OptimaHealth

SURA/Jefferson Science Associates

Vantage 10/25

Effective Date: 04/01/2013

www.optimahealth.com

OptimaHealth

Medical Loss Ratio Information--The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference. A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011. You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov.

Important Notice Regarding Health Reform

The information contained in your Benefit Information Guide is subject to all federal and state health reform regulations issued under the Affordable Care Act. The information is subject to change based on guidance or information from the federal government. For the most up-to-date and comprehensive information on health reform, please visit the health reform section of our Web site, **www.optimahealth.com/healthreform.**

Other resources, such as Frequently Asked Questions (FAQs) are also located on our Web site. These FAQs are updated frequently based on new information received from the federal government, please check them regularly. If you have questions regarding health reform and how it may impact you, please contact Optima Health Member Services at the number included in this guide or located on your member ID Card.

Optima Health Plans

Employer Group Plan Changes

The following changes are effective August 1, 2012 upon group's effective date or renewal date.

Coverage for Women's Preventive Services:

Women's Preventive Services as defined by, and mandated by, the Patient Protection and Affordable Care Act (PPACA), will be available to members without a Copayment or Coinsurance responsibility. Additionally, tubal ligations will be covered at 100 percent when performed by In-Network Plan Providers. Grandfathered Large Group plans are excluded from this coverage. This mandated change applies to all Optima Health Plans.

Examples of Women's Preventive Services include: Breast feeding comprehensive support and counseling, and access to breastfeeding supplies for pregnant and nursing women; Contraception: all Food and Drug Administration-approved contraceptive methods*, sterilization procedures, and patient education and counseling, not including abortifacient drugs; Domestic and interpersonal violence screening and counseling for all women; Gestational Diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes; Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women; Human Papillomavirus (HPV) DNA Test: High-risk HPV DNA testing every three years for women with normal cytology results who are 30 or older; Sexually Transmitted Infection (STI) counseling for sexually active women; and well-woman visits for adult women to obtain the recommended preventive services that are age and developmentally appropriate.

*Generic oral contraceptives are eligible for 100 percent coverage and no cost share to members. Brand name oral contraceptives will be covered based on the plan's formulary and the appropriate Copayment or Coinsurance will apply based on the drug tier. Please visit optimahealth.com to determine member cost share for brand name oral contraceptives.

Optima Vantage 10/25M
Summary of Benefits

SURA/Jefferson Science Associates
Effective April 1, 2013
Grandfathered
RX 10/20/40/40
Group # 2704

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Evidence of Coverage or Certificate of Insurance, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. Some benefits require Pre-Authorization before You receive them.

Except for covered Emergency Services the Plan will not pay for treatment or services You receive from Non-Plan Providers.

Deductible

Your Plan Does not have a Deductible

Maximum Out-of-Pocket Amount

$2,000 per Member Per Calendar Year[1]
$4,000 per Family Per Calendar Year[1]

Physician Services

Pre-Authorization is required for in-office surgery. Copayment or Coinsurance applies to Covered Services done in the Physician's office. An additional Copayment or Coinsurance may apply to outpatient therapy, rehabilitative services, and injectable and infused medications, and outpatient advanced imaging procedures done in the Physician's office.

Physician Office Visits	Copayments/Coinsurance	Comments
Primary Care Physician (PCP) Office Visit	$10 Copayment	
Specialist Office Visit	$25 Copayment	
Vaccines and Immunotherapeutic Agents	Covered at 50%[3] Member is responsible for Coinsurance amount up to a maximum Copayment amount of $250 per dose.	
Preventive Care Visits	**Copayments/Coinsurance**	**Comments**
Routine Annual Physical Exams **Well Baby Exams** **Annual Gyn Exams and Pap Smears** **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Women's Preventive Services**	Covered at 100%	
Screening Colonoscopy **Screening Mammograms**	Covered at 100%	

Outpatient Therapy and Rehabilitation Services

Copayment or Coinsurance applies to Covered Services provided in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or in a Member's home as part of Skilled Home Health Care Services benefit. Short-term therapy and rehabilitation means services that can be expected to result in the significant improvement of a member's condition within a period of 90 days.

Short Term Therapy Services	Copayments/Coinsurance	Comments
Physical Therapy **Occupational Therapy** **Speech Therapy**	$10 Copayment per PCP office visit. $25 Copayment per Specialist office visit. $25 Copayment per outpatient facility visit/treatment.	Pre-Authorization is required.
Short Term Rehabilitation Services	**Copayments/Coinsurance**	**Comments**
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation**	$10 Copayment per PCP office visit. $25 Copayment per Specialist office visit. $25 Copayment per outpatient facility visit/treatment.	Pre-Authorization is required.

Other Outpatient Treatments	Copayments/Coinsurance	Comments
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	$10 Copayment per PCP office visit. $25 Copayment per Specialist office visit. $25 Copayment per outpatient facility visit/treatment.	Pre-Authorization is required for IV Therapy with medications and Inhalation therapy.
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require prior-authorization. *(This does not include chemotherapy medications, allergy injections or serum.)* Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.	Covered at 80%[3]	

Outpatient Dialysis Services

	Copayments/Coinsurance	Comments
Dialysis Services	$10 Copayment Copayment or Coinsurance applies regardless of place of service.	

Outpatient Surgery

	Copayments/Coinsurance	Comments
Outpatient Surgery Copayment or Coinsurance applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	$100 Copayment per Admission	Pre-Authorization is required.

Outpatient Diagnostic Procedures

Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.

	Copayments/Coinsurance	Comments
Diagnostic Procedures	$25 Copayment	Pre-Authorization is required.
X-Ray **Ultrasound** **Doppler Studies**	$25 Copayment	
Lab Work	$25 Copayment	

Outpatient Advanced Imaging Procedures

	Copayments/Coinsurance	Comments
Magnetic Resonance Imaging (MRI) **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)** Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	$150 Copayment	Pre-Authorization is required.

Maternity Care[2]

	Copayments/Coinsurance	Comments
Maternity Care Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	$100 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	Pre-Authorization is required for prenatal services.

Inpatient Services		
	Copayments/Coinsurance	**Comments**
Inpatient Hospital Services Transplants are covered at contracted facilities only.	$100 Copayment per day up to a $500 maximum Copayment per inpatient Admission	Pre-Authorization is required.
Skilled Nursing Facilities/Services Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days per calendar year per illness or condition that in the Plan's judgment requires Skilled Nursing Services [4]	Covered at 100% [3] after inpatient hospital Copayment has been met.	Pre authorization is required.
Ambulance Services		
	Copayments/Coinsurance	**Comments**
Ambulance Services For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan	$25 Copayment per transport each way [5]	Pre-Authorization is required for non-emergent transportation only.
Emergency Department Services		
	Copayments/Coinsurance	**Comments**
Emergency Department Services Includes emergency department facility, Physician, and ancillary services provided during an emergency department visit.	$200 Copayment per visit. If the Member is admitted the Copayment will be waived, and the Member will pay the Inpatient Hospital Services Copayment or Coinsurance. [5]	Pre-Authorization is not required.
Urgent Care Center Services		
	Copayments/Coinsurance	**Comments**
Urgent Care Services Includes urgent care center 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 be responsible for any applicable emergency department Copayment or Coinsurance.	$25 Copayment	Pre-Authorization is not required.
Behavioral Health Care		
Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental illnesses.		
	Copayments/Coinsurance	**Comments**
Inpatient Services	$100 Copayment per day up to a $500 maximum Copayment per inpatient Admission	Pre-Authorization is required for all inpatient services, and partial hospitalization services.
Outpatient Services	$10 Copayment per outpatient visit/hour	Pre-Authorization is required for intensive outpatient Program (IOP), psychological and neuro-psychological testing, and electro-convulsive therapy.

Other Covered Services		
	Copayments/Coinsurance	**Comments**
Artificial Limb Services [4] For adults 18 and over, artificial limbs, including repair and replacement, will be covered up to a $10,000 lifetime maximum per limb, per occurrence. For children under age 18, artificial limbs, including repair and replacement, will be covered up to $10,000 per limb for a maximum of two occurrences.	Covered at 100%[3]	Pre-Authorization is required.
Autism Spectrum Disorder **Pre-Authorization is required.** Covered Services include diagnosis and treatment of Autism Spectrum Disorder in children from age two through six. "Autism spectrum disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder - Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder. "Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) **applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.** "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for Applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000 per child.	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.	

