POS
CITY OF VIRGINIA BEACH & VIRGINIA BEACH CITY PUBLIC SCHOOLS
Plan Effective Date: 01/01/2023

Sentara Health Plans, Inc.
Large Group Benefit Summary

This benefit summary is not a contract or health plan policy from Optima Health. If there are any differences between this benefit summary and the employer group Plan Document, the provisions of the coverage documents will prevail for all benefits, conditions, cost sharing, and limitations and exclusions.

This Benefit Summary is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. There are two benefit columns. One column lists cost sharing amounts You will pay for In-Network benefits from Plan Providers. The other column lists cost sharing amounts You will pay for Out-of-Network benefits from Non-Plan Providers. This Plan has tiered Copayment or Coinsurance amounts listed for In-Network benefits. For some services You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals or other Facilities or providers. You or Your means the Subscriber and each family member who is a Covered Person under the Plan. Details about Covered Services are in the section "What is Covered." Details about services and treatments that are not covered are in the section "What is Not Covered."

Some benefits require Pre-Authorization before You receive them. These services are marked with an * in the Benefit Summary.

Some Covered Services may have visit limits. Once a visit limit is reached, no additional services are covered under the benefit. If a service is shown as covered under Out-of-Network benefits visit limits are combined with In-Network and Out-of-Network benefits unless otherwise stated.

Services or treatment You receive Out-of-Network or from Non-Plan Providers will be covered under the Plan's Out-of-Network benefits unless:

1. The Covered Service is an Emergency Service;
2. During treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

If Your Plan has a Deductible that is the dollar amount that must be paid out-of-pocket by a Member for Covered Services each year before the Plan begins to pay for benefits. Your Plan may have separate Deductibles for In-Network and Out-of-Network benefits.

Copayments and Coinsurances listed in this Benefit Summary are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan's Allowable Charge for Your Covered Service. You will pay a Copayment or a Coinsurance, but not both, for a Covered Service. For some benefits you may see the statement, "Cost sharing determined by the type and place of service." For these services Your cost sharing will be based on where you receive a service, for example in a physician office or inpatient setting, and/or the type of service. You may also have to pay for balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers.

Your Plan's Maximum Out-of-Pocket Amount means the total dollar amount Members pay, or that are paid on their behalf, out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the maximum amount. Your Plan may have separate maximum amounts for In-Network and Out-of-Network benefits.

Effective Period: From 01/01/2023 through 12/31/2023			
Deductible and Maximum Out-of-Pocket Amount (MOOP)			
	Tier 1 SQCN Network	**Tier 2 Optima Health/PHCS Network**	**Out-of-Network**
Deductible Plan Year	$850/Individual; $1,700/Family		$1,700/Individual; $3,400/Family

The Plan has one combined In-Network Deductible for Tier 1 and Tier 2 In-Network Covered Services, and a separate Deductible for Out-of-Network Covered Services. Most amounts You pay for Tier 1 and Tier 2 Covered Services will count toward meeting the In-Network Deductible. Most amounts You pay for Out-of-Network Covered Services will count toward meeting the Out-of-Network Deductible.

The Deductible applies to all Covered Services except for:

- In-Network Preventive Care Services required by law;
- Other services in this Benefit Summary shown as covered without a Deductible.

If You are the Subscriber, and the only Member covered under Your Plan, the Individual Deductible amount applies. If You have other Family Members on Your Plan the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one Family Member meets the Individual Deductible his or her benefits will begin. Once the total Family coverage Deductible is met benefits are available for all Family Members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a Member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible.
Any amounts applied to the Plan Deductible(s) during the last three months of the Plan year can be carried forward to the next year.

