The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://www.optimahealth.com/eoccoidoc/Plus_MM_PPO__201701.pdf or call 1-800-275-3755. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the glossary at healthcare.gov/sbc-glossary/ or call 1-800-275-3755 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person / **$2,000** family In-Network **$3,000** person / **$6,000** family Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs; most services that require a copayment; and preventive care, vision, and materials are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. For in-network providers **$4,000** person / **$8,000** family and out-of-network providers **$8,000** person /**$16,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, healthcare this plan does not cover, and pre-authorization penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.optimahealth.com or call 1-800-275-3755.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copayment per visit; deductible does not apply	40% Coinsurance	None
	Specialist visit	$40 Copayment per visit; deductible does not apply	40% Coinsurance	None
	Preventive care/screening/immunization	No Charge ; deductible does not apply	40% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Benefits may be denied or reduced without pre-authorization
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at optimahealth.com.	Generic drugs (Tier 1)	$15 Copayment retail/$38 Copayment mail order	$15 Copayment retail/Mail Order Not Covered	Coverage is limited to FDA-approved prescription drugs. For non-selected brand and specialty drugs, the out-of-pocket amount is limited to $250 Copayment per retail prescription. If brand drugs are used when a generic is available, you must pay the difference in cost plus the Copayment or Coinsurance amount. Covers up to a 31-day supply (retail); 31- to 90-day supply (mail order). Not all drugs are available through a mail order program.
	Preferred brand drugs (Tier 2)	$40 Copayment retail/$100 Copayment mail order	$40 Copayment retail/Mail Order Not Covered	
	Non-preferred brand drugs (Tier 3)	Greater of $75 Copayment retail or 20% Coinsurance/Greater of $225 Copayment mail order or 20% Coinsurance	Greater of $75 Copayment retail or 20% Coinsurance/Mail Order Not Covered	
	Speciality drugs (Tier 4)	20% Coinsurance retail	20% Coinsurance retail	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Benefits may be denied or reduced without pre-authorization
	Physician/ surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	$25 Copayment per trip then 20% Coinsurance	40% Coinsurance	None
	Urgent care	$40 Copayment per visit; deductible does not apply	40% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Benefits may be denied or reduced without pre-authorization
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you have mental health, behavioral health, or substance abuse services	Outpatient services	Mental Health Outpatient: $25 Copayment per visit; deductible does not apply EAV: No Charge ; deductible does not apply	Mental Health Outpatient: 40% Coinsurance EAV: Not Covered	Benefits may be denied or reduced without pre-authorization for intensive outpatient program, partial hospitalization services, electro-convulsive therapy, and Transcranial Magnetic Stimulation. EAV: 3 visits/presenting issue by Optima EAV providers only
	Inpatient services	20% Coinsurance	40% Coinsurance	Benefits may be denied or reduced without pre-authorization for all inpatient services.
If you are pregnant	Office visits	20% Coinsurance	40% Coinsurance	Benefits may be denied or reduced without pre-authorization for prenatal services. Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Benefits may be denied or reduced without pre-authorization. 100 visits/plan year
	Rehabilitation services	Physical and Occupational Therapy: 20% Coinsurance Speech Therapy: 20% Coinsurance	Physical and Occupational Therapy: 40% Coinsurance Speech Therapy: 40% Coinsurance	Benefits may be denied or reduced without pre-authorization. 30 visits/plan year for PT, OT. 30 visits/plan year for ST
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Benefits may be denied or reduced without pre-authorization. 90 days/plan year
				Benefits may be denied or reduced

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	30% Coinsurance	40% Coinsurance	without pre-authorization for single items over $750, all rental items, and repair and replacement.
	Hospice services	20% Coinsurance	40% Coinsurance	Benefits may be denied or reduced without pre-authorization
If your child needs dental or eye care	Children's eye exam	No Charge ; deductible does not apply	$30 Reimbursement; deductible does not apply	Coverage limited to one exam/plan year from participating EyeMed providers
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric Dental Check-ups
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic Care
- Routine eye care (Adult)

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-800-275-3755. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, at 1-877-310-6560 or bureauofinsurance@scc.virginia.gov; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan. For a denial of a claim. This complaint is called a grievance or appeal. For more Information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan. Documents also provide complete information to Submit a claim, appeal, or a grievance for any reason to your plan.For more information about your rights, this notice, or assistance, contact: Member Services at the number on the back of your member ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or your state department of insurance at the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O.Box 1157, Richmond, VA, 23218, 1-877-310-6560 or bureauofinsurance@scc.virginia.gov.

Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$30
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$0
Total Peg would pay is	**$3,330**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$60
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Joe would pay is	**$960**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
Total Mia would pay is	**$1,060**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-275-3755.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://www.optimahealth.com/eoccoidoc/Vant_MM_HMO__201701.pdf or call 1-800-275-3755. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the glossary at healthcare.gov/sbc-glossary/ or call 1-800-275-3755 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person / **$2,000** family In-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs; most services that require a copayment; and preventive care, vision, and materials are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. For in-network providers **$3,500** person / **$7,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, healthcare this plan does not cover, and pre-authorization penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.optimahealth.com or call 1-800-275-3755.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copayment per visit; deductible does not apply	Not Covered	None
	Specialist visit	$40 Copayment per visit; deductible does not apply	Not Covered	None
	Preventive care/screening/immunization	No Charge ; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not Covered	Benefits may be denied or reduced without pre-authorization.
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at optimahealth.com.	Generic drugs (Tier 1)	$15 Copayment retail/$38 Copayment mail order	$15 Copayment retail/Mail Order Not Covered	Coverage is limited to FDA-approved prescription drugs. For non-selected brand and specialty drugs, the out-of-pocket amount is limited to $250 Copayment per retail prescription. If brand drugs are used when a generic is available, you must pay the difference in cost plus the Copayment or Coinsurance amount. Covers up to a 31-day supply (retail); 31- to 90-day supply (mail order). Not all drugs are available through a mail order program.
	Preferred brand drugs (Tier 2)	$40 Copayment retail/$100 Copayment mail order	$40 Copayment retail/Mail Order Not Covered	
	Non-preferred brand drugs (Tier 3)	Greater of $75 Copayment retail or 20% Coinsurance/Greater of $225 Copayment mail order or 20% Coinsurance	Greater of $75 Copayment retail or 20% Coinsurance/Mail Order Not Covered	
	Speciality drugs (Tier 4)	20% Coinsurance retail	20% Coinsurance retail	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	Benefits may be denied or reduced without pre-authorization.
	Physician/ surgeon fees	20% Coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	$100 Copayment per trip	Not Covered	None
	Urgent care	$40 Copayment per visit; deductible does not apply	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	Benefits may be denied or reduced without pre-authorization.
	Physician/surgeon fees	20% Coinsurance	Not Covered	None
If you have mental health, behavioral health, or substance abuse services	Outpatient services	Mental Health Outpatient: $20 Copayment Per visit; deductible does not apply EAV: No Charge ; deductible does not apply	Mental Health Outpatient: Not Covered EAV: Not Covered	Benefits may be denied or reduced without pre-authorization for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy, and Transcranial Magnetic Stimulation. EAV: 3 visits/presenting issue by Optima EAV providers only
	Inpatient services	20% Coinsurance	Not Covered	Benefits may be denied or reduced without pre-authorization for all inpatient services.
If you are pregnant	Office visits	$450 Copayment Global; deductible does not apply	Not Covered	Benefits may be denied or reduced without pre-authorization for prenatal services. Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	Not Covered	
	Childbirth/delivery facility services	20% Coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	$20 Copayment per visit; deductible does not apply	Not Covered	Benefits may be denied or reduced without pre-authorization. 100 visits/plan year
	Rehabilitation services	Physical and Occupational Therapy: 20% Coinsurance Speech Therapy: 20% Coinsurance	Physical and Occupational Therapy: Not Covered Speech Therapy: Not Covered	Benefits may be denied or reduced without pre-authorization. 30 visits/plan year for PT, OT. 30 visits/plan year for ST
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% Coinsurance	Not Covered	Benefits may be denied or reduced without pre-authorization. 100 days/plan year
				Benefits may be denied or reduced

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	30% Coinsurance	Not Covered	without pre-authorization for single items over $750, all rental items, and repair and replacement.
	Hospice services	No Charge	Not Covered	Benefits may be denied or reduced without pre-authorization.
If your child needs dental or eye care	Children's eye exam	No Charge ; deductible does not apply	$30 Reimbursement; deductible does not apply	Coverage limited to one exam/plan year from participating EyeMed providers
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric Dental Check-ups
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Routine eye care (Adult)

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Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan. For a denial of a claim. This complaint is called a grievance or appeal. For more Information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan. Documents also provide complete information to Submit a claim, appeal, or a grievance for any reason to your plan.For more information about your rights, this notice, or assistance, contact: Member Services at the number on the back of your member ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or your state department of insurance at the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O.Box 1157, Richmond, VA, 23218, 1-877-310-6560 or bureauofinsurance@scc.virginia.gov.

Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$450
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$0
Total Peg would pay is	**$3,300**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$60
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Joe would pay is	**$960**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
Total Mia would pay is	**$1,060**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-275-3755.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://www.optimahealth.com/eoccoidoc/EqPlus_MM_PPO__201701.pdf or call 1-800-275-3755. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the glossary at healthcare.gov/sbc-glossary/ or call 1-800-275-3755 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** person / **$6,000** family In-Network **$4,500** person / **$9,000** family Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, vision, and materials; and prescription drugs considered by the plan to be for preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. For in-network providers **$5,000** person / **$10,000** family and out-of-network providers **$9,000** person /**$18,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, healthcare this plan does not cover, and pre-authorization penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.optimahealth.com or call 1-800-275-3755.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	30% Coinsurance	None
	Specialist visit	No Charge	30% Coinsurance	None
	Preventive care/screening/immunization	No Charge ; deductible does not apply	30% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	30% Coinsurance	Benefits may be denied or reduced without pre-authorization
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at optimahealth.com.	Generic drugs (Tier 1)	$10 Copayment retail/$30 Copayment mail order	$10 Copayment retail/Mail Order Not Covered	The deductible does not apply to prescription drugs considered by the plan to be for preventive care. Coverage is limited to FDA-approved prescription drugs. For non-selected brand and specialty drugs, the out-of-pocket amount is limited to $250 Copayment per retail prescription. If brand drugs are used when a generic is available, you must pay the difference in cost plus the Copayment or Coinsurance amount. Covers up to a 31-day supply (retail); 31- to 90-day supply (mail order). Not all drugs are available through a mail order program.
	Preferred brand drugs (Tier 2)	$40 Copayment retail/$120 Copayment mail order	$40 Copayment retail/Mail Order Not Covered	
	Non-preferred brand drugs (Tier 3)	Greater of $60 Copayment retail or 20% Coinsurance/Greater of $180 Copayment mail order or 20% Coinsurance	Greater of $60 Copayment retail or 20% Coinsurance/Mail Order Not Covered	
	Speciality drugs (Tier 4)	20% Coinsurance retail	20% Coinsurance retail	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% Coinsurance	Benefits may be denied or reduced without pre-authorization
	Physician/ surgeon fees	No Charge	30% Coinsurance	None
If you need immediate medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	30% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	No Charge	30% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% Coinsurance	Benefits may be denied or reduced without pre-authorization
	Physician/surgeon fees	No Charge	30% Coinsurance	None
If you have mental health, behavioral health, or substance abuse services	Outpatient services	Mental Health Outpatient: No Charge EAV: No Charge ; deductible does not apply	Mental Health Outpatient: 30% Coinsurance EAV: Not Covered	Benefits may be denied or reduced without pre-authorization for partial hospitalization services, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation. EAV: 3 visits/presenting issue by Optima EAV providers only
	Inpatient services	No Charge	30% Coinsurance	Benefits may be denied or reduced without pre-authorization for all inpatient services.
If you are pregnant	Office visits	No Charge	30% Coinsurance	Benefits may be denied or reduced without pre-authorization for prenatal services. Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	30% Coinsurance	
	Childbirth/delivery facility services	No Charge	30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	30% Coinsurance	Benefits may be denied or reduced without pre-authorization. 100 visits/plan year
	Rehabilitation services	Physical and Occupational Therapy: No Charge Speech Therapy: No Charge	Physical and Occupational Therapy: 30% Coinsurance Speech Therapy: 30% Coinsurance	Benefits may be denied or reduced without pre-authorization. 30 visits/plan year for PT, OT. 30 visits/plan year for ST
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	No Charge	30% Coinsurance	Benefits may be denied or reduced without pre-authorization. 90 days/plan year
				Benefits may be denied or reduced

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No Charge	30% Coinsurance	without pre-authorization for single items over $750, all rental items, and repair and replacement.
	Hospice services	No Charge	30% Coinsurance	Benefits may be denied or reduced without pre-authorization
If your child needs dental or eye care	Children's eye exam	No Charge ; deductible does not apply	$30 Reimbursement; deductible does not apply	Coverage limited to one exam/plan year from participating EyeMed providers
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric Dental Check-ups
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic Care
- Routine eye care (Adult)

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-800-275-3755. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, at 1-877-310-6560 or bureauofinsurance@scc.virginia.gov; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan. For a denial of a claim. This complaint is called a grievance or appeal. For more Information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan. Documents also provide complete information to Submit a claim, appeal, or a grievance for any reason to your plan.For more information about your rights, this notice, or assistance, contact: Member Services at the number on the back of your member ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or your state department of insurance at the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O.Box 1157, Richmond, VA, 23218, 1-877-310-6560 or bureauofinsurance@scc.virginia.gov.

Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Peg would pay is	**$3,020**

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

The plan's overall deductible	$3,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Joe would pay is	**$3,030**

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

The plan's overall deductible	$3,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Mia would pay is	**$1,300**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-275-3755.

UNITED CONCORDIA® DENTAL

Dental Benefits Summary for VMDO Architects — Low OPTION

Effective Date: December 1, 2017 — *Advantage Plus 2.0*

Benefit Category[1]	CONCORDIA FLEX PLAN	
	In-Network[2]	Non-Network[2]
Class I – Diagnostic/Preventive Services		
Exams	100%	100%
Bitewing X-rays		
All Other X-rays		
Space Maintainers		
Cleanings & Fluoride Treatments		
Sealants		
Palliative Treatment		
Class II – Basic Services		
Basic Restorative (Fillings)	80%	80%
Simple Extractions		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns , Implants	0%	0%
Prosthetics (Bridges, Dentures)		
Included Plan Features		
Pregnancy Benefit	• Covers 1 additional cleaning during pregnancy • Covers 1 additional periodontal maintenance	
Smile for Health®--Wellness[3] *Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis and stroke*	• Covers 1 additional periodontal maintenance per year and all are covered at 100% • Scaling and root planning are covered at 100% • 4 periodontal surgery procedures are covered at 100%	
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)		
Annual Program Deductible (per person/per family)	$50/$150 Excludes Class I	
Annual Program Maximum (per person)	$1,000 Excludes Class I	
Reimbursement	**Adv+ 2.0**	**90th Percentile**

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

1. Unmarried dependent children covered to age 26.
2. . Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between the 90th percentile allowance and their fee (also known as balance billing). United Concordia Dental's standard exclusions and limitations apply
3. Members (subscribers or covered dependents) with certain medical conditions must sign up for this program through **My Dental Benefits** on **UnitedConcordia.com**.
4. Includes full mouth white fillings (composites) covered under class 2 services
5. Check for in network dental providers at www.unitedconcordia.com Network choice Advantage Plus
6. Preventive Incentive benefit included. None of the class 1 services count towards the plan maximum

UNITED CONCORDIA® DENTAL

Dental Benefits Summary for VMDO Architects High Option

Effective Date: December 1, 2017 ***Advantage Plus 2.0***

Benefit Category[1]	CONCORDIA FLEX PLAN	
	In-Network[2]	Non-Network[2]
Class I – Diagnostic/Preventive Services		
Exams Bitewing X-rays All Other X-rays Space Maintainers Cleanings & Fluoride Treatments Sealants Palliative Treatment	100%	100%
Class II – Basic Services		
Basic Restorative (Fillings) Simple Extractions Repairs of Crowns, Inlays, Onlays, Bridges & Dentures Endodontics Nonsurgical Periodontics Surgical Periodontics Complex Oral Surgery General Anesthesia	80%	80%
Class III – Major Services		
Inlays, Onlays, Crowns , Implants Prosthetics (Bridges, Dentures)	50%	50%
Orthodontics for dependent children to age 19		
Diagnostic, Active, Retention Treatment	Not Applicable	Not Applicable
Included Plan Features		
Pregnancy Benefit	• Covers 1 additional cleaning during pregnancy • Covers 1 additional periodontal maintenance	
Smile for Health®--Wellness[3] *Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis and stroke*	• Covers 1 additional periodontal maintenance per year and all are covered at 100% • Scaling and root planning are covered at 100% • 4 periodontal surgery procedures are covered at 100%	
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)		
Annual Program Deductible (per person/per family)	$50/$150 Excludes Class I	
Annual Program Maximum (per person)	$1,250 Excludes Class 1	
Reimbursement	**Advantage Plus 2.0**	**90th Percentile**

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

1. Unmarried dependent children covered to age 26
2. Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between the 90th percentile allowance and their fee (also known as balance billing). United Concordia Dental's standard exclusions and limitations apply
3. Members (subscribers or covered dependents) with certain medical conditions must sign up for this program through **My Dental Benefits** on **UnitedConcordia.com**.
4. Includes full mouth white fillings (composites) covered under class 2 services
5. Check for in network dental providers at www.unitedconcordia.com Network choice Advantage Plus 2.0