



# COMPARISON OF BENEFITS

**PLUS**  
**ASSOCIATION PLANS**

Underwritten by Optima Health Insurance  
Company

OptimaHealth 

v : 01.09





## *Our Value Statement*

At Optima Health, we help our members get the quality healthcare services they need, while working hard to make their healthcare coverage affordable, accessible, and easy to use.

## *Our Commitment Goes Online*

Helping people achieve optimal health means going the extra mile to build stronger relationships with members, employers, providers, and brokers. We are committed to providing reliable online information to all our healthcare partners. Our vision is to be the health plan of choice in the communities we serve!

### Optimahealth.com allows you to:

---

- Find a participating provider or facility and search provider directories
- Learn more about the products we offer
- Research health conditions and access the latest health headlines

### As a registered member on optimahealth.com, you can:

---

- View a list of participating providers
- Change your primary care physician (PCP)
- Update your home address, phone number or email address
- Order a new member ID card
- View your claims history and authorizations
- View your benefits
- Download member forms
- Learn about member discounts
- Manage your pharmacy benefit (if administered by Optima Health)
- Research drug options and pricing
- Opt to receive your Explanation of Benefits (EOB) online
- Research conditions, treatment options and hospital quality

Visit [optimahealth.com](http://optimahealth.com) as we continue to grow and evolve.

If you have any questions about the information presented, please contact us at 757-687-6030, 1-877-552-7401 or email [sales@optimahealth.com](mailto:sales@optimahealth.com).



*We know how you value your employees.  
Thank you for considering Optima Health to  
meet your employees' healthcare needs.*

## **Optima Health Products and Services**

---

Optima Health offers a broad spectrum of innovative products and service solutions designed for employers, employees and their families. Progressive plan designs encourage greater employee participation in health care decisions and can reduce administrative costs while improving service quality. Better informed employees make better decisions.

We offer special programs through our integrated clinical and behavioral health services that support members with chronic illnesses in the management of their conditions as well as customized wellness programs.



# TABLE OF CONTENTS

---

Optima Plus Association Plan Options .....	2
Optima FourSight Plan Options .....	7
Pharmacy Prescription Drug Rider Information	
Optima Plus and FourSight Pharmacy Exclusions and Limitations .....	11
Optima Plus and FourSight Pharmacy Benefit Information .....	13
Exclusions and Limitations .....	16





## *Comparison of Benefits*

### *Optima Plus Association Plan Options*

Value Added Association Plan Benefits have  
been **highlighted** for your convenience!