	Tier 1 SQCN Network	**Tier 2 Optima Health/PHCS Network**	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$3,000/Individual; $6,000/Family		$4,500/Individual; $9,000/Family

The Plan has one combined In-Network Maximum Out-of-Pocket Amount for Tier 1 and Tier 2 In-Network Covered Services, and a separate Maximum Out-of-Pocket Amount for Out-of-Network Covered Services. Most amounts You pay, or that are paid on Your behalf, for Tier 1 and Tier 2 Covered Services will count toward meeting the In-Network Maximum. Most amounts You pay, or that are paid on Your behalf, for Out-of-Network Covered Services will count toward meeting the Out-of-Network Maximum.

The following will not count toward the Plan maximum amount(s):

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic is available;
- Other services in this Benefit Summary that are shown as excluded from the maximum amount.

This Plan has an embedded maximum out of pocket. If You are the Subscriber, and the only Member covered under Your Plan, the Individual maximum applies. If You have other Family Members on Your Plan the Family maximum applies. Under Family coverage the Individual maximum applies separately to each covered Family Member. Once the total Family coverage maximum is met the Family maximum amount is satisfied. No one Member can contribute more than their Individual maximum amount to the Family limit.

Benefit	Tier 1 SQCN Network	Tier 2 Optima Health/PHCS Network	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Optima Health approved providers. ***Pre-Authorization is required for in-office surgery.** **SQCN - Sentara Quality Care Network** SQCN providers are currently available in Hampton Roads, Charlottesville and Rockingham zip codes only. Members who do not reside in those areas will pay the SQCN provider coinsurance. Members who reside in SQCN available zip codes and choose a non-SQCN provider will pay the higher coinsurance. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits.			
Primary Care Visit	You Pay $20	You Pay $40	After Deductible You Pay 40%
Virtual Consult Available for common, non-emergent services via phone or video, by approved Optima Health providers (includes e-visits and MDLIVE)	No Charge	No Charge	Virtual Consults are Not Covered Out-of-Network
Specialist Visit	You Pay $40	You Pay $60	After Deductible You Pay 40%
Preventive Care Recommended Preventive Care Services are covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/			
Recommended exams, screenings, tests, immunizations, and other services	No Charge		After Deductible You Pay 40%
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for 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. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits.			
Physical Therapy* Rehabilitative/Habilitative Services limited to 30 combined visits per Plan year.	After Deductible You Pay 15%		After Deductible You Pay 40%
Occupational Therapy* Rehabilitative/Habilitative Services limited to 30 combined visits per Plan year.	After Deductible You Pay 15%		After Deductible You Pay 40%