Diabetic Supplies and Equipment Includes FDA approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment per 31-day supply.	Covered at 80%[3] for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. No Copayment or Coinsurance for insulin pumps. No Copayment or Coinsurance for outpatient self-management training and education, including medical nutritional therapy.	
Durable Medical Equipment (DME) and Supplies[4] **Orthopedic Devices and Prosthetic Appliances[4]** Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.	Covered at 100%[3]	Pre-Authorization is required for single items over $750. Pre-Authorization is required for all rental items. Pre-Authorization is required for repair and replacement.
Early Intervention Services.[4] Covered for Dependents from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Pre-authorization is required.
Home Health Care Skilled Services A member must be homebound and unable to receive services outside the home to receive care. An outpatient therapy Copayment or Coinsurance will also apply to physical, occupational, and speech therapy received in the home.	Covered at 100%[3]	Pre-Authorization is required.
Hospice Care	Covered at 100%[3]	Pre-Authorization is required.
Vision Care and Materials Rider[4] Optima Health Contracts with EyeMed Vision Services to administer this benefit for vision care services and materials. Members may call EyeMed at 1-888-610-2268 for information about Participating Providers. Each Covered Person is eligible to receive a routine eye examination, refraction; lenses and frames; or contact lenses once every 12 months from a Participating EyeMed Provider.	$0 Copayment per eye examination and materials. Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost. Lenses (single, vision, bifocal, trifocal) covered in full. Frames covered in full up to $100 retail. Contact lenses (in lieu of glasses) covered in full up to $100 retail.	For eye examinations from Out-of-Network providers Member's will be reimbursed $30 for an eye examination only. Copayments or Coinsurance for covered services under this rider are not applied toward any Plan maximum out of pocket and must continue to be paid after the maximum is met.
Reduction Mammoplasty Coinsurance will apply to all applicable services associated with Reduction Mammoplasty including but not limited to Physician, facility, surgical, and/or diagnostic services. This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy.	Covered at 50%[3]	Pre-Authorization is required.

Notes

All benefits are subject to the terms and conditions in the *Evidence of Coverage* OHP.HMO.EOC.09

1 Maximum Out of Pocket Amount means the total amount a Member pays during a calendar year. Applicable Copayments or Coinsurances for, vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, any covered medical expenses paid at a rate of 50% or less, except vaccines do not count toward the Maximum Out of Pocket Amount and must continue to be paid after the Maximum Out of Pocket Amount has been met.

2 Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services the Member is entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments the Member would have paid on a per visit or per procedure basis.

3 Benefits are payable at the percent specified of the Plan's fee schedule.

4 Amounts in excess of a benefit dollar limit and/or visit limit as stated in the Face Sheet or added by a Plan rider are excluded from Coverage.

5 All Emergency, Urgent Care, Ambulance and Emergency Mental Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an emergency, the Plan will have no responsibility for the cost of the treatment and the Member will be solely responsible for payment. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the Member received care from a Plan Provider.

Optima Vantage
$10/20/40/40 Outpatient Prescription Drug Rider
Schedule of Benefits

This schedule of benefits describes Your outpatient prescription drug coverage. All drugs must be FDA approved and you must have a prescription. You will need to pay Your Copayment or Coinsurance when you fill your prescription at the pharmacy. If Your Plan has a Deductible you must meet that amount before your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. Your drug coverage has specific Exclusions and Limitations so please read the next few pages carefully. Optima's Pharmacy and Therapeutics Committee places covered drugs into the following Tiers.

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

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

- **Non-Selected Brand (Tier 3)** includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a generic equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers.

- **All Other (Tier 4)** includes those drugs not classified by the Plan as Tier 1, Tier 2, or Tier 3; those drugs not excluded from Coverage; and those drugs that are not recognized by the Plan to be any more effective than other drugs available at Tier 1, Tier 2, or Tier 3 or over the counter**.**

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

Copayments and Coinsurances.	
For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge. Certain prescription drugs will be covered at a generic product level established by the Plan. If a generic product level has been established for a drug and You or Your prescribing Physician requests the brand-name drug or a higher costing generic, You must pay the difference between the cost of the dispensed drug and the generic product level in addition to the Copayment charge.	
Selected Generic (Tier 1)	$10 Copayment
Selected Brand & Other Generic (Tier 2)	$20 Copayment
Non-Selected Brand (Tier 3)	$40 Copayment
All Other (Tier 4))	$40 Copayment
Mail Order Pharmacy Benefit Copayments and Coinsurances	
Some Outpatient prescription drugs are available through the Plan's Mail Order Provider. You may call Caremark at 1-888-766-5495 to find out if a drug is available. If Your drug is available You may purchase up to a 90-day supply for two Copayments or the applicable Coinsurance amount. Specialty drugs are not available under the Plan's Mail Order Benefit.	
Selected Generic (Tier 1)	$20 Copayment
Selected Brand & Other Generic (Tier 2)	$40 Copayment
Non-Selected Brand (Tier 3)	$80 Copayment
All Other (Tier 4))	$80 Copayment

EXCLUSIONS AND LIMITATIONS AND OTHER COVERAGE TERMS.

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

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded form Coverage.
2. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.
3. Copayment and Coinsurance are out of pocket amounts You pay directly to the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge.
4. Deductible means the dollar amount You must pay out of pocket each year for Covered Services before the Plan begins to pay for Your benefits.
5. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out of Pocket Limit.
6. The Plan will not cover any additional benefits after benefit Limits have been reached. You will be responsible for payment for all outpatient prescription drugs after a benefit Limit has been reached.
7. Amounts You pay for any outpatient prescription drug after a benefit Limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out of Pocket Amount.
8. Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan at the same level as the Plan gives to participating pharmacies.
9. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law. Medications with no approved FDA indications are excluded from Coverage.
10. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage.
11. The Plan may approve Coverage of Limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs
12. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. Benefits for Covered Services may be reduced or denied for not complying with the Plan's Pre-Authorization requirements.
13. At its sole discretions Optima's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
14. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
15. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
16. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
17. Insulin, syringes, and needles are covered under the prescription drug rider. Diabetic supplies and equipment, in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, other than those listed as covered under this prescription drug rider are covered under the Plan's medical benefit. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under this rider or the Plan's medical benefit.
18. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
19. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
20. Injectables (other than those self-administered and insulin) are excluded from Coverage under this rider.
21. Medication taken or administered to the Member in the Physician's office is excluded from Coverage under this rider.
22. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage under this rider.
23. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
24. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
25. Replacement prescriptions resulting from loss, theft, or breakage are excluded from Coverage.

26. Therapeutic devices or appliances, including but not Limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
27. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
28. Infertility drugs are excluded from Coverage.
29. Medications for smoking cessation, including but not Limited to Nicorette gum, nicotine patches, nicotine spray are excluded from Coverage.
30. Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
31. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
32. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.optimahealth.com/member or by calling (800) 741-9910. Reference #2704

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0 person/$0 family in-network	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $2,000 person/$4,000 family in-network.	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and healthcare this plan does not cover, pre-authorization penalties. There are other exclusions.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what Optima Health will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, For a list of participating providers, see www.optimahealth.com or call (800) 741-9910.	If you use a participating provider or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 4. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Copayment	Not covered	--none--
	Specialist visit	$25 Copayment	Not covered	--none--
	Other practitioner office visit	Not covered	Not covered	--none--
	Preventive care/screening/immunization	No charge	Not covered	--none--
If you have a test	Diagnostic test (x-ray, blood work)	$25 Copayment	Not covered	Pre-Authorization required.
	Imaging (CT/PET scans, MRIs)	$150 Copayment	Not covered	Pre-Authorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optimahealth.com/member.	Selected Generic drugs	$10 Copayment retail prescription/$20 mail order prescription	$10 Copayment retail prescription/$20 mail order prescription	If brand drugs are used when a generic is available, you must pay the difference in cost plus the Copayment. Covers up to 31-day supply (retail prescription); 31-90-day supply (mail order prescription).
	Selected brand and other generic drugs	$20 Copayment retail prescription/$40 mail order prescription	$20 Copayment retail prescription/$40 mail order prescription	
	Non-selected brand drugs	$40 Copayment retail prescription/$80 Copayment mail	$40 Copayment retail prescription/$80 Copayment mail	

		order prescription	order prescription	
	All other drugs	$40 Copayment retail prescription/$80 Copayment mail order prescription	$40 Copayment retail prescription/$80 Copayment mail order prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copayment/ admission	Not covered	Pre-Authorization required.
	Physician/ surgeon fees	No charge	Not covered	--none--
If you need immediate medical attention	Emergency room services	$200 Copayment/visit	$200 Copayment/visit	--none--
	Emergency medical transportation	$25 Copayment	Not covered	Pre-Authorization required for non-emergent transportation only.
	Urgent care	$25 Copayment	Not covered	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copayment/day	Not covered	Pre-Authorization required. $500 maximum Copayment per admission.
	Physician/surgeon fee	No charge	Not covered	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 Copayment / visit	Not covered	Pre-Authorization required.
	Mental/Behavioral health inpatient services	$100 Copayment/day	Not covered	Pre-Authorization required. $500 maximum Copayment per admission.
	Substance use disorder outpatient services	$10 Copayment / visit	Not covered	Pre-Authorization required.
	Substance use disorder inpatient services	$100 Copayment/day	Not covered	Pre-Authorization required. $500 maximum Copayment per admission.
If you are pregnant	Prenatal and postnatal care	$100 Global Copayment	Not covered	Pre-Authorization required.
	Delivery and all inpatient services	$100	Not covered	Pre-Authorization required.