# OPTIMA Plus Association

Services	15/90%	15/80%	20/80%
<b>In-Network Deductible</b>	None	None	None
<b>Physician Office Services</b> - Includes covered services performed in the physician's office during the physician's office visit.			
❖ PCP Office Visit	\$15 copay	\$15 copay	\$20 copay
❖ Specialist Office Visit	\$25 copay	\$30 copay	\$40 copay
❖ Preventive Care Visits	Covered at 100%	Covered at 100%	Covered at 100%
❖ Preventing Screenings-(mammograms and colonoscopies)	Covered at 100%	Covered at 100%	Covered at 100%
❖ Maternity Care	90%	80%	80%
<b>Outpatient Services</b> – Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.			
❖ Outpatient Surgery	\$100 copay then 90%	\$100 copay then 80%	\$100 copay then 80%
❖ Outpatient Therapy Services	90%	80%	80%
❖ Outpatient Rehabilitation Services	90%	80%	80%
❖ Outpatient Diagnostic Procedures-(Diagnostic Procedures, X-ray, Ultrasound and doppler studies)	90%	80%	80%
❖ Diagnostic Advanced Imaging Services (MRI, MRA, CT, CTA and PET Scans)	90%	80%	80%
❖ Outpatient Treatment-(Chemo-Radiation, IV and Inhalation Therapy Services)	90%	80%	80%
<b>Inpatient Hospital Services</b> – Includes, but not limited to, room and board, general nursing care, lab, x-ray, and other diagnostic services.			
❖ Inpatient Care	\$300 copay then 90%	\$300 copay then 80%	\$400 copay then 80%
<b>Emergency Services</b> – Includes those emergency department facility, Physician, and ancillary services that are rendered during an emergency visit.			
❖ Emergency Department	\$100 copay then 90%	\$100 copay then 80%	\$100 copay then 80%
❖ Urgent Care Center	\$25 copay	\$30 copay	\$40 copay
<b>Mental Health Care and Substance Abuse Services</b> – Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental health. Inpatient Mental health care and outpatient psychological testing require Pre-Authorization.			
❖ Inpatient Mental Health Care	\$300 copay then 90%	\$300 copay then 80%	\$400 copay then 80%
❖ Outpatient Mental Health Care	\$25 copay	\$30 copay	\$30 copay
<b>Employee Assistance Program</b>	6 visits per presenting issue		
<b>Other Services</b>			
❖ Diabetes Supplies & Education	Supplies covered at 90% if prescribed by your physician.	Supplies covered at 80% if prescribed by your physician.	Supplies covered at 80% if prescribed by your physician.
<b>Prescription Drug Benefit</b> -closed formulary (mail order also available)	\$10/\$20/*\$50 or 20%/*\$75 or 20% **option available	\$10/\$20/*\$50 or 20%/*\$75 or 20% **option available	\$10/\$20/*\$50 or 20%/*\$75 or 20% **option available
<b>Lifetime Maximum</b>	None	None	None
<b>Out-of-Network Lifetime Max</b>	\$3,000,000	\$3,000,000	\$3,000,000
<b>In-Network Out of Pocket Max</b>	\$1,000 / \$2,000	\$2,000 / \$4,000	\$3,000 / \$6,000
<b>Out-of-Network Deductible</b>	\$200 / \$400	\$400 / \$800	\$500 / \$1,000
<b>Out-of-Network Co-Insurance</b>	80% <sup>AD/AC</sup>	70% <sup>AD/AC</sup>	70% <sup>AD/AC</sup>
<b>Out-of-Network Out of Pocket Max</b>	\$4,000 / \$8,000	\$5,000 / \$10,000	\$6,000 / \$12,000

\*Copay or 20% Coinsurance, whichever is greater, for Premium (Third & Fourth) tier drugs up to a maximum Copayment of \$250 per prescription per month

\*\* 3 Tier Generic Pharmacy option available

# OPTIMA Plus Association

\$500/25/80%	\$750/25/80%	\$1000/25/80%	\$1500/25/80%	\$1750/25/70%
\$500 / \$1,000	\$750 / \$1,500	\$1,000 / \$2,000	\$1,500 / \$3,000	\$1,750 / \$3,500
<b>Physician Office Services</b> - Includes covered services performed in the physician's office during the physician's office visit.				
\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay
\$35 copay	\$35 copay	\$35 copay	\$35 copay	\$30 copay
Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
<b>Outpatient Services</b> – Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.				
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
<b>Inpatient Hospital Services</b> – Includes, but not limited to, room and board, general nursing care, lab, x-ray, and other diagnostic services.				
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
<b>Emergency Services</b> – Includes those emergency department facility, Physician, and ancillary services that are rendered during an emergency visit.				
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
\$40 copay	\$40 copay	\$40 copay	\$40 copay	\$30 copay
<b>Mental Health Care and Substance Abuse Services</b> – Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental health. Inpatient Mental health care and outpatient psychological testing require Pre-Authorization.				
80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>	70% <sup>AD</sup>
\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay
<b>Employee Assistance Program</b>		6 visits per presenting issue		
<b>Other Services</b>				
Supplies covered at 80% <sup>AD</sup> if prescribed by your physician.	Supplies covered at 80% <sup>AD</sup> if prescribed by your physician.	Supplies covered at 80% <sup>AD</sup> if prescribed by your physician.	Supplies covered at 80% <sup>AD</sup> if prescribed by your physician.	Supplies covered at 70% <sup>AD</sup> if prescribed by your physician.
\$50 deductible then \$10/\$30/**\$50 or 20%/**\$75 or 20%	\$75 deductible then \$10/\$30/**\$50 or 20%/**\$75 or 20%	\$100 deductible then \$10/\$30/**\$50 or 20%/**\$75 or 20%	\$150 deductible then \$10/\$30/**\$50 or 20%/**\$75 or 20%	\$150 deductible then \$10/\$30/**\$50 or 20%/**\$75 or 20%
**option available	**option available	**option available	**option available	**option available
None	None	None	None	None
\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000
\$2,500 / \$5,000	\$3,250 / \$6,500	\$3,500 / \$7,000	\$4,000 / \$8,000	\$5,000 / \$10,000
\$750 / \$1,500	\$1,000 / \$2,000	\$1,250 / \$2,500	\$1,750 / \$3,500	\$2,000 / \$4,000
60% <sup>AD/AC</sup>	60% <sup>AD/AC</sup>	60% <sup>AD/AC</sup>	60% <sup>AD/AC</sup>	50% <sup>AD/AC</sup>
\$7,500 / \$15,000	\$7,500 / \$15,000	\$7,500 / \$15,000	\$9,000 / \$18,000	\$10,000 / \$20,000