Benefit	Tier 1 SQCN Network	Tier 2 Optima Health/PHCS Network	Out-of-Network
Speech Therapy* Rehabilitative/Habilitative Services limited to 30 combined visits per Plan year.	After Deductible You Pay 15%		After Deductible You Pay 40%
Cardiac Rehabilitation* Services limited to 30 combined visits per Plan year.	After Deductible You Pay 15%		After Deductible You Pay 40%
Pulmonary Rehabilitation* Services limited to 30 combined visits per Plan year.	After Deductible You Pay 15%		After Deductible You Pay 40%
Vascular Rehabilitation* Services limited to 30 combined visits per Plan year.	After Deductible You Pay 15%		After Deductible You Pay 40%
Vestibular Rehabilitation* Services limited to 30 combined visits per Plan year.	After Deductible You Pay 15%		After Deductible You Pay 40%
IV Infusion Therapy	**PCP Office Visit** You Pay $20 **Specialist Office Visit** You Pay $40 **Outpatient Facility** After Deductible You Pay 15%		After Deductible You Pay 40%
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $20 **Specialist Office Visit** You Pay $40 **Outpatient Facility** After Deductible You Pay 15%		After Deductible You Pay 40%
Chemotherapy and Chemotherapy Drugs	**PCP Office Visit** You Pay $20 **Specialist Office Visit** You Pay $40 **Outpatient Facility** After Deductible You Pay 15%		After Deductible You Pay 40%
Radiation Therapy	**PCP Office Visit** You Pay $20 **Specialist Office Visit** You Pay $40 **Outpatient Facility** After Deductible You Pay 15%		After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	Tier 1 SQCN Network	Tier 2 Optima Health/PHCS Network	Out-of-Network
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs	After Deductible You Pay 15%		After Deductible You Pay 40%
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.			
Dialysis Services	After Deductible You Pay 15%		After Deductible You Pay 40%
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.			
Surgery Services*	After Deductible You Pay 15%		After Deductible You Pay 40%
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient facility or lab or a Hospital outpatient facility or lab. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits.			
Diagnostic Procedures	After Deductible You Pay 15%		After Deductible You Pay 40%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 15%		After Deductible You Pay 40%
Lab Work	After Deductible You Pay 15%		After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	Tier 1 SQCN Network	Tier 2 Optima Health/PHCS Network	Out-of-Network
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a free-standing outpatient facility or a Hospital outpatient facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.			
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	After Deductible You Pay 15%		After Deductible You Pay 40%
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.			
Maternity Care ***Pre-Authorization is required for prenatal services**	You Pay $350 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	You Pay $500 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 40%
Inpatient Services			
Inpatient Hospital Services*	After Deductible You Pay 15%		After Deductible You Pay 40%
Transplants*	After Deductible You Pay 15%		After Deductible You Pay 40%
Skilled Nursing Facility Services* Limited to a maximum of 100 days per Plan year.	After Deductible You Pay 15%		After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	Tier 1 SQCN Network	Tier 2 Optima Health/PHCS Network	Out-of-Network
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.			
Air, Water, Ground Services Non-Emergent Transportation *Pre-Authorization is required for non-emergency transportation.	You Pay 15% No Charge - If transported by a Virginia Beach Volunteer Rescue Squad		You Pay 15%
Emergency Services Includes medical and mental health and substance use disorder, Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including an independent freestanding Emergency Department, In-Network or Out-of-Network.			
Emergency Services	After Deductible You Pay 15%		After Deductible You Pay 15%
Emergency Ambulance	After Deductible You Pay 15% No Charge - If transported by a Virginia Beach Volunteer Rescue Squad		After Deductible You Pay 15%
Urgent Care Services 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 the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.			
Urgent Care Services	You Pay 15%		You Pay 40%
Mental Health and 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 Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.** Virtual Consults must be furnished by approved Optima Health providers. Residential Treatment Coverage includes inpatient services for mental health and/or substance use disorder treatment provided in a Facility licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-day nursing care by, or under the supervision of a registered nurse (RN).			
Inpatient Hospital Services*	After Deductible You Pay 15%		After Deductible You Pay 40%
Residential Treatment Services*	After Deductible You Pay 15%		After Deductible You Pay 40%
