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, call 1-800-741-9910 or visit optimahealth.com and sign into the Member Portal. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-741-9910 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0/Individual or $0/family In-Network $500/Individual or $1,000/family Out-of-Network</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs, most services that require a copayment, preventive care, and a routine eye exam are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-carebenefits/">https://www.healthcare.gov/coverage/preventive-carebenefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For In-Network $3,000 person / $6,000 family and out-of-network-providers $4,500 person / $9,000 family</td>
<td>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 limit until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.optimahealth.com">http://www.optimahealth.com</a> or call 1-800-741-9910.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network (You will pay the least)</th>
<th>Out-of-Network (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copayment</td>
<td>30% coinsurance</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 copayment</td>
<td>30% coinsurance</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>You may have to pay for services that aren’t <strong>preventive</strong>. Ask your provider if the services you need are <strong>preventive</strong>. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred Generic Drugs (Tier 1)</td>
<td>$15 copayment retail $37.50 copayment mail order</td>
<td>Not covered retail Not covered mail order</td>
<td>Coverage is limited to FDA-approved prescription drugs. For specialty drugs, the out-of-pocket amount is limited to $250 copayment per retail prescription and $250 copayment per mail order prescription. If brand drugs are used when a generic is available, you must pay the difference in cost plus the copayment or coinsurance amount. One copayment or coinsurance amount covers up to a 30-day supply; two copayments or coinsurance amounts cover a 31- to 60-day supply; and three copayments or coinsurance amounts cover a 61- to 90-day supply (retail). Some outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available in a 90-day supply through mail order. Tier 4 Specialty Drugs are only available from a</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand and Other Generic Drugs (Tier 2)</td>
<td>$40 copayment retail $100 copayment mail order</td>
<td>Not covered retail Not covered mail order</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand Drugs (Tier 3)</td>
<td>$60 copayment retail $180 copayment mail order</td>
<td>Not covered retail Not covered mail order</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 4)</td>
<td>20% coinsurance retail 20% coinsurance mail order</td>
<td>Not covered retail Not covered mail order</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at https://apps.optimahealth.com/Public/OHBRFileManager/DownloadFile.aspx?filePath=%2Fresales%2F2022%2FEOCCOI-For-SBC%2F2022_MMLGPOCOI_O.pdf
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>Plan Specialty Pharmacy and are limited to a 30-day supply (retail and mail order).</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>Pre-authorization required.</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$200 copayment/Visit</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$25 copayment/Transport each way</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40 copayment</td>
<td>None.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$200 copayment/Admission</td>
<td>Pre-authorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>$20 copayment office visits</td>
<td>Pre-authorization required for intensive outpatient program, partial hospitalization services, and electro-convulsive therapy, and Transcranial Magnetic Stimulation. EAV: 5 visits/presenting issue by Optima EAV providers only.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$200 copayment/Admission</td>
<td>None.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>Pre-authorization required for prenatal services. Cost sharing does not apply to certain preventive services. Maternity care</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network (You will pay the least)</td>
<td>Out-of-Network (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>$200 *<em>copayment</em>/Admission 20% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td>may include tests and services described elsewhere in this SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td>Rehabilitation PT/OT: 20% <strong>coinsurance</strong></td>
<td>Rehabilitation PT/OT: 30% <strong>coinsurance</strong></td>
<td>Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% <strong>copayment</strong> after Inpatient <strong>copayment</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td>Pre-authorization required. 90 days/plan year.</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td>Pre-authorization required for single items over $750, all rental items, and repair and replacement.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td>Pre-authorization required.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None.</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None.</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at https://apps.optimahealth.com/Public/OHBRFileManager/DownloadFile.aspx?filePath=%2Fpresales%2F2022%2FEOCOIFor-SBC%2F2022_MMLGPPOCOI_O.pdf
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Bariatric Surgery</td>
</tr>
<tr>
<td>• Cosmetic Surgery</td>
</tr>
<tr>
<td>• Dental Care (Adult)</td>
</tr>
<tr>
<td>• Dental Care (Pediatric)</td>
</tr>
<tr>
<td>• Glasses</td>
</tr>
<tr>
<td>• Habilitative services</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight Loss Programs</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic Care</td>
</tr>
<tr>
<td>• Infertility Treatment</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S. (under out-of-network benefit)</td>
</tr>
</tbody>
</table>

Your Rights to Continue Coverage:
For more information on your rights to continue coverage, contact the plan at 1-800-741-9910. 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. 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 plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

* For more information about limitations and exceptions, see the plan or policy document at https://apps.optimahealth.com/Public/OHBRFileManager/DownloadFile.aspx?filePath=%2Fpresales%2F2022%2FEOCCOI-For-SBC%2F2022_MMLGPPOCOI_O.pdf
Language Access Services:
Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwiijigo holne' 1-855-687-6260.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>20%</td>
<td>$20</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
</tr>
<tr>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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

**Total Example Cost** | **$12,700** |

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,200</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$60</strong></td>
</tr>
</tbody>
</table>

The total Peg would pay is **$2,460**

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

**Total Example Cost** | **$5,600** |

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$20</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$20</strong></td>
</tr>
</tbody>
</table>

The total Joe would pay is **$940**

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

**Total Example Cost** | **$2,800** |

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$400</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

The total Mia would pay is **$800**

The plan would be responsible for the other costs of these EXAMPLE covered services.