescription per 31 day supply.
Mail Order Pharmacy Benefit Copayments and Coinsurances	
Some Outpatient prescription drugs are available through the Plan's Mail Order Provider. <u>This does not include Tier 4 Specialty Drugs.</u> You may call OptumRx Home Delivery at 866-244-9113 to find out if a drug is available. If Your drug is available You may purchase up to a 90-day supply for 2.5 Copayments or the applicable Coinsurance amount. If available under mail order benefits Prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider are covered with no Member cost sharing.	
Selected Generic (Tier 1)	You Pay $38 Copayment
Selected Brand & Other Generic (Tier 2)	You Pay $100 Copayment
Non-Selected Brand (Tier 3)	You Pay $188 Copayment
Specialty Drugs (Tier 4)	No 90-day mail order benefits are available for Tier 4 Specialty Drugs.

LIMITATIONS AND OTHER COVERAGE TERMS.

The following is a list of exclusions, Limitations and other conditions that apply to Your drug benefit.

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 the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's Allowable Charge.
3. Deductible means the dollar amount You must pay out-of-pocket each year for Covered Services before the Plan begins to pay for Your benefits.
4. Prescriptions may be filled at a Plan pharmacy or at a non-participating pharmacy if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies.
5. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law.
6. Amounts You pay for any outpatient prescription drug after a benefit Limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.
7. 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. However, the Plan may approve Coverage of limited quantities of an OTC drug. You 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.
8. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. You can call Member Services at the number on Your ID card to verify that your prescription drug has been pre-authorized.
9. Unless required by law, certain Prescription Drugs may not be Covered under the Plan if You could use a "clinically equivalent drug." "Clinically equivalent drug" means a drug that for most individuals will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered by the Plan please call the Member Services number on the back of Your Optima identification card. If You or Your doctor believes You need to use a different Prescription Drug, please have Your doctor contact Us. If We agree that it is Medically Necessary and appropriate we will cover the other Prescription Drug instead of the "clinically equivalent drug."
10. At its' sole discretion Optima Health's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in or if a particular drug is included on the Plan's formulary. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list or Your Plan's formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
11. Insulin, syringes, needles, blood glucose monitors, test strips, lancets, lancet devices, and control solution are covered under the Plan's prescription drug benefit. Insulin pumps, pump infusion sets and 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 non-insulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, are covered under the Plan's medical benefit. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under the Plan.
12. 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.
13. 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.
14. 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.

15. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
16. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to two 90 day courses of treatment per year when prescribed by a health care provider.

PRESCRIPTION DRUG COVERAGE EXCLUSIONS.

The following is a list of exclusions that apply to Your drug benefit.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications with no approved FDA indications are excluded from Coverage.
3. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
4. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
5. 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.
6. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage under this rider.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage under this rider.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage under this rider.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. 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.
13. 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.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded from Coverage
18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country
20. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage
22. Medical foods are excluded from Coverage.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following Standard reference compendia are not Covered Services:
    a. American Hospital Formulary Service Drug Information;
    b. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
    c. Elsevier Gold Standard's Clinical Pharmacology.
24. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
25. Non-Sedating antihistamines are excluded from Coverage.
26. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage.
27. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
28. Prescriptions written by a licensed dentist are excluded from Coverage, except for the prevention of infection or pain in conjunction with a Covered dental procedure.

29. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription
30. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
31. Infertility drugs are excluded from Coverage.
32. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.

Synchronization of Medication. For prescription drugs Covered under the Plan We will permit and apply a prorated daily cost sharing rate to prescriptions that are dispensed by an In-Network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the Member, and the Member requests or agrees to a partial supply for the purpose of synchronizing the Member's medications. Proration will not occur more frequently than annually.

The Plan will not deny Coverage for the dispensing of a medication by an In-Network pharmacy on the basis that the dispensing is for a partial supply if the prescribing provider or the pharmacist determines the fill or refill is in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the Member's medications.