

**HDHP**  
**Optima Equity Vantage 3000/0%**  
**PORTSMOUTH PUBLIC SCHOOLS**  
**Plan Effective Date: 01/01/2022**  
**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 Optima Health coverage documents issued when You are enrolled, 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. 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 not be covered under Your Plan 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.

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.

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.

Effective Period: From 01/01/2022 through 12/31/2022		
Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	Out-of-Network
<b>Deductible</b> Plan Year	\$3,000/Individual; \$6,000/Family	Not Covered
<p>Amounts You Pay for In-Network Covered Services will count toward meeting the In-Network Deductible. The Deductible applies to all Covered Services except for:</p> <ul style="list-style-type: none"> <li>• In-Network Preventive Care Services required by law;</li> <li>• Other services in this Benefit Summary shown as covered without a Deductible.</li> </ul> <p>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.</p>		
	In-Network	Out-of-Network
<b>Maximum Out-of-Pocket</b> Plan Year	\$6,000/Individual; \$12,000/Family	Not Covered
<p>Most amounts You pay, or that are paid on Your behalf, for In-Network Covered Services will count toward meeting the In-Network Maximum Out of Pocket Amount.</p> <p>The following will not count toward the Plan maximum amount(s):</p> <ul style="list-style-type: none"> <li>• Amounts You pay for services not covered under Your Plan;</li> <li>• Amounts You pay for any services after a benefit limit has been reached;</li> <li>• Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;</li> <li>• Premium amounts;</li> <li>• Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;</li> <li>• Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available;</li> <li>• Other services in this Benefit Summary that are shown as excluded from the maximum amount.</li> </ul> <p>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.</p>		

Benefit	In-Network	Out-of-Network
<b>Physician Office Visits</b> 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, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Optima Health approved providers. <b>*Pre-Authorization is required for in-office surgery.</b>		
<b>Primary Care Visit</b>	After Deductible No Charge	Not Covered
<b>Virtual Consult</b>	After Deductible No Charge (You Pay \$39 before deductible is met)	Not Covered
<b>Specialist Visit</b>	After Deductible No Charge	Not Covered
<b>Vaccines and Immunotherapeutic Agents</b> This does not include routine immunizations covered under Preventive Care.	After Deductible No Charge	Not Covered
<b>Preventive Care</b> 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: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/">https://www.healthcare.gov/what-are-my-preventive-care-benefits/</a>		
<b>Recommended exams, screenings, tests, immunizations, and other services</b>	No Charge	Not Covered
<b>Outpatient Therapies and Services</b> 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. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder.		
<b>Occupational and Physical Therapy*</b> Services limited to 30 combined visits per Plan year.	After Deductible No Charge	Not Covered
<b>Speech Therapy*</b> Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
<b>Cardiac Rehabilitation*</b> Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
<b>Pulmonary Rehabilitation*</b> Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
<b>Vascular Rehabilitation*</b> Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
<b>Vestibular Rehabilitation*</b> Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
<b>IV Infusion Therapy</b>	After Deductible No Charge	Not Covered

<b>Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Respiratory/Inhalation Therapy</b>	After Deductible No Charge	Not Covered
<b>Chemotherapy and Chemotherapy Drugs</b>	After Deductible No Charge	Not Covered
<b>Radiation Therapy</b>	After Deductible No Charge	Not Covered
<b>Pre-Authorized Injectable and Infused Medications*</b> 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 No Charge	Not Covered
<b>Outpatient Dialysis</b> You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.		
<b>Dialysis Services</b>	After Deductible No Charge	Not Covered
<b>Outpatient Surgery</b> You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.		
<b>Surgery Services*</b>	After Deductible No Charge	Not Covered
<b>Outpatient Lab, Diagnostic, Imaging and Testing</b> You pay a Copayment or Coinsurance for services done in a free-standing outpatient facility or lab or a Hospital outpatient facility or lab.		
<b>Diagnostic Procedures</b>	After Deductible No Charge	Not Covered
<b>X-Ray Ultrasound Doppler Studies</b>	After Deductible No Charge	Not Covered
<b>Lab Work</b>	After Deductible No Charge	Not Covered
<b>Outpatient Advanced Imaging, Testing and Scans</b> 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.		
<b>Magnetic Resonance Imaging (MRI)*</b> <b>Magnetic Resonance Angiography (MRA)*</b> <b>Positron Emission Tomography (PET)*</b> <b>Computerized Axial Tomography (CT)*</b> <b>Computerized Axial Tomography Angiogram (CTA)*</b> <b>Magnetic Resonance Spectroscopy (MRS)</b> <b>Single Photon Emission Computed Tomography (SPECT)</b> <b>Nuclear Cardiology</b> <b>Sleep Studies</b>	After Deductible No Charge	Not Covered