		Copayment/day		$500 maximum Copayment per admission.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-Authorization required. Annual visit limits apply.
	Rehabilitation services	$10 Copayment/PCP $25 Copayment/Specialist and Outpatient	Not covered	Pre-Authorization required. Annual visit limits apply.
	Habilitation services	Not covered	Not covered	--none--
	Skilled nursing care	No charge after in-patient Copayment met	Not covered	Pre-Authorization required. Annual visit limits apply.
	Durable medical equipment	No charge	Not covered	Pre-Authorization required for single items over $750, all rental items, and repair and replacement.
	Hospice service	No charge	Not covered	Pre-Authorization required.
If your child needs dental or eye care	Eye exam	No charge	$30 Reimbursement	Coverage is limited to one exam every 12 months. Additional cost may apply for contact lens exam.
	Glasses	$100 allowance	Not covered	Coverage is limited to one every 12 months.
	Dental check-up	Not covered	Not covered	--none--

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 741-9910. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

For group health coverage subject to ERISA, you may 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 (Toll Free), or bureauofinsurance@scc.virginia.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact Member Services at the number on the back of your member ID card, 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 (Toll Free), or bureauofinsurance@scc.virginia.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218, 1-877-310-6560, or http://www.scc.virginia.gov/boibureauofinsurance@scc.virginia.gov.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 741-9910.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,142
- **Patient pays** $324

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$324
Coinsurance	$0
Limits or exclusions	$0
Total	**$324**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,711
- **Patient pays** $779

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$779
Coinsurance	$0
Limits or exclusions	$0
Total	**$779**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

HOW TO
LOOK UP THE COST OF YOUR PRESCRIPTIONS & SEE ALTERNATIVES TO DISCUSS WITH YOUR DOCTOR

- Optima's public site (**optimahealth.com**) will allow you to see the tier and generic availability for covered drugs.

- For out of pocket information on all covered outpatient prescription drugs *for your specific plan of benefits and drug store*, please use your Member ID number and *register* as a member at **optimahealth.com**.

- Equity members will need to use the secure tool to see discounted price that will apply until the annual deductible is met.

- Log-in to your secure site and go to *Pharmacy Resources* (menu on left). Choose MY COPAY from the menu across the top.

- *Note: If there is a generic available for your covered drug, then the generic is covered under the plan. There will be a brand buy-up charge if you choose brand when generic is available.*

HOW TO
REGISTER ON LINE FOR MAIL ORDER DRUG

- Go to Caremark.com

- Ignore and by-pass the pop-up message about a CVS Prescription ID. This actually means your Optima 7 digit ID. Go straight to registration.

- Prescription Benefit ID is your Member number preceding the asterisk. Only use the first 7 digits of your Member Number

- The Group Number requested is a letter code: OPTMA

- Print out the Registration Review page #3 before you accept the terms at the bottom of the page to keep a record of the information.

Abbreviated Preferred Drug List January-March 2013

Tier 1		Tier 2		Tier 3		Tier 4
ANTIBIOTICS (All Oral Dosage Forms)						
amoxicillin	Ery Ped	Avelox	**Suspensions/**	Augmentin XR	Tequin	
amox/clav, ES	Eryc (G)	Biaxin XL	**Liquids Only**	Ceclor CD	Vantin	
ampicillin	EryTab (G)	Dificid (PA)	Furadantin	Cefzil (tabs)		
azithromycin	erythromycin	levofloxacin	Lorabid	Cedax		
Biaxin (G)	Erythrocin (G)	PCE		Cipro XR		
Ceftin (G)	erythromycin base	Suprax		Dynabac		
cefprozil	minocycline	Zyvox		Flagyl ER		
cephalexin	nitrofurantoin	voriconazole		Floxin (G)		
cephradine	Omnicef (G)			Noroxin		
clarithromycin	penicillin VK			Spectracef		
ciprofloxacin	smz/tmp					
clindamycin	tetracycline					
dicloxacillin	trimethoprim					
EES (G)	Zithromax (G)					
ALLERGY DRUGS						
clemastine syrup	hydroxyzine HCL	Nasonex		Nasalide	Tanafed	Allegra Susp
cyproheptadine	hydroxyzine pamoate			Nasacort, AQ		Astelin
diphenydramine 50 mg	promethazine			Rhinocort		Astepro
fluticasone				Rhinocort Aqua		Clarinex, Clairnex D
guafenisin PSE						Omnaris (SE)
						Patanase
						Veramyst (SE)
ANTIDEPRESSANTS						
amitriptyline	mirtazapine			Cymbalta (SE)		Luvox CR (SE)
budeprion XL	nefazodone			Pristiq (SE)		
bupropion, SR, XL	nortriptyline			Viibryd (SE)		
citalopram	paroxetine, CR					
doxepin	sertraline					
escitalopram	trazodone					
fluvoxamine	venlafaxine					
fluoxetine	venlafaxine ER					
imipramine						
ANTIPSYCHOTIC DRUGS						
chlorpromazine	risperidone	Abilify (SE)				Invega (SE)
clozapine	thioridazine	Seroquel XR (SE)				Fanapt (SE)
fluphenazine	thiothixene					Latuda (SE)
haloperidol	trifluoperazine					Saphris (SE)
loxapine	ziprasidone					
olanzapine						
perphenazine						
quetiapine						
ASTHMA DRUGS						
aminophylline		Accolate	Maxair	Aerobid, -M	Xopenex (PA)	Brovana
cromolyn neb		Advair	Qvar	Azmacort		Perforomist
theophylline, SR		Asmanex	Serevent	Alvesco		Zyflo CR
budesonide		Dulera	Singulair	Proair		
		Flovent	Symbicort	Proventil HFA		
		Foradil	Ventolin HFA	Qvar		
		Intal				
BIRTH CONTROL PILLS						
Apri	Nortrel	EstroStep		Kariva		Beyaz
Aviane	Ocella	Femcon FE		Kelnor		Ella
Cryselle	Ogestrel	Jolessa		Seasonale		Generess FE
Enpresse	Portia	Nuvaring		Zovia		Lo Loestran Fe
Junel, FE	Previfem	Quasense				Lybrel
Lessina	Solia	Ortho Tri-Cyclen Lo				Neevo DHA
Levora	Sprintec	Ovcon				Prenexa Premier
Low-Ogestrel	Tri-nessa	Plan B				Safyral
Lutera	Tri-Previfem	Yasmin				Natafort Tab
Microgestin, FE	Tri-Sprintec					
Mononessa	Trivora					
Necon						