Outpatient Office Services (PCP, Specialist or Virtual Consults)	You Pay $20	You Pay $20	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	Tier 1 SQCN Network	Tier 2 Optima Health/PHCS Network	Out-of-Network
Partial Hospitalization / Intensive Outpatient Program Facility Services*	After Deductible You Pay 15%		After Deductible You Pay 40%
Other Outpatient Services	After Deductible You Pay 15%		After Deductible You Pay 40%
Diabetes Treatment Includes supplies, equipment, and education. Members may call 1-800-SENTARA for information on educational classes. Training must be provided by a certified, registered, or licensed health care professional. An annual diabetic eye exam is covered from an In-Network Plan Provider or a participating Vision Services Plan (VSP) provider at the office visit Copayment or Coinsurance amount.			
Insulin Pumps*	No Charge		You Pay 40%
Pump Infusion Sets and Supplies*	No Charge		You Pay 40%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors, continuous glucose monitors and control solution. ***Pre-Authorization is required for talking blood glucose monitors**	Covered under the Plan's Prescription Drug Benefit		Covered under the Plan's Prescription Drug Benefit
Insulin, Needles, Syringes	Covered under the Plan's Prescription Drug Benefit		Covered under the Plan's Prescription Drug Benefit
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge		You Pay 40%
Prosthetic Limb Replacement			
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible You Pay 15%		After Deductible You Pay 40%
Autism Spectrum Disorder Includes diagnosis and treatment of Autism Spectrum Disorder.			
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.		Cost sharing determined by the type and place of service.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	Tier 1 SQCN Network	Tier 2 Optima Health/PHCS Network	Out-of-Network
Durable Medical Equipment (DME) and Supplies			
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement and rental items.**	After Deductible You Pay 15%		After Deductible You Pay 40%
Early Intervention Services For Dependent children from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services.			
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices. *	Cost sharing determined by the type and place of service.		Cost sharing determined by the type and place of service.
Family Planning			
Family Planning - Vasectomy	After Deductible No Charge		After Deductible You Pay 40%
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home			
Home Health Care* Limited to a maximum of 100 visits per Plan year.	After Deductible You Pay 15%		After Deductible You Pay 40%
Hospice Care			
Hospice Care*	After Deductible You Pay 15%		After Deductible You Pay 40%
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.			
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing is determined by the type and place of service.		Cost sharing is determined by the type and place of service.
Clinical Trials Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.			
Clinical Trial Services*	Cost sharing is determined by the type and place of service.		Cost sharing is determined by the type and place of service.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	Tier 1 SQCN Network	Tier 2 Optima Health/PHCS Network	Out-of-Network
Allergy Care			
Allergy Care, Testing, Injections, Serum and RAST testing	You Pay 15%		You Pay 40%
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment; however, this is not a virtual consult as described on page 3 of this document. 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.			
Telemedicine Services	Cost sharing is determined by the type and place of service.		Cost sharing is determined by the type and place of service.
Chiropractic Care Rider Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit.			
Chiropractic Care Rider ***Pre-Authorization is required by ASH for all Chiropractic services.** Maximum number of visits 30 per Calendar year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Calendar year when medically necessary.	You Pay 15%		You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Hearing Aid Rider		
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $2,000 per ear: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 36 months from date of acquisition. Batteries and supplies are not covered.	After Deductible You Pay $40	After Deductible You Pay 40%
Vision Care and Materials Rider Optima Health contracts with Vision Services Plan (VSP) to administer this benefit.		
Includes a routine eye examination, refraction, and materials including lenses and frames, or contact lenses once every 12 months (from date of last exam) from a Participating Vision Services Plan (VSP) Provider.	**Examinations** Spectacle Exam: You Pay $20 ***OR*** Contact Lens Exam: You Pay $40 **Materials** Lenses (single, vision, bifocal, trifocal) covered in full. Frames covered in full up to $150 retail. Contact lenses (in lieu of glasses) covered in full up to $150 retail.	For eye examinations from Out-of-Network Non-Plan Providers Member's will be $40 for an eye examination only (once every 12 months from date of last exam). No coverage for eye glasses or contacts