Benefit	In-Network	Out-of-Network
<b>Maternity Care</b> 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.		
<b>Maternity Care</b> *Pre-Authorization is required for prenatal services	After Deductible No Charge for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
<b>Inpatient Services</b>		
<b>Inpatient Hospital Services*</b>	After Deductible No Charge	Not Covered
<b>Transplants*</b> Covered at contracted facilities only.	After Deductible No Charge	Not Covered
<b>Skilled Nursing Facility Services*</b> Limited to a maximum of 90 days per Plan year.	After Deductible No Charge	Not Covered
<b>Ambulance Services</b> Includes Emergency transportation, or non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way.		
<b>Air, Water, Ground Services</b> *Pre-Authorization is required for non-emergency transportation.	After Deductible No Charge	Not Covered except for Emergency Services
<b>Emergency Services</b> Includes 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 In-Network or Out-of-Network.		
<b>Emergency Services</b>	After Deductible No Charge	After Deductible No Charge
<b>Urgent Care Services</b> 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.		
<b>Urgent Care Services</b>	After Deductible No Charge	Not Covered
<b>Mental Health and Substance Use Disorder Services</b> Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. *Pre-Authorization is required for Inpatient Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy. Virtual Consults must be furnished by approved Optima Health providers.		
<b>Inpatient Services*</b>	After Deductible No Charge	Not Covered
<b>Outpatient Office Visits</b>	After Deductible No Charge	Not Covered
<b>Virtual Consults</b>	After Deductible No Charge	Not Covered
<b>Other Outpatient Visits (Facility/Freestanding Centers)</b>	After Deductible No Charge	Not Covered
<b>Employee Assistance Visits</b> Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174	No Charge for up to 3 visits from Optima Health Employee Assistance providers per presenting issue as determined by treatment protocols.	

Benefit	In-Network	Out-of-Network
<b>Diabetes Treatment</b> Includes supplies, equipment, and education. An annual diabetic eye exam is covered from an In-Network Plan Provider or a participating EyeMed Vision Services provider at the office visit Copayment or Coinsurance amount.		
<b>Insulin Pumps*</b>	After Deductible No Charge	Not Covered
<b>Pump Infusion Sets and Supplies*</b>	After Deductible No Charge	Not Covered
<b>Testing Supplies</b> Includes test strips, lancets, lancet devices, blood glucose monitors and control solution. <b>*Pre-Authorization is required for talking blood glucose monitors</b>	After Deductible No Charge	Not Covered
<b>Insulin, Needles, Syringes</b>	Covered under the Plan's Prescription Drug Benefit	Not Covered
<b>Outpatient Self-Management Training, Education, Nutritional Therapy</b>	After Deductible No Charge	Not Covered
<b>Prosthetic Limb Replacement</b>		
<b>Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*</b>	After Deductible No Charge	Not Covered
<b>Autism Spectrum Disorder</b> Includes diagnosis and treatment of Autism Spectrum Disorder.		
<b>Autism Spectrum Disorder*</b> Covered Services include diagnosis and treatment of Autism Spectrum Disorder in children from age two through ten.	Cost sharing determined by the type and place of service.	Not Covered
<b>Durable Medical Equipment (DME) and Supplies</b>		
<b>DME, Orthopedic Devices, Prosthetic Appliances, Devices</b> <b>*Pre-Authorization is required for items over \$750</b> <b>*Pre-Authorization is required for repair, replacement and rental items.</b>	After Deductible No Charge	Not Covered
<b>Early Intervention Services</b> For Dependent children from birth to age three.		
<b>Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices. *</b>	Cost sharing determined by the type and place of service.	Not Covered
<b>Home Health Care</b> 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		
<b>Home Health Care*</b> Limited to a maximum of 100 visits per Plan year.	After Deductible No Charge	Not Covered