\*Copay or 20% Coinsurance, whichever is greater, for Premium (Third & Fourth) tier drugs up to a maximum Copayment of \$250 per prescription per month

\*\* 3 Tier Generic Pharmacy option available





## *Comparison of Benefits*

Optima FourSight Association Plan Options



# OPTIMA Foursight Association

Services	500/10/80%	1000/10/80%	2000/10/80%
<b>Annual Deductible</b>	\$500/\$1,000	\$1,000/\$2,000	\$2,000/\$4,000
<b>Physician Office Services</b> – Includes covered services performed in the physician’s office during the physician’s office visit.			
❖ Physician Visits 1-4 visits	\$10 copay	\$10 copay	\$10 copay
❖ Physician Visits 5+ visits	Deductible applied, once met, \$15 copay and paid at coinsurance level	Deductible applied, once met, \$15 copay and paid at coinsurance level	Deductible applied, once met, \$15 copay and paid at coinsurance level
❖ Preventive Care Visits	Paid at 100% up to a max of \$350 then at 80% <sup>AD</sup>	Paid at 100% up to a max of \$350 then at 80% <sup>AD</sup>	Paid at 100% up to a max of \$350 then at 80% <sup>AD</sup>
❖ Maternity Care	\$500 copay, then 80% <sup>AD</sup>	\$500 copay, then 80% <sup>AD</sup>	\$500 copay, then 80% <sup>AD</sup>
<b>Outpatient Services</b> – Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.			
❖ Outpatient Surgery	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>
❖ Outpatient Therapy Services	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>
❖ Outpatient Rehabilitation Services	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>
❖ Outpatient Diagnostic Procedures	Paid at 100% up to \$500 then 80% <sup>AD</sup>	Paid at 100% up to \$500 then 80% <sup>AD</sup>	Paid at 100% up to \$500 then 80% <sup>AD</sup>
❖ Outpatient Treatments-Chemo-Radiation, IV and Inhalation Services	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>
<b>Inpatient Hospital Services</b> – Includes, but not limited to, room and board, general nursing care, lab, x-ray, and other diagnostic services.			
❖ Inpatient Care	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>
<b>Emergency Services</b> – Includes those emergency department facility, Physician, and ancillary services that are rendered during an emergency visit.			
❖ Emergency Department	\$75 copay, then paid at 80% <sup>AD</sup>	\$75 copay, then paid at 80% <sup>AD</sup>	\$75 copay, then paid at 80% <sup>AD</sup>
❖ Urgent Care Center	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>
<b>Mental Health Care and Substance Abuse Services</b> – Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental health. Inpatient Mental health care and outpatient psychological testing require Pre-Authorization.			
❖ Inpatient Mental Health Care	80% <sup>AD</sup>	80% <sup>AD</sup>	80% <sup>AD</sup>
❖ Outpatient Mental Health Care	\$15 copay first 4 visits; above 5 visits, \$15 copay then covered at 80% <sup>AD</sup>	\$15 copay first 4 visits; above 5 visits, \$15 copay then covered at 80% <sup>AD</sup>	\$15 copay first 4 visits; above 5 visits, \$15 copay then covered at 80% <sup>AD</sup>
<b>Employee Assistance Program</b>	6 visits per presenting issue		
<b>Other Services</b>			
❖ Diabetes Supplies	Pumps and supplies covered at 80% <sup>AD</sup> if prescribed by your physician.		
<b>Prescription Drug Benefit-</b> closed formulary (mail order also available)	\$50 deductible then \$10/\$30/*\$50 or 20%/*\$75 or 20%  **option available	\$50 deductible then \$10/\$30/*\$50 or 20%/*\$75 or 20%  **option available	\$50 deductible then \$10/\$30/*\$50 or 20%/*\$75 or 20%  **option available
<b>Lifetime Maximum</b>	\$3,000,000	\$3,000,000	\$3,000,000
<b>In network Out of Pocket Maximum</b>	\$3,000/\$9,000	\$3,500/\$10,500	\$4,000/\$12,000
<b>Out-of-Network Deductible</b>	\$1,000/\$3,000	\$1,500/\$4,500	\$2,500/\$7,500
<b>Out-of-Network Co-Insurance</b>	50% <sup>AD AC</sup>	50% <sup>AD AC</sup>	50% <sup>AD AC</sup>
<b>Out-of-Network Out of Pocket Max</b>	\$7,500/\$15,000	\$7,500/\$15,000	\$7,500/\$15,000