Tier 1		Tier 2		Tier 3		Tier 4
BLOOD PRESSURE AND HEART DRUGS						
acebutolol	irbesartan, HCT	Aggrenox		Atacand (SE)		Azor (SE)
amlodipine besylate	labetalol	Betapace		Amturnide (SE)		BiDil
atenolol	lisinopril	Cardene, SR		Benicar, HCT (SE)		Bystolic
benazepril	metolazone	Catapres-TTS		Caduet (PA)		Coreg CR (SE)
bumetanide	losartan	DynaCirc, CR		Covera-HS		Exforge, HCT (SE)
candasartan HCTZ	losatan hctz	Effient		Diovan (SE)		
captopril	metoprolol, XL	Lanoxin		Edarbi (SE)		
carvedilol	moexipril	Letairis		Edarbyclor (SE)		
chlorothiazide	nicardipine	Lotrel		Micardis, HCT (SE)		
chlorthalidone	pindolol	Procanbid		Tekturna,HCT(SE)		
clopidogrel	procainamide SR	Revatio		Teveten HCT (SE)		
cilostazol	propranolol, SR	Verelan PM		Tribenzor (SE)		
digoxin	quinapril			Tekamlo (SE)		
diltiazem CD, SR, XR	ramipril					
doxazosin	terazosin					
enalapril	timolol					
eprosartan	trandolapril					
felodipine	triamterene/HCTZ					
fosinopril	verapamil, SR					
furosemide	warfarin					
hdyrochlorothiazide	valsartan HCTZ					
indapamide						
CHOLESTEROL DRUGS						
atorvastatin	pravastatin	Niaspan		Crestor (PA)	Vytorin (PA)	Lovaza (PA)
cholestyramine	simvastatin	Tricor		Lescol, XL (PA)	Zetia	Simcor (PA)
gemfibrozil		Welchol		Livalo (PA)		Trilipix (PA)
lovastatin (G)						
DIABETES DRUGS						
glimepiride		Actoplus Met XR	Humalog vial	Byetta		Onglyza (PA)
glipizide, XL		Avandamet	Humulin insulins, vial	Bydureon		Victoza (PA)
glyburide, micro		Avandaryl	Janumet, RX	Novolin and Novolog insulin vials		Cysloset
glyburide-metformin		Avandia	Januvia	Levemir vial		Kombiglyze XR
metformin		Duetact	Juvisync	Prandin		
metformin ER		Duetact	Lantus	Precose		
		Glyset	Lantus Solostar	Symlin		
		pioglitazone	Starlix			
		pioglitazone and metf	Tradjenta			
GI DRUGS						
cimetidine	Omeprazole 20mg	Asacol		Dexilant (SE)		Aciphex (SE)
dicyclomine	Omeprazole OTC	Carafate Susp				Nexium (SE)
diphenoxylate/atropine	pantoprazole	Colazal				Relistor (PA)
hyoscyamine, ER	sucralfate	Creon				Vimovo
lactulose	sulfasalazine	Dipentum				
metoclopramide		Pancrease MT				
misoprostol		Pentasa				
nizatadine		Prilosec OTC				
HEADACHE DRUGS						
APAP/caffeine/butalbital	butorphanol NS - PA,2 bottles/ 30 days	Depakote ER	Imitrex **brand** -9 tabs/30 days (SE)	Axert - 12 tabs/ 30 days (SE)	Maxalt, MLT - 12 tabs/30 days (SE)	Treximet - 9 tabs/ 30 days (SE)
APAP/caffeine/butalbital w/codeine	Sumatriptan 20mg-nasal 6 bottles/ 30 days	Midrin		Frova - 12 tabs/ 30 days (SE)	Zomig,ZMT – 12 tabs/ 30 days (SE)	Sumavel -inj-8 syr/ 30 days
aspirin/caffeine/butalbital	Sumatriptan -inj-8 syr/ 30 days	Migranal - 1 box/ 30 days		Relpax - 12 tabs/ 30 days	Zomig nasal spray - 6 bottles/ 30 days (SE)	Alsuma-inj-8 syr/ 30 days
aspirin/caffeine/butalbital w/codeine	Sumatriptan 100mg-9 tabs/ 30 days					
Sumatripta 20mg n-nasal 6 bottles/ 30 days	Sumatriptan 25mg, 50mg- 18 tabs/30 days					
naratriptan 9 tabs/ 30 days						

Tier 1		Tier 2		Tier 3		Tier 4
HORMONE DRUGS						
Camila	medroxyprogesterone	Aygestin	Ovrette	Enjuvia		Elestrin Gel
estradiol tab,patch	norethindrone	CombiPatch	Premarin	Esclim		EvaMist
esterified estrogens	Premphase	Estraderm	Prempro	Femhrt		
estropipate		Estratest, HS		Vivelle		
Jolivette		Ortho-Prefest				
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS						
diclofenac potassium	meloxicam			Arthrotec		Cambia (SE)
diclofenac sodium	nabumetone			Celebrex (PA)		Flector
etodolac	naproxen					Voltaren Gel
ibuprofen	naproxen sodium					Pennsaid (SE)
indomethacin, SR	oxaprozin					Sprix 5/5 2 refill limit
ketoprofen, SR	piroxicam					
ketorolac tabs (20/Rx)	sulindac					
meclofenamate	tolmentin					
OSTEOPOROSIS DRUGS						
alendronate		Didronel	Miacalcin injectable	Actonel		
		Evista	Miacalcin Nasal Spray	Boniva		
		Fosamax Plus D				
UROLOGY DRUGS						
doxazosin	oxybutinin, XL	Caverject	Jalyn	Cialis-4tabs/30d	Staxyn-4tabs/30d	Gelnique Gel
finasteride	phenazopyridine	Detrol	Muse	Levitra-4tabs/30d		Sanctura SR
hyoscyamine XR	terazosin	Flomax	Viagra-4 tabs/30d	Detrol LA		Toviaz

PA = Prior Authorization Required; **G** = Brand name listed, but plan pays for generic product at the Preferred copay level

SE= Step Edit (prior drug therapy) required

This is an abbreviated version of the preferred, standard, premium and permium plus drug list. This is provided as a reference and is subject to change. Physician and pharmacy providers receive the entire drug list a minimum of two times per year. Updates are provided quarterly. Not all drugs are covered under every pharmacy benefit. Not all plans have a pharmacy benefit. To determine coverage, or to ask about a drug not on this list, call Member Services at the number listed on your membership card. When the drug prescribed for you is available as a generic, the generic will be dispensed unless your physician has indicated otherwise. If the brand name product is dispensed, you may be responsible for the difference between the cost of the generic drug and the brand name product.

Additional copays for multiple packages may apply, a one month supply may require the payment of multiple copays, check with your benefit plan.

This listing is not inclusive of all group benefits. Some may include or exclude additional drugs. This listing is subject to change.

Newly FDA approved medications will be classified as Premium Plus agents until reviewed by the P&T committee.

Prior Authorization Required

Tiers 1 and 2

Adcirca® (tadalafil) Differin® (adapalene) Epogen® (erythropoietin) Fentanyl (generic Actiq) Kalydeco® (ivacaftor)	Leukine® (sargramostim, GM-CSF) Neumega® (oprelvekin) Neupogen® (filgrastim, G-CFS) Procrit® (erythropoietin)	Retin-A® (tretinoin)[Ŧ] Revatio® (sildenafil) Stadol® Nasal Spray (butorphanol) Synarel® (nafarelin acetate) [Ŧ]	Tev-Tropin® (somatropin) Tretinoin [Ŧ] Xalkori® (crizotimib) Zelboraf® (verurafenib)

Tiers 3 and 4

Abstral (fentanyl sublingual) Accretropin® (somatropin) Acthar HP Inj (corticotropin inj) [Ŧ] Actiq® (oral transmucosal fentanyl) Actemra® (tocilizumab) Ampyra® (dalfampridine) Aranesp (darbepoetin) Butrans® (buprenorphine transdermal system) Caduet® (amlodipine/atorvastatin) Cambia® (diclofenac potassium) Celebrex® (celecoxib) Crestor® (rosuvastatin) Cimzia® (certolizumab pegol) Dificid™ (fidaxomicin) Egrifta® (tesamorelin) Enbrel® (entanercept)	Exalgo® (hydromorphone hydrochloride ER tablets) Fentora (fentanyl, buccal) Gamunex C (immune globulin) Genotropin® (somatropin) Gilenya® (fingolimod) Hizentra ® (immune globulin subcutaneous) Humatrope® (somatropin) Humira™ (adalimumab) Kineret® (anakinra) Lazandra® (fentanyl) Lescol XL® (fluvastatin) Livalo® (pitavastatin) Lovaza® (omega-3-acid ethyl ester) Neulasta® (pegfilgrastim) Nexavar® (sorafenib tosylate)	Norditropin® (somatropin) Nucynta™ (tapentadol) Nucynta ER ™ (tapentadol) Nuedexta® (dextromethorphan/quinidine sulfate) Nutropin® (somatropin) Nuvigil ® (armodafinil) Omnitrope® (somatropin) Onsolis (fentanyl film) Opana, Opana ER (oxymorphone HCL) Orencia® (abatacept) OxyContin® (oxycodone controlled release) Pennsaid® (diclofenac sodium 1.5% solution) Pradaxa ® (dabigatran etexilate)	Potiga® (ezogabine) Provigil ® (modafinil) Revlimid (lenalidomide) Saizen® (somatropin) Samsca (tolvaptan) Sancuso (granisetron) Serostim® (somatropin) Simcor® (niacin and simvastatin) Simponi® (golimumab) Subsys® (fentanyl sublingual spray) Sutent® (sunitinib malate) Tykerb® (lapatinib) Ulesfia™ (benzyl alcohol) Vytorin™ (eztimibe/simvastatin) Xarelto® (rivaroxaban) Zorbtive (somatropin) Xyrem (sodium oxybate)

