Optima Vantage 10/25M
Summary of Benefits

SURA/Jefferson Science Associates

Effective April 1, 2011

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**	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.
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. Services are covered up to a maximum benefit of $3,000 per member per calendar year.	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. Coverage is limited to $5,000 per Member per calendar year.	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.	$15 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

This rider covers outpatient prescription drugs. All drugs must be approved by the United States Food and Drug Administration (FDA). Some drugs require Pre-Authorization and some quantities may be limited. Please read this rider's limitations and exclusions carefully. Optima places covered drugs into Tiers that determine Your Copayment or Coinsurance amounts. Tier definitions and Your Copayments or Coinsurance amounts are listed below. If Your Plan has a Deductible or a Maximum Benefit that is also listed below. You can call Member Services or log on to www.optimahealth.com to find out what Tier a drug is in.

- **Preferred (Tier 1)** drugs include the majority of commonly prescribed and widely available generic drugs. Some preferred drugs are covered at this lowest Copayment level. Some brand-name drugs may be included in this category if the Plan recognizes they show documented long-term decreases in Illness and death. Large published peer-reviewed clinical trials are used to make this determination.
- **Standard (Tier 2)** drugs include brand-name drugs that are considered by the Plan to be standard therapy, and generic drugs with significantly higher costs than the average Tier 1 generic drugs that are considered by the plan to be standard therapy.
- **Premium (Tier 3)** drugs include those generic and 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 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.
- **Premium Plus (Tier 4)** drugs include those drugs not classified by the Plan as Tier 1, Tier 2, or Tier 3; those drugs not excluded from Coverage under the Pharmacy Rider; 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**.**

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.	
Preferred (Tier 1)	$10 Copayment
Standard (Tier 2)	$20 Copayment
Premium (Tier 3)	$40 Copayment for Tier Three drugs.
Premium Plus (Tier 4)	$40 Copayment for Tier Four drugs.
Mail Order Pharmacy Benefit Copayments and Coinsurances	
Some outpatient prescription drugs may not be 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 available You may purchase up to a 90-day supply for two prescription drug Copayments or the applicable Coinsurance amount.	
Preferred (Tier 1)	$20 Copayment
Standard (Tier 2)	$40 Copayment
Premium (Tier 3)	$80 Copayment for Tier Three drugs.
Premium Plus (Tier 4)	$80 Copayment for Tier Four drugs.

EXCLUSIONS AND LIMITATIONS. The following is a list of exclusions and limitations that apply to Your Coverage. Words that are capitalized are defined terms in the Definitions Section I of the Evidence of Coverage.

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 Amount.
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.

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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. 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.
30. 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.
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 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.