Benefit	In-Network	Out-of-Network
<b>Hospice Care</b>		
<b>Hospice Care*</b>	After Deductible No Charge	Not Covered
<b>Vision Care</b> Optima Health contracts with EyeMed Vision Services to administer this benefit. Services must be received from EyeMed providers.		
<b>Vision Exams</b> Limited to one exam every 12 months from an EyeMed provider.	No Charge Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.	Members will be reimbursed up to \$30 for an eye examination
<b>Reconstructive Breast Surgery</b> Includes Covered Services for Members who have had a mastectomy.		
<b>Surgery and Reconstruction*</b> <b>Prostheses*</b> <b>Physical Complications*</b> <b>Lymphedema*</b>	Cost sharing is determined by the type and place of service.	Not Covered
<b>Clinical Trials</b> 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.		
<b>Clinical Trial Services*</b>	Cost sharing is determined by the type and place of service.	Not Covered
<b>Allergy Care</b>		
<b>Allergy Care, Testing, and Serum</b>	Cost sharing is determined by the type and place of service.	Not Covered
<b>Telemedicine Services</b> Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. 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.		
<b>Telemedicine Services</b>	Cost sharing is determined by the type and place of service.	Not Covered

## **Prescription Drugs**

### **AD\_15\_40\_50\_20% Prev Rx BD**

This Benefit Summary describes Your Plan's outpatient prescription drug coverage. All drugs must be United States Food, Drug Administration (FDA) approved, and you must have a prescription. You will need to pay Your Copayment or Coinsurance when you fill your prescription at the pharmacy. If Your Plan has a Deductible, You must meet that amount before your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. 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](http://optimahealth.com) for a list of Specialty Drugs.



<b>Deductibles, Maximum Out of Pocket Amount (MOOP), and Benefits</b>	
<b>Deductibles</b>	You must meet the medical Deductible listed on Your Plan's Schedule of Benefits before coverage for Tier 1, Tier 2, Tier 3, and Tier 4 drugs begin.
<b>Maximum Out-of-Pocket Amount</b>	<p>Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Maximum Medical Out-of-Pocket Limit</p> <p>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.</p>
<b>Insulin, syringes, and needles</b>	<p>A Member's cost sharing payment for a covered insulin drug will not exceed \$50 per 30-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. You pay the cost sharing for the applicable Tier. Deductible does not apply.</p>
<b>Formulary</b>	<p>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:  <a href="https://www.optimahealth.com/documents/drug-lists/form-doc-drug-list-standard-formulary.pdf">https://www.optimahealth.com/documents/drug-lists/form-doc-drug-list-standard-formulary.pdf</a></p> <p>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 or Coinsurance charge.</p>

<b>Copayment and Coinsurance Retail Pharmacy or Optima Specialty Pharmacy for up to a 31 day supply</b>	
<b>ACA Preventive Drugs</b> 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: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/">https://www.healthcare.gov/what-are-my-preventive-care-benefits/</a>	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.
<b>Other Preventive Drugs HSA</b> Includes outpatient prescription drugs that are considered by the Plan to be preventive care. Please use this link for a list of drugs under this benefits: <a href="https://www.optimahealth.com/documents/drug-lists/form-doc-equity-preventive-drug-list-preventive-class.pdf">https://www.optimahealth.com/documents/drug-lists/form-doc-equity-preventive-drug-list-preventive-class.pdf</a>	You pay the cost sharing for the applicable Tier. Deductible does not apply.
<b>Selected Generic Drugs</b> <b>Tier 1</b>	After Deductible You Pay \$15
<b>Selected Brand &amp; Other Generic Drugs</b> <b>Tier 2</b>	After Deductible You Pay \$40
<b>Non-Selected Brand Drugs</b> <b>Tier 3</b>	After Deductible You Pay \$50
<b>Specialty Drugs</b> <b>Tier 4</b>	After Deductible You Pay 20% up to a maximum Copayment of \$200.

**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 OptumRx Home Delivery. You may call OptumRx Home Delivery at 1-866-244-9113 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.

<b>ACA Preventive Drugs</b> 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: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/">https://www.healthcare.gov/what-are-my-preventive-care-benefits/</a>	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.
<b>Other Preventive Drugs HSA</b> Includes outpatient prescription drugs that are considered by the Plan to be preventive care. Please use this link for a list of drugs under this benefits: <a href="https://www.optimahealth.com/documents/drug-lists/form-doc-equity-preventive-drug-list-preventive-class.pdf">https://www.optimahealth.com/documents/drug-lists/form-doc-equity-preventive-drug-list-preventive-class.pdf</a>	You pay the cost sharing for the applicable Tier. Deductible does not apply.
<b>Selected Generic Drugs Tier 1</b>	After Deductible You Pay \$45
<b>Selected Brand &amp; Other Generic Drugs Tier 2</b>	After Deductible You Pay \$120
<b>Non-Selected Brand Drugs Tier 3</b>	After Deductible You Pay \$150
<b>Specialty Drugs Tier 4</b>	After Deductible You Pay 20% up to a maximum Copayment of \$200.

**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 lahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'í' hólne'.

1-855-687-6260