Drugs with Step-Edits

Abilify *Trial/failure of 2 antipsychotics* Aciphex *Trial/failure of a generic PPI and Dexilant* Adoxa *Trial/failure of doxycycline* Alsuma *Trial/failure of sumatriptan injection* Amerge *Trial/failure of sumatriptan or naratriptan* Amturnide *Trial/failure of a generic ARB and Edarbi or Edarbyclor* Androderm *Trial/failure of Androgel and Axiron* Atacand,HCT *Trial/failure of a generic ARB and Edarbi or Edarbyclor* Avidoxy DK *Trial/failure of doxycycline* Azor *Trial/failure of a generic ARB and Edarbi or Edarbyclor* Axert *Trial/failure of sumatriptan or naratriptan* Betaseron *Trial/failure of two of the following: Avonex, Copaxone or Rebif* Benicar, HCT *Trial/failure of a generic ARB and Edarbi or Edarbyclor* Byetta and Bydureon ***(Family Care Only)*** *Trial/failure of Januvia/ Janumet or Tradjenta/Jentadueto* Cardura XL *Trial/failure of Cardura* Coreg CR *Trial/failure of Coreg*	Cymbalta *Trial/failure of venlafaxine XR (other requirements possible)* Daytrana *Trial/failure of methylphenidate ER or dextroamphetamine/amphetamine and Vyvanse* Dexilant *Trial/failure of a generic PPI* Deprizine Kit *Trial/failure of ranitidine* Diovan *Trial/failure of a generic ARB and Edarbi or Edarbyclor* Doryx *Trail/failure of doxycycline* Edarbi *Trial/failure of a generic ARB* Edarbyclor *Trial/failure of a generic ARB* Edluar *Trial/failure of temazepam, zolpidem, zolpidem CR or zaleplon* Extavia *Trial/failure of two of the following: Avonex, Copaxone or Rebif* Exforge, HCT *Trial/failure of a generic ARB* Fanapt *Trial/failure of 2 antipsychotics* Fanatrex *Trial/failure Neurontin Solution* Focalin XR *Trial/failure of methylphenidate ER or dextroamphetamine/amphetamine and Vyvanse* Fortesta *Trial/failure of Androgel and Axiron* Frova *Trial/failure of sumatriptan or naratriptan*	Ferriprox *Trial/failure of Exjade* Horizant *Trial/failure of pramipexole, ropinirole gabapentin* Intermezzo *Trial/failure of temazepam, zolpidem, olpidem CR or zaleplon* Intuniv *Trial/failure of guanfacine* Invega *Trial/failure of 2 antipsychotics* Kapvay *Trial/failure of clonidin* Kombiglyze XR *Trial/failure of Janumet or Janumet XR and Jentadueto* Latuda *Trial/failure of 2 antipsychotics* Latuda *Trial/failure of 2 antipsychotics* Lindane *Trial/failure of Ovide* Lunesta *Trial/failure of temazepam, zolpidem zolpidem CR or zaleplon* Luvox CR *Trial/failure of 2 SSRIs or 1 SSRI and venlafaxine XR* Lyrica *Trial/failure of gabapentin* Maxalt *Trial/failure of sumatriptan or naratriptan* Maxalt MLT *Trial/failure of sumatriptan or naratriptan* Metadate CD *Trial/failure of methylphenidate ER or dextroamphetamine/amphetamine and Vyvanse*

*Member should be on no more than one drug at a time in the same therapeutic category.

[Ŧ] *Limitation on Transition of Care authorization*

Drugs with Step-Edits

continued

Metozolv ODT
Trial/failure of metoclopramide
Micardis, HCT
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Natroba
Trial/failure of malathion
Neupro
Trial/failure of pramipexole or ropinirole
Nexium
Trial/failure of a generic PPI and Dexilant
Nexiclon
Trial/failure of clonidine
Nutridox
Trial/failure of doxycycline
Oleptro ER
Trial/failure of trazodone
Omnaris
Trial/failure of fluticasone
Onglyza
Trial/failure of Januvia and Tradjenta
Oravig
Trial/failure of clotrimazole or fluconazole
Oracea
Trail/failure of doxycycline
Orbivan
Trial/failure of butal/APAP/caffeine 50/325/40
Potiga
Trial/failure of 2 anticonvulsants

Pristiq
Trial/failure of 2 SSRIs or 1 SSRI and venlafaxine XR
Rozerem
Trial/failure of temazepam, zolpidem, zolpidem CR or zaleplon
Rybix
Trial/failure of tramadol
Savella
Trial/failure of gabapentin
Silenor
Trial/failure of doxepin
Saphris
Trial/failure of 2 antipsychotics
Seroquel, XR
Trial/failure of 2 antipsychotics
Singulair-Family Care Members Only
Trial/failure of antihistamine and nasal steroid, or Dx of Asthma
Solodyn
Trial/failure of minocycline
Strattera
Trial/failure of methylphenidate ER or dextroamphetamine/amphetamine and Vyvanse
Sumavel DosePro
Trial/failure of sumatriptan injection
Tekamlo
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Tekturna, HCT
Trial/failure of a generic ARB and Edarbi or Edarbyclor

Testim
Trial/failure of Androgel and Axiron
Teveten, HCT
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Tribenzor
Trial/failure of a generic ARB and Edarbi or Edarbyclor
Trilipix
Trial/failure of Tricor or any fenofibrate
Treximet
Trial/failure of sumatriptan or naratriptan
Uloric
Trial/failure of allopurinol
Veramyst
Trial/failure of Flonase
Viibryd
Trial/ failure of 2 generic SSRI - OR – 1 generic SSRI and Effexor XR
Victoza
Trial/failure of Byetta or Bydureon
Vimpat
Trial/failure of 2 anticonvulsants
Zolpimist
Trial/failure of temazepam, zolpidem, zolpidem CR or zaleplon
Zomig
Trial/failure of sumatriptan or naratriptan
Zuplenz
Trial/failure of ondansetron

Drugs with Quantity Limits

Drug	*Quantity Limit*	*Drug*	*Quantity Limit*
Alsuma	8 syringes/30 days	Sprix	5 bottles/5days; limit 2 fills per 30 days
Amerge*	9 tablets/30 days	Stadol Nasal Spray	2 bottles/ 30 days
Ampyra	60 tablets/30 days	Staxyn	4 tablest/30 days
Anzemet*	10 tablets/Rx	Sumatriptan tablets 100 mg *	9 tablets/30 days
Axert*	12 tablets/30 days	Sumatriptan tablets 50 mg*	18 tablets/30 days
Cialis*	4 tablets/30 days	Sumatriptan tablets 25*	18 tablets/30 days
Cialis 2.5mg*	5 tablets/30 days	Sumatriptan Nasal Spray 5mg*	12 bottles/30 days
Edluar 10mg	30 tablets/30 days	Sumatriptan Nasal Spray 20mg*	6 bottles/30 days
Edluar 5mg	60 tablets/30 days	Sumatriptan Injection*	8 syringes/30 days
Emend	3 tablets/Rx	Sumavel DosePro	8 syringes/30 days
Emend Pack	1 pack/Rx	Tamiflu	10 capsules or 75ml/183 days
Frova*	12 tablets/30 days	Temazepam 7.5, 15mg	60 capsules/30 days
Flurazepam	30 capsules/30 days	Temazepam 22.5, 30mg	30 capsules/30 days
Granisetron*	15 tablets/Rx	Treximet*	9 tablets/30 days
Intermezzo	30 tablets/30 days	Triazolam 0.125mg	60 tablets/30 days
Ketorolac tablets	20 tablets/Rx	Triazolam 0.25mg	30 tablets/30 days
Levitra*	4 tablets/30days	Viagra*	4 tablets/30 days
Lunesta 1mg	60 tabs/30 days	zaleplon	30 tablets/30 days
Lunesta 2, 3mg	30 tablets/ 30 days	Zolpidem 5mg	60 tablets/30 days
Maxalt, MLT*	12 tablets/30 days	Zolpidem 10mg	30 tablets/30 days
Migranal	4 bottles/30 days	Zomig*	12 tablets/30 days
Regranex	2 tubes, lifetime limit	Zuplenz 4mg oral film	10 oral soluble film/RX
Relenza	20 disks/183 days , (1 course/flu season)	Zomig Nasal Spray	12 bottles/30 day
Relpax*	12 tablets/30 days	Zolpidem CR	30 tablets/30 days
Rozerem	30 tablets/30 days	Zolpimist	1 bottle/30 days
Sancuso	2 boxes/ 30 days		

Diabetic Equipment and Supplies

Coverage includes benefits for equipment, supplies, and in-person outpatient self-management training and education; including medical nutrition therapy, treatment of insulin-dependent diabetes, gestational diabetes, insulin-using diabetes, and non-insulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. “Equipment” and “supplies” shall not be considered durable medical equipment. This benefit is not subject to any policy or calendar-year dollar or durational benefit limitations or maximums for benefits or services.

The Member will be responsible for any applicable Copayment, Coinsurance, or Deductible as specified on the FaceSheet depending upon the type service received. Diabetic equipment and supplies are covered when received from Plan providers only.

To qualify for Coverage under this section, diabetes in-person outpatient self-management training and education shall be provided by a certified, registered, or licensed health care professional. Members may call 1-800-SENTARA for information on educational classes. **Members may call Liberty Medical Supplies at 1-866-846-9361 to arrange for prescribed supplies to be delivered to them at home.** Members will be responsible for the Copayment or Coinsurance as specified on the FaceSheet.