\*copay or 20% Coinsurance, whichever is greater, for Premium (Third & fourth) tier drugs up to a maximum Copayment of \$250 per prescription per month

\*\* 3 Tier Generic Pharmacy option available





# **Pharmacy Benefit Information**

Underwritten by Optima Health Insurance Company  
Visit [www.optimahealth.com](http://www.optimahealth.com)

# Optima Health Prescription Drug Rider

## Optima Plus & Optima FourSight Association Plans

Members are entitled to receive the following FDA-approved prescription drugs, when prescribed by a participating Physician, from a participating pharmacy or from 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.

This Plan uses a closed formulary. Recommendations on drug coverage are made by the Pharmacy and Therapeutics Committee composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add a drug to, or remove a drug from the preferred/standard drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. Selected drugs may require your physician to obtain Pre-Authorization from the Plan in order to be covered. The Pharmacy and Therapeutics Committee may establish monthly quantity limits for selected medications. Members will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in. Covered prescription drugs are placed into Copayment tiers according to the following:

- **Preferred (Tier 1) include:** The majority of commonly prescribed and widely available generic drugs. Preferred drugs are covered at the 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) include:** Brand-name drugs that are considered by the Plan to be standard therapy; and generic drugs with significantly higher costs than the average Preferred (Tier 1) generic drugs, that are considered by the plan to be standard therapy.
- **Premium (Tier 3) include:** Those generic and brand name drugs not included by the Plan on another tier. 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) include:** Those generic and brand name drugs not classified by the Plan as Preferred (Tier 1), Standard (Tier 2), or Premium (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 the Preferred (Tier 1), Standard (Tier 2), or Premium (Tier 3) tiers or over the counter.

Members may purchase a 90-day supply of maintenance drugs for two prescription drug Copayments. If a Member has a question about the Mail Order Prescription Drug Program or about whether a prescription is available through the program, he or she may contact CVS/Caremark Pharmacy Services (formerly PharmaCare Specialty Pharmacy) at: 1-888-766-5495 or write to:

CVS/Caremark Pharmacy Services  
600 Penn Center Blvd.  
Pittsburgh, PA 15235

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 the Member or prescribing Physician requests the brand-name drug or a higher costing generic, the Member must pay the difference between the cost of the dispensed drug and the generic product level in addition to the Standard or Premium tier Copayment charge.

All covered outpatient prescription drugs have been approved by the Food and Drug Administration and require a prescription either by state or federal law.

All compounded prescriptions require prior authorization and must contain at least one prescription ingredient.

Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization.

**Underwritten by Optima Health Insurance Company**

# Optima Health Prescription Drug Rider

## Optima Plus & Optima FourSight Association Plans

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so 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.

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.

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.

The Pharmacy and Therapeutics Committee may establish monthly quantity limits for selected medications. Please call Member Services with any questions about what tier a particular prescription drug falls under and any applicable quantity limits. This information is also available at the Plan's website [www.optimahealth.com](http://www.optimahealth.com).

For a single Copayment charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug.

Depo-Provera and Lunelle injections, Intrauterine devices (IUDs), and cervical caps and their insertion are covered under medical benefits. Please see Section IV Family Planning.

Limited over the counter drugs may be covered at quantities approved by the Plan. The Member 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.

**EXCLUSIONS.** The following are excluded or limited under the Prescription Drug Rider:

1. 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.
2. 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.
3. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
4. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from coverage.
5. Immunization agents, biological sera, blood or blood products are excluded from Coverage.
6. Infertility drugs are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage.
9. Medication taken or administered in whole or in part, while he/she is a patient in a licensed Hospital, rest home, sanatorium, extended care facility, convalescent Hospital, nursing home, or similar institution is excluded from Coverage .
10. Investigational or experimental medications are excluded from Coverage.
11. Medications for cosmetic purposes only, including but not limited to Retin-A for aging, are excluded from Coverage.
12. Medications for smoking cessation, including but not limited to Nicorette gum, nicotine patches, nicotine spray are excluded from Coverage.