Prescription Drugs

This Benefit Summary describes Your Plan's outpatient prescription drug coverage for medical and mental health substance use disorder treatment. 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. Details about Covered Services are in the section "What is Covered". Details about services and treatments that are not covered are in the section "What is Not Covered."

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.

Prescription drugs are placed into Tiers by the Plan's Pharmacy and Therapeutics Committee. For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug at a retail pharmacy or Optima's Specialty Pharmacy. Specialty Drugs will be delivered to Your home address from Our specialty mail order drug pharmacy.

Selected Generic Drugs (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 Drugs (Tier 2) includes brand-name drugs and some Generic Drugs with higher costs than Tier 1 Generic Drugs that are considered by the Plan to be standard therapy.

Non-Selected Brand Drugs (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 Product Level 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 compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. 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.. Specialty Drugs include the following:

1. Medications that treat certain patient populations including those with rare diseases;
2. Medications that require close medical and pharmacy management and monitoring;
3. Medications that require special handling and/or storage;
4. Medications derived from biotechnology and/or blood derived drugs or small molecules;
5. Medications that can be delivered via injection, infusion, inhalation, or oral administration; and
6. Medications subject to restricted distribution by the U.S. Food and Drug 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. 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.

Deductibles, Maximum Out of Pocket Amount (MOOP), and Benefits	
Deductibles	Your Plan Does Not Have a Deductible
Maximum Out-of-Pocket Amount	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 Amount and must continue to be paid after the Maximum Out-of-Pocket Amount has been met.
Insulin, and Needles and Syringes for Injection	You pay the cost sharing for the applicable Tier. Deductible does not apply.
Diabetic Testing Supplies covered including blood glucose monitors, test strips, lancets, lancet devices, and control solution	No Charge
Continuous Glucose Monitors, Sensors and Supplies	No Charge
Formulary	This Plan has a closed formulary and covers a specific list of drugs and medications. If Your drug is not on Our formulary, We have a process in place to request coverage. Please use the following link to see a list of drugs on the Plan's formulary: https://www.optimahealth.com/documents/drug-lists/form-doc-drug-list-standard-formulary.pdf 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 Drug, You must pay the difference between the cost of the dispensed drug and the Generic Product Level in addition to the Copayment charge (not to exceed $150 per each 31-day supply prescription), in addition to the Copayment charge.

Copayment and Coinsurance Retail Pharmacy or Optima Specialty Pharmacy for up to a 31 day supply	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. Please use this link for a list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/	No Charge. Deductible does not apply. 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.

Preferred Network – You will pay a lower Copayment if you fill your prescriptions at a Walgreens, Walmart, Sam's Club, Cardinal-Leadernet, Wegmans, EPIC, Rite Aid, Ahold, Publix, Costco, Albertsons, Safeway, SHA in VA, Arete or Sentara Pharmacies. You may purchase up to a 90-day supply for 3 Copayments or Coinsurance amounts.	
Selected Generic Drugs **Tier 1**	You Pay $10 (or the plan's negotiated cost of the drug, if less)
Selected Brand & Other Generic Drugs **Tier 2**	You Pay $25 (or the plan's negotiated cost of the drug, if less)
Non-Selected Brand Drugs **Tier 3**	You Pay 25% up to a maximum Copayment of $50

Non-Preferred Pharmacy (all retail other than Walgreens, Walmart, Sam's Club, Cardinal-Leadernet, Wegmans, EPIC, Rite Aid, Ahold, Publix, Costco, Albertsons, Safeway, SHA in VA, Arete or Sentara Pharmacies). You may purchase up to a 31-day.	
Selected Generic Drugs **Tier 1**	You Pay $25 (or the plan's negotiated cost of the drug, if less)
Selected Brand & Other Generic Drugs **Tier 2**	You Pay $45 (or the plan's negotiated cost of the drug, if less)
Non-Selected Brand Drugs **Tier 3**	You Pay 25% up to a maximum Copayment of $75
Specialty Drugs **Tier 4**	You Pay 25% up to a maximum Copayment of $200.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Copayment and Coinsurance Mail Order (If Your Drug is available) for up to a 90 day supply Some Outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available from the Plan's Mail Order Pharmacy, Express Scripts Pharmacy. You may call Express Scripts Pharmacy at 1-888-899-2653 to find out if Your drug is available. Tier 4 Specialty Drugs are only available from the Plan's Specialty Pharmacy, Proprium Pharmacy and are limited to a 31 day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. Please use this link for a list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/	No Charge. Deductible does not apply. 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.
Selected Generic Drugs **Tier 1**	You Pay $25 (or the plan's negotiated cost of the drug, if less)
Selected Brand & Other Generic Drugs **Tier 2**	You Pay $60 (or the plan's negotiated cost of the drug, if less)
Non-Selected Brand Drugs **Tier 3**	You Pay 25% up to a maximum Copayment of $125

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of month they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health 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.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

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Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.