Optima Vantage Plan
Behavioral Health and Substance Abuse Benefit

Behavioral healthcare and substance abuse services are included as part of the healthcare coverage.

How to receive services
Behavioral healthcare and substance abuse services may be accessed in the following ways:

- Call 1-800-648-8420 to be directed to a participating behavioral health provider. It is not necessary to go through the Primary Care Physician (PCP); or
- Contact a participating behavioral health provider directly to arrange for an initial authorization.

If hospitalization is required, the behavioral health provider will arrange for admission to the appropriate In-Network facility. Pre-Authorization must be obtained prior to receiving inpatient services.

Pre-Authorization penalty
Failure to pre-authorize inpatient services may result in the member's responsibility to pay a $500 penalty.

Emergency services
If currently in treatment, contact the attending behavioral health provider.

If not currently receiving care, call 1-800-648-8420 and arrangements will be made for the member to be seen by a behavioral health professional. In order to ensure a prompt response to any clinical emergency, a 24-hour crisis hotline is available after normal business hours, weekends, and holidays.

Please call 911 or go directly to an emergency department facility if any covered member is engaged in behaviors that pose an immediate danger to themselves or to the life of another.

Exclusions
Non-medical ancillary services are not covered. These may include, but are not limited to: vocational rehabilitation services, employment counseling, health education, and expressive therapies. Residential Treatment is not covered by the Plan. A complete list of exclusions can be found in the Evidence of Coverage.

Additional information
Current members with questions regarding benefits should call Member Services at the number on the back of their member ID card.

If you are considering enrolling for the first time and have questions, please consult with the group's Benefit Administrator.

A Telecommunications Device for the Deaf (TDD) can be accessed by dialing 1-800-225-7784.

Vision Care and Materials Rider

This rider includes covered services for expanded vision care services in lieu of preventive vision care benefits.

EyeMed Vision Services administers this benefit for vision care services and materials. Each covered person is eligible to receive a routine eye examination, refraction, and lenses, frames, and contact lenses once every 12 months from an EyeMed network provider for the Copayment of $0, per eye examination and materials.

Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost. Lenses (single, vision, bifocal, trifocal) are covered in full. Frames are covered in full up to $100 retail. Contact lenses (in lieu of glasses) are also covered in full up to $100 retail.

For eye examinations from Out-of-Network providers, members will be reimbursed $30 for an eye examination only.

Copayments or Coinsurance for covered services under this rider are not applied toward any Plan out-of-pocket maximum and must continue to be paid after the maximum is met.

To receive covered cervices

- Select a participating EyeMed Vision Services network provider from the Plan's provider directory or by calling EyeMed at 1-888-610-2268. Automated location information is available 24 hours a day. Customer service representatives are available Monday through Friday 9 a.m. - 9 p.m., and Saturday 9 a.m. - 5 p.m.

- Visit or call the participating provider and identify yourself as a member by providing your Member ID information. The provider will verify eligibility, your Plan's covered services, and any applicable Copayment or Coinsurance. Payment is due when you receive services.

- If the vision provider determines that you need additional medical care, you should contact your Plan physician.

Additional information

Current members with questions regarding benefits should call Member Services at the number on the back of their member ID card. If considering enrolling for the first time and you have questions, please consult with the group’s Benefits Administrator.

Preventive Vision Discount Fee Schedule

A Defined Materials Discount

Vision Care Services	Member Cost
Complete Pair of Glasses Purchased*: Frame, lenses, and lens options must be purchased in the same transaction to receive full discount.	
Standard Plastic Lenses:	
Single Vision	$ 50
Bifocal	$ 70
Trifocal	$105
Frames: Any frame available at provider location	40 percent discount off retail price
Lens Options:	
UV Coating	$15
Tint (solid and gradient)	$15
Standard Scratch-Resistance	$15
Standard Polycarbonate	$40
Standard Progressive (add-on to bifocal)	$65
Standard Anti-Reflective Coating	$45
Other Add-ons and Services	20 percent discount
Contact Lens Materials:	
(Discount applied to materials only)	
Disposable	No discount on disposable
Conventional	15 percent discount off retail price
Laser Vision Correction:	
Lasik or PRK	15 percent discount off retail price or 5 percent discount off promotional price

**Items purchased separately will be discounted 20 percent off the retail price.*

These discounts apply for all Optima Health members and do not, in any way, affect your premium, nor are they covered benefits under your health plan.

These discounts cannot be used in conjunction with any other discount, rider, or benefit; and you will be responsible for applicable taxes.

EyeMed VISION CARE℠

Out-Of-Network Claim Form

Most EyeMed Vision Care plans allow members the choice to visit an in-network or out-of-network vision care provider. You only need to complete this form if you are visiting a provider that is not a participating provider on the EyeMed network. Not all plans have out-of-network benefits, so please consult your member benefits information to ensure coverage of services and/or materials from non-participating providers.

If you choose an out-of-network provider, please complete the following steps prior to submitting the claim form to EyeMed. Any missing or incomplete information may result in delay of payment or the form being returned. Please complete and send this form to EyeMed within 1 year from the original date of service at the out-of-network provider's office.

1. When visiting an out-of-network provider, you are responsible for payment of services and/or materials at the time of service. EyeMed will reimburse you for authorized services according to your plan design.
2. Please complete all sections of this form to ensure proper benefit allocation. Plan information may be found on your benefit ID Card, or via your human resources department.
3. EyeMed will only accept **itemized paid receipts** that indicate the services provided and the amount charged for each service. The services must be paid in full in order to receive benefits. Handwritten receipts must be on the provider's letterhead. Attach itemized paid receipts from your provider to the claim form. If the paid receipt is not in US dollars, please identify the currency in which the receipt was paid.
4. Please include a copy of your Explanation of Benefits if submitting for a Secondary Insurance Benefit.
5. If the reimbursement is to be sent to someone other than the primary subscriber, a copy of a cancelled check or credit card receipt (in addition to the paid itemized receipt) must be included. A copy of a receipt showing payment in cash is also acceptable.

If applicable, check the box for payment to be addressed to the patient in lieu of the subscriber.

☐ By signing below, you are representing that you are legally divorced or separated and the patient is entitled to the reimbursement. If it is later determined that the patient was not entitled to the reimbursement, you agree to refund EyeMed in full.

6. Sign the claim form below.

Date of Service: ___/___/_____

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birth Date: _____

Plan Information:

Subscriber Name

Last:_____ First: _____ MI: _____

Plan Name: _____

Subscriber ID: _____

Request For Reimbursement –Please Enter Amount Charged. Remember to include itemized paid receipts:			
Exam: $_____	Frames: $_____	Lenses: $_____	Contact Lenses – (includes fit and follow-up, please submit $_____ all contact related charges at the same time)
If lenses were purchased, please circle type: Single Bifocal Trifocal Progressive			

I hereby understand that without prior authorization from EyeMed Vision Care LLC for services rendered, I may be denied reimbursement for submitted vision care services for which I am not eligible. I hereby authorize any insurance company, organization employer, ophthalmologist, optometrist, and optician to release any information with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct.

Member/Guardian/Patient Signature (not a minor) _____ Date: _____

To Fax: 866-293-7373 To Email Form and Receipts: oonclaims@eyemedvisioncare.com

To Mail: EyeMed Vision Care Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Fraud Warning Statements

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Department of Insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing a false, incomplete or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

Kansas: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application or claim for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is found guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in § 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application or false claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Alternative Medicine Discount Program

Each covered individual is offered a discount on acupuncture, chiropractic, and massage therapy services administered by American Specialty Health Networks™ (ASHN). Participating providers extend up to a 25 percent discount off their usual and customary charges.

How to receive services
Select a participating complementary healthcare provider from the Plan's Benefit Information Guide or from the Plan's website at optimahealth.com.

Schedule an appointment with a participating provider. A physician referral is not necessary. The participating provider will develop, if necessary, a treatment plan for the member. There are no visit limitations. A change from a participating provider is permitted at any time.

In order to receive the complementary discount, present your member ID card to the participating provider at the time of service. The member is responsible for payment of services at each visit. There are no claim forms to file.

If chiropractic care is covered under the Plan's medical benefit, the member may find it beneficial to use this discount program after the annual Plan limit has been met, or for services not covered under that benefit.

Additional Information
For more information regarding this discount program, or to nominate a provider not yet in the network, please call ASHN's Member Services at 1-877-327-2746 or refer to the Plan's website at optimahealth.com. ASHN's Member Service representatives are available from 8 a.m. to 9 p.m. (Monday-Friday).

Current members with questions regarding benefits should call Member Services at the number on the ID card. If you are considering enrolling for the first time and have questions, please consult with your group's Benefit Administrator. A Telecommunications Device for the Deaf (TDD) can be accessed by dialing 1-800-225-7784.