**Underwritten by Optima Health Insurance Company**

# Optima Health Prescription Drug Rider

## Optima Plus & Optima FourSight Association Plans

13. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
14. Medications with no approved FDA indications are excluded from Coverage.
15. 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 unless listed as covered on the Plan's formulary.
16. Replacement prescriptions resulting from loss, theft or breakage are excluded from Coverage.
17. 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.
18. 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.
19. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are excluded from Coverage.

**Non-formulary requests.** You have the right to request a non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of covered drugs (formulary), or You have been receiving a specific nonformulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your physician must complete a medical necessity form and deliver it to the Optima Health pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, Optima Health will make a determination. Optima Health will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.

# Optima Health Prescription Drug Rider Optima Plus & Optima FourSight Association Plans

## Member Copayments and Coinsurances

### Optima Plus Association Plans 15/90%; 15/80% and 20/80%

#### Retail

For a single Copayment or Coinsurance charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug.

- \$10.00 Copayment for Preferred (First) tier drugs.
- \$20.00 Copayment for Standard (Second) tier drugs.
- \$50.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$250 per prescription per month
- \$75.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$250 per prescription per month
- Maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

#### Mail Order

Copayment for up to a 90-day supply of a covered outpatient maintenance drug when available through the Plan's mail order drug program:

- \$20.00 Copayment for Preferred (First) tier drugs.
- \$40.00 Copayment for Standard (Second) tier drugs.
- \$100.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$500 per prescription per month
- \$150.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$500 per prescription per month
- Maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

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

## Member Copayments and Coinsurances

### Optima Plus Association Plan 500/25/80%

#### \$50 Deductible per individual per calendar year (for both retail and mail order)

#### Retail

For a single Copayment or Coinsurance charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug at a retail pharmacy.

- After Deductible \$10.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$30.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$50.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$250 per prescription per month
- After Deductible \$75.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$250 per prescription per month
- Maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

#### Mail Order

Copayment for up to a 90-day supply of a covered outpatient maintenance drug when available through the Plan's mail order drug program:

- After Deductible \$20.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$60.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$100.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$500 per prescription per month
- After Deductible \$150.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$500 per prescription per month
- Maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

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

Underwritten by Optima Health Insurance Company

# Optima Health Prescription Drug Rider Optima Plus & Optima FourSight Association Plans

## Member Copayments and Coinsurances

### Optima Plus Association Plan 750/25/80%

**\$75 Deductible per individual per calendar year (for both retail and mail order)**

#### Retail

For a single Copayment or Coinsurance charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug at a retail pharmacy.

- After Deductible \$10.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$30.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$50.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$250 per prescription per month
- After Deductible \$75.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$250 per prescription per month
- Member maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

#### Mail Order

Copayment for up to a 90-day supply of a covered outpatient maintenance drug when available through the Plan's mail order drug program:

- After Deductible \$20.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$60.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$100.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$500 per prescription per month
- After Deductible \$150.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$500 per prescription per month
- Member maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs

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

## Member Copayments and Coinsurances

### Optima Plus Association Plan 1000/25/80%

**\$100 Deductible per individual per calendar year (for both retail and mail order)**

#### Retail

For a single Copayment or Coinsurance charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug at a retail pharmacy.

- After Deductible \$10.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$30.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$50.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$250 per prescription per month
- After Deductible \$75.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$250 per prescription per month
- Member maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

#### Mail Order

Copayment for up to a 90-day supply of a covered outpatient maintenance drug when available through the Plan's mail order drug program:

- After Deductible \$20.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$60.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$100.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$500 per prescription per month
- After Deductible \$150.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$500 per prescription per month
- Member maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

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

Underwritten by Optima Health Insurance Company

# Optima Health Prescription Drug Rider Optima Plus & Optima FourSight Association Plans

## Member Copayments and Coinsurances

**Optima Plus Association Plans 1500/25/80%; 1750/25/70%**

**\$150 Deductible per individual per calendar year (for both retail and mail order)**

### Retail

For a single Copayment or Coinsurance charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug at a retail pharmacy.