CAM 0812

EXCLUSIONS AND LIMITATIONS

VANTAGE PRODUCTS

The following is a list of Exclusions and Limitations that generally apply to all Optima Health plans. Once you are an enrolled member please refer to your Plan documents for the Exclusions and Limitations specific to your plan.

Underwritten by Optima Health Plan

v8.12

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section of the Optima coverage documents for your plan. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan.

A

Abortion is covered in the first 12 weeks of pregnancy. After 12 weeks abortion is covered if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

Acupuncture is not covered**.**

Adaptations to Your Home, Vehicle or Office are not covered. Handrails, ramps, escalators, elevators, or any other changes because of a medical condition or disability are not covered.

Against Medical Advice (AMA). If You decide not to follow a prescribed treatment for a medical condition the Plan will not assume any further liability for that condition unless You later decide to follow prescribed treatment under the care of the ordering physician. Coverage is subject to the terms of Your Plan.

Ambulance Service for non-emergency transportation is not covered unless We authorize the service.

Non medical **Ancillary Services** You are referred to are not covered. Vocational rehabilitation services, employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education, or other non-medical services are not covered.

General **Anesthesia** in a Physician's office is not covered.

Aromatherapy is not covered.

Artificial Hearts or mechanical heart devices, or their placement **is not covered.**

Autopsies are not covered.

B

Batteries are not covered except for motorized wheelchairs and cochlear implants when authorized.

Biofeedback is not covered unless We authorize it.

Blood and Blood Products are not covered. We do not cover any costs for finding blood donors. We do not cover the cost of transportation and storage of blood in or outside the Plan's Service Area.

Bone Densitometry Studies more than once every two years are not covered unless We authorize them.

Bone or Joint treatment involving a bone or joint of the head, neck, face or jaw is covered like any other bone or joint of the skeletal structure. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone.

Botox injections are not covered unless We have approved them.

Breast Augmentation or Mastopexy is not covered unless We have approved them. Cosmetic procedures or surgery for breast enlargement or reduction are not covered. Procedures for correction of cosmetic physical imperfections are not covered. Breast implants are not covered. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Breast Ductal Lavage is not covered.

Breast Milk from a donor is not covered.

C

Chelation Therapy is not covered except for arsenic, copper, iron, gold, mercury or lead poisoning.

Chiropractic Care is not covered unless Your Plan includes a rider. Chiropractic care includes diagnosis, correction, and management of vertebral subluxations or neuromusculoskeletal conditions.

Circumcision is not covered after age six weeks unless Medically Necessary.

Cold Therapy Machine is not covered.

Contact Lenses are not covered. Fitting of lenses or eyeglasses is not covered. We will cover the first pair of lenses following cataract surgery including contact lens, or placement of intraocular lens or eyeglass lens only.

Cosmetic Surgery and Cosmetic Procedures are not covered. We do not cover medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **We will not cover any of the following:**

- surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- non-medically necessary treatment or services resulting from complications due to cosmetic experimental procedures;
- breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following mastectomy;
- tattoo removal;
- keloid treatment as a result of the piercing of any body part;
- consultations or office visits for obtaining cosmetic or experimental procedures;
- penile implants;
- vitiligo **or other cosmetic skin condition** treatments by laser, light or other methods.

Costs of Services paid for by Another Payor are not covered. We do not cover the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as

Workers Compensation, occupational disease laws and other employers' liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of covered services in those cases where You received services in accordance with the Plan's authorization procedures. We will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

Court ordered examinations or treatments are not covered unless they are determined to be medically necessary and We have authorized them.

Custodial Care is not covered. **We will not cover any of the following:**

- residential care;
- rest cures;
- care from institutions or facilities licensed solely as residential treatment centers, intermediate care facilities, or other non-skilled sub-acute inpatient settings;
- examination or care ordered by a court of law not authorized by the Plan to be provided at a Plan Provider.

D

Dentistry/Oral Surgery/Dental Care

Dentistry

- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are not covered.
- We will cover Medically Necessary dental services from an accidental injury. It does not matter when the injury occurred. For injuries occurring on or after Your effective date of coverage treatment must be sought within 60 days of the accident.
- We will cover Medically Necessary dental services performed during an emergency department visit immediately after a traumatic injury and in conjunction with the initial stabilization of the traumatic injury subject to utilization review for Medical Necessity.
- Cosmetic services to restore appearance are not covered.
- Dental implants or dentures and any preparation work for them are not covered.
- Dental services performed in a hospital or any outpatient facility are not covered. This does not include covered services listed under “Hospitalization and Anesthesia for Dental procedures."

Oral Surgery

- Oral surgery which is part of an orthodontic treatment program is not covered.
- Orthodontic treatment prior to orthognathic surgery is not covered.
- Dental implants or dentures and any preparation work for them are not covered.
- Extraction of wisdom teeth is not covered unless Your plan includes a rider.

Dental Care

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are not covered.
- Dental implants or dentures and any preparation work for them are not covered.

Diagnostic tests or Surgical Procedures are not covered where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes**.**

Disposable Medical Supplies are not covered. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide and other disposable supplies are not covered.

Driver Training is not covered.

Durable Medical Equipment (DME) is covered up to the limits stated on Your Plan's face sheet or schedule of benefits. We will only cover an amount, supply or type of DME that We determine will safely and adequately treat Your condition. **We will not cover any of the following:**

- more than one item of DME for the same or similar purpose;
- DME and appliances not uniquely relevant to the treatment of disease;
- disposable medical supplies and medical equipment;
- medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide;
- DME for use in altering air quality or temperature;
- DME for exercise or training;
- DME mainly for comfort, **convenience**, well being **or education;**
- batteries for repair or replacement except for motorized wheelchairs **or cochlear implants;**
- blood pressure monitors unless authorized by the plan.

E

Electron Beam Computer Tomography (EBCT) is not covered. We do not cover any **other diagnostic imaging test where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.**

Services, treatment or testing required to complete **Educational Programs,** degree requirements, or residency requirements are not covered.

Educational Testing, Evaluation, Screening, or tutorial services are not covered. Any other service related to school or classroom performance is not covered**.** This does not include services that qualify as Early Intervention Services under the Plan's benefit; **or if Your plan includes coverage for Autism Spectrum Disorder those services covered under Autism Spectrum disorder benefits.**

Enteral or Parenteral Feeding supplements are not covered unless they are used as the sole **or major** source of nutrition. We do not cover over the counter supplements.

Examinations, testing or treatment required for employment, insurance, or judicial or administrative proceedings are not covered.

Exercise Equipment is not covered. We do not cover bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment. We do not cover pool, gym, or health club membership fees.

Experimental or Investigative drugs, devices, treatments, or services are not covered. **Experimental or Investigative means any of the following situations:**

- the majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- the use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable value as reported by current scientific literature and/or regulatory agencies; or
- the research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
- the drug or device is not approved for marketing by the United States Food and Drug Administration (FDA); or

- the drug, device, medical treatment or procedure is currently under study in a **Non-FDA approved** Phase I or Phase II clinical trial, an experimental study/investigational arm of a Phase III clinical study, or otherwise under study to determine safety and efficacy or to compare its safety and efficacy to current standards of care; or
- The drug device or medical services is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment.

Eye Examinations required for work are not covered. Corrective or protective eyewear required for work is not covered.

Eye Glasses and contract lenses are not covered. Fitting of lenses or eyeglasses is not covered. We will cover the first pair of lenses following cataract surgery including contact lenses, or placement of intraocular lenses or eyeglass lenses only.

Eye Movement Desensitization and Reprocessing Therapy is not covered.

Eye Corrective Surgery such as Radial Keratotomy, PRK, LASIK, or any other eye corrective surgery is not covered.

F

We **do not cover** the following **Foot Care Services** unless We authorize them:

- operations which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions;
- **treatment and services related to plantar warts.**

We **do not cover** any of the following **Foot Care Services** except for Members with Diabetes or severe vascular problems:

- removal of corns or calluses;
- nail trimming;
- treatment and services for or from flat-feet, fallen arches, weak feet, or chronic foot strain;
- foot Orthotics of any kind;
- customized or non-customized shoes, boots, and inserts.

G

Genetic Testing and Counseling is not covered unless We have authorized the services.

GIFT programs (Gamete Intrafallopian Transfer) are not covered.

Growth Hormones are only covered under the Plan's Outpatient Prescription Drug Rider. Growth hormones for the treatment of idiopathic short stature are not covered**.**

H

Hearing Aids are not covered unless Your plan has a rider. Fittings, molds, batteries or other supplies are not covered unless Your plan has a rider.

Home Births are not covered.

Home Health Care Skilled Services are not covered unless You are homebound**.** Services are limited as stated on Your Plan's face sheet or schedule of benefits. We do not cover any services after You

have reached Your Plan's limit. We only cover services or supplies listed in Your home health care plan. We do not cover custodial care. We do not cover transportation.

Home Sleep Studies are not covered.

Hypnotherapy is not covered.

I

Immunizations required for foreign travel or for employment are not covered.

Implants for cosmetic breast enlargement are not covered. We do not cover cosmetic procedures or cosmetic surgery for breast enlargement or reduction. We do not cover procedures for correction of cosmetic physical imperfections. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Incarceration - We do not cover services and treatments done during incarceration in a Local, State, Federal or Community Correctional Facility or prison.

Infertility Services are not covered unless Your Plan includes a rider. **We will not cover any of the following:**

- services, tests, medications, and treatments for the diagnosis or treatment of Infertility**;**
- services, tests, medications, and treatments for the enhancement of conception;
- services, tests, medications, and treatments that aid in or diagnose potential problems with conception;
- in-vitro Fertilization programs;
- artificial insemination or any other types of artificial or surgical means of conception;
- drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- reproductive material storage;
- treatment or testing related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- semen recovery or storage,
- sperm washing;
- services to reverse voluntary sterilization;
- infertility Treatment or services from reversal of sterilization;
- semen analysis;
- Sims-Huhner test (smear);
- drugs used to treat infertility.

J

K

Keloids from body piercing or pierced ears are not covered.

L

Laboratory Services for Vantage HMO plans:

Laboratory Services from Non-Plan providers or laboratories are not covered. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

Laboratory Services for Vantage POS plans:

Laboratory Services from Non-Plan providers or laboratories are covered under Out of Network Benefits. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

Laser Therapy for Vitiligo, psoriasis, **or any other cosmetic skin conditions** is not covered**.**

Lung Cancer Screening Helical CT Scans are not covered.

M

Magnetic Resonance Spectroscopy is not covered**.**

Massage Therapy is not covered.

Matristem Extracellular Wound Care System is not covered.

Maximum Benefit Amounts are stated on Your Plan's Face Sheet or Schedule of Benefits. We do not cover any additional benefits after a benefit limit has been reached.

Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not covered.

Medically Necessary Treatments - Any services, supplies, treatments, or procedures not specifically listed as a Covered Service, and any other services, supplies, or treatments or procedures determined not to be Medically Necessary are not covered.

Medication Dispensing Services in a clinic setting are not covered.

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not covered. **We do not cover any of the following:**

- exercise equipment;
- air conditioners, purifiers, humidifiers and dehumidifiers,
- whirlpool baths,
- hypoallergenic pillows or bed linens,
- telephones,
- handrails, ramps, elevators and stair glides;
- orthotics not approved by Us;
- changes made to vehicles, residences or places of business;
- adaptive feeding devices, adaptive bed devices;
- water filters or purification devices;
- disposable Medical Supplies such as medical dressings, disposable diapers;

- over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

Membership Fees to pools, gyms, health clubs, or athletic clubs are not covered. .

Mobile Cardiac Outpatient Telemetry - (MCOT) is not covered.

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not covered unless Your plan includes a rider, and services have been **authorized by Us for members who meet established criteria.**

Motorized or Power Operated Vehicles or chair lifts are not covered unless authorized by the Plan.
N

Neuro-cognitive therapy following a neurological event, or to restore cognitive deficits is not covered.

Neuropsychological Services including psychological examinations, testing or treatment to obtain or keep employment or insurance, or related to judicial or administrative proceedings are not covered unless approved by the Plan.

Newborns or other children of a Covered Dependent Child are not covered.

O

Obstetrical Care home births are not covered.

Oral Surgery services listed below **<u>are not covered</u>**:

- oral surgery which is part of an orthodontic treatment program;
- orthodontic treatment prior to orthognathic surgery;
- dental implants or dentures and any preparation work for them;
- extraction of wisdom teeth unless Your plan includes a rider.

Orthoptics or vision or visual training and any associated supplemental testing are not covered.

Out Of Network Medical, Mental Health, and Laboratory Services for Vantage HMO plans:

Out Of Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers are not covered. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.
Out Of Network Medical, Mental Health, and Laboratory Services for Vantage POS plans:

Out Of Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers are covered under Out of Network Benefits. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

P

PARS System (Physical Activity Reward System) is not covered.

Pass Devices (Patient Activated Serial Stretch) are not covered.

Paternity Testing is not covered.

Penile implants are not covered.

Personal comfort items are not covered. Telephones, televisions, extra meal trays, personal hygiene items, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs and any other similar items for personal comfort are not covered.

PET Scans are not covered unless authorized by the Plan.

Physician Examinations <u>are limited as follows</u>:

- physicals for employment, insurance or recreational activities are not covered.
- executive physicals are not covered.
- school physicals are not covered except when You have not had a health assessment with a physician during the calendar year.
- a second opinion from a Non-Plan Provider is covered only when authorized by the Plan.
- services or supplies ordered or done by a provider not licensed to do so are not covered.

Physician's Clerical Charges are not covered**. C**harges for broken appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records or correspondence to other parties, and any other clerical services are not covered.

Outpatient **Prescription Drugs** are not covered unless Your plan includes a rider.

Private Duty Nursing is not covered.

Pulsed Irrigation Evacuation System is not covered.

Q

R

Reconstructive surgery - is not covered unless services follow trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. If the trauma occurred before the Member's effective date of Coverage, the reconstructive surgery is covered subject to the Plan's pre-existing condition exclusion provisions and Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is covered.

Residential or Sub-Acute Level of Care or treatment is not covered.

S

Saliva Tests are not covered.

Second Opinions – For Vantage HMO plans a second opinion from a Non-Plan Provider is covered only when authorized by the Plan. For Vantage POS plans a second opinion from a Non-Plan Provider is covered only under out of network benefits.

Services – <u>We do not cover any of the following:</u>

- services for which a charge is not normally made;
- services or supplies prescribed, performed or directed by a provider not licensed to do so;
- services provided before Your plan effective date;
- services provided after Your coverage ends;
- telephone consultations,
- charges for missed appointments;
- charges for completing forms
- charges for copying medical records.
- services not listed as a covered service under this plan.
- non-medically necessary complications of non-covered services including medical, mental health and surgical services related to the complication.

Sex Orientation or Gender Identity Disorder Treatment of any kind is not covered. This includes surgery, therapy, and any other medical or behavioral health services related to gender identity.

Sex Change Operations and treatment of gender identity disorders are not covered.

Smoking Cessation medications are not covered.

Spinal Manipulation is not covered unless covered under a Chiropractic Care Rider.

S**terilization**

- Reversal of voluntary sterilization is not covered.
- Any infertility services required because of a reversal are not covered.

T

Services delivered under a **TDO (Temporary Detention Order)** are not covered.

Therapies. Physical, Speech, and Occupational **Therapies** are limited as stated on Your face sheet or schedule of benefits. Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. **<u>We do not cover any of the following except for those services that are covered through Early Intervention Services; or if Your plan includes coverage for Autism Spectrum Disorder those services covered under Autism Spectrum disorder benefits:</u>**

- therapies for developmental delay or abnormal speech pathology;
- therapies which are primarily educational in nature;
- special education services;
- treatment of learning disabilities;
- lessons for sign language;
- therapies to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering);
- therapies to maintain current status or level of care;
- restorative therapies to maintain chronic level of care;
- therapies available in a school program;
- therapies available through state and local funding;
- recreation therapies;
- art, dance, or music, therapies;
- exercise, or equine, therapies;
- sleep therapies;

- driver evaluations as part of occupational therapy;
- driver training;
- functional capacity testing needed to return to work;
- work hardening programs;
- remedial education and programs.

Total Body Photography is not covered.

Transplant Services. <u>We do not cover any of the following</u>:
- organ and tissue transplant services not listed as covered;
- organ and tissue transplants not medically necessary;
- organ and tissue transplants considered experimental or investigative;
- services from non-contracted providers unless pre-authorized by the plan;
- services and supplies for organ donor screenings, searches and registries.

Travel and Transportation expenses are not covered. Medically Necessary transport is covered only when approved by the Plan. E**lective or non-emergent** ambulance services are only covered when approved and authorized by Us. Treatment and services, other than Emergency Services, received outside of the United States of America are not covered.

U

Urea Breath Testing is not covered**.**

V

Vaccines are not covered unless approved by the Plan.

Video Recording or Video Taping of any covered service procedure is not covered.

Virtual Colonoscopy is not covered unless approved by the Plan.

Vision Materials not listed under Covered Services are not covered**.**

Vitiligo Treatments by laser, light or other methods is not covered.

W

Wigs or cranial prostheses for hair loss for any reason are not covered.

Wisdom Teeth extraction is not covered unless under a rider**.**

X

Y

Z