- After Deductible \$10.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$30.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$50.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$250 per prescription per month
- After Deductible \$75.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$250 per prescription per month
- Member maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

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

### Mail Order

Copayment for up to a 90-day supply of a covered outpatient maintenance drug when available through the Plan's mail order drug program:

- After Deductible \$20.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$60.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$100.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$500 per prescription per month
- After Deductible \$150.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$500 per prescription per month
- Member maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

## Member Copayments and Coinsurances

**Optima FourSight Association Plans 500/10/80%; 1000/10/80% and 2000/10/80%**

**\$50 Deductible per individual per calendar year (for both retail and mail order)**

### Retail

For a single Copayment or Coinsurance charge, a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug at a retail pharmacy.

- After Deductible \$10.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$30.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$50.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$250 per prescription per month
- After Deductible \$75.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$250 per prescription per month
- Member maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs.

\* Benefits are payable at the percent specified of the Plan's fee schedule

### Mail Order

Copayment for up to a 90-day supply of a covered outpatient maintenance drug when available through the Plan's mail order drug program:

- After Deductible \$20.00 Copayment for Preferred (First) tier drugs.
- After Deductible \$60.00 Copayment for Standard (Second) tier drugs.
- After Deductible \$100.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium (Third) tier drugs up to a maximum Copayment of \$500 per prescription per month
- After Deductible \$150.00 Copayment or Covered at 20%\* Coinsurance, whichever is greater, for Premium Plus (Fourth) tier drugs up to a maximum Copayment of \$500 per prescription per month
- Member maximum combined out of pocket amount of \$3000 per calendar year for third and fourth tier drugs

Underwritten by Optima Health Insurance Company



# **Exclusions and Limitations**

Underwritten by Optima Health Insurance Company  
Visit [www.optimahealth.com](http://www.optimahealth.com)

The following is a list of services, supplies, equipment and benefits that are limited in or excluded from Coverage.

### A

**Abortion** - Elective termination of pregnancy is covered during the first 12 weeks of pregnancy. The Plan covers abortion after the first 12 weeks only if the life of the mother would be endangered if the fetus were carried to full term; or if there is reasonable medical evidence of lethal fetal abnormalities; or in the case of rape or incest.

**Acupuncture** - is excluded from Coverage.

**Adaptations to the Home** - are excluded from Coverage. Examples include, but are not limited to, handrails, ramps, escalators, elevators, or other disability modifications.

**Allergy Testing** - Food allergy ingestion testing, IGE immunoassays for quantitative Invitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST is excluded from Coverage.

**AMA - Against Medical Advice** - A Member may opt not to comply with recommended treatment. In such cases, the Plan will not assume any further liability for the particular condition unless the Member later decides to follow prescribed treatment under the care of the ordering physician and subject to the terms of the Member's Coverage.

**Ambulance Services** - other than for emergency transportation are excluded from Coverage unless authorized by the Plan.

**Ancillary Services** - non-medical ancillary services for which the Member is referred are excluded from Coverage. These include, but are not limited to, vocational rehab services, employment counseling, marriage counseling, expressive therapies and health education.

**Anesthesia** – General anesthesia in a Physician's office is excluded from Coverage.

**Aromatherapy** - is excluded from Coverage.

**Autopsies** - are excluded from Coverage.

### B

**Batteries** - Batteries for repair or replacement are excluded from Coverage. This does not apply to batteries for motorized wheelchairs.

**Biofeedback** - is excluded from Coverage except when authorized by the Plan.

**Blood Pressure Monitors** - are excluded from Coverage unless authorized by the Plan.

**Blood and Blood Products** - are excluded from Coverage. The cost of securing the services of blood donors are excluded from Coverage. The cost of transportation and storage of blood if used in or outside the Plan's Service Area is excluded from Coverage.

**Bone Densitometry** - studies done more frequently than once every two years are excluded from Coverage unless authorized by the Plan.

**Bone or Joint treatment** – The Plan does not exclude coverage for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw or impose limits that are more restrictive than limits on coverage applicable to such treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

**Botox injections** - are excluded from Coverage unless approved by the Plan. Botox injections for the following are excluded from Coverage: headaches, cosmetic procedures, bone and joint conditions, and writers cramp.

**Breast Augmentation/Mastopexy** - Procedures requested for the purpose of correction of cosmetic physical imperfections, except as required by State or Federal law regarding breast reconstruction and symmetry following mastectomy are excluded from Coverage.

**Breast Ductal Lavage** - is excluded from Coverage.

**Breast Milk** – donor breast milk is excluded from Coverage.

### C

**Chelation Therapy** - is excluded from Coverage for other than arsenic, copper, iron, gold, mercury or lead poisoning.

**Chiropractic Care (For Optima Equity PPO Plans only)** - which shall mean the detection, treatment and correction of structural imbalance, subluxation or misalignment of the vertebral column in the human body, for the purpose of alleviating pressure on the spinal nerves and its associated effects related to such structural imbalance, misalignment or distortion, by physical or mechanical means is excluded from Coverage.

**Circumcision** - is excluded from Coverage for non-medically indicated reasons after six weeks of age.

**Cold Therapy Machine** - is excluded from Coverage.

**Contact Lenses** - or eyeglasses or the fitting thereof are excluded from Coverage, except for the first pair of lenses (this may include contact lens, or placement of intraocular lens or eyeglass lens only) following cataract surgery.

**Cosmetic Surgery** - Emotional conflict or distress does not constitute medical necessity. The following are excluded from Coverage:

- Any cosmetic surgery and any hospital, physician, or other health service related thereto, except to the extent Medically Necessary to restore function;
- Non-Medically Necessary treatment or services resulting from complications due to cosmetic and/or experimental procedures;
- Breast Augmentation/Mastopexy procedures requested for the purpose of 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 and/or office visits for the purpose of obtaining cosmetic and/or experimental procedures;
- Penile Implants;
- Vitiligo treatments by laser, light or other methods are excluded from Coverage.

**Covered Services by Another Payor** - 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, are excluded from Coverage. Should a Member 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 the Member received services in accordance with the Plan's referral procedures. The Plan will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

**Custodial Care** - or domiciliary care, rest cures, or any examination and/or care ordered by a court of law, which has not received prior authorization by the Plan and has been arranged through, or provided at, a Plan Provider is excluded from Coverage.

## D

**Dentistry/Oral Surgery** - the following is a listing of specific dental and oral surgery exclusions, including, but not limited to:

### 1. Dentistry

- Restorative services and supplies necessary to repair or replace sound natural teeth even if loss is due to an injury or accident excluded from Coverage.
- Services to restore appearance or for cosmetic purposes are excluded from Coverage.
- Dental implants and any preparation work for implants or dentures are excluded from Coverage.
- Dental services performed in a hospital or any outpatient facility except as described in the Member's Covered Services under "Hospitalization and Anesthesia for Dental procedures" are excluded from Coverage.

### 2. Oral Surgery

- Oral surgery, which is part of an orthodontic treatment program, is excluded from Coverage.
- Orthodontic treatment prior to orthognathic surgery is excluded from Coverage.
- Dental implants and any preparation work for implants or dentures are excluded from Coverage.
- Extraction of wisdom teeth is excluded from Coverage unless covered under a rider

### 3. Dental Care

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are excluded from Coverage.
- Dental implants, and any preparation work for implants or dentures are excluded from Coverage

**Disposable Medical Supplies** - are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.

**Driver Training** - is excluded from Coverage.

**Durable Medical Equipment (DME)** - The rental, purchase, repair and replacement of durable medical equipment are limited to the level of Coverage indicated on the Face Sheet or Schedule of Benefits. DME and surgical equipment benefits are excluded for:

- More than one item of equipment for the same or similar purpose.

- An amount that exceeds the cost of a similar supply that would have been sufficient to safely and adequately treat the Member's physical condition.
- Equipment and appliances which are not uniquely relevant to the treatment of disease.
- Disposable medical supplies and medical equipment are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.
- DME for use in altering air quality or temperature or for exercise or training.
- DME primarily for the comfort and well being of the Member.
- Batteries for repair or replacement. This does not apply to batteries for motorized wheelchairs.
- Blood Pressure Monitors unless authorized by the Plan.

## E

### **Electron Beam Computer Tomography (EBCT)**

- is excluded from coverage.

**Educational/Teacher Services/Evaluations** - educational, tutorial, evaluation, testing, screening and any other services relating to school or classroom performance are excluded from Coverage. This exclusion does not apply to those services that qualify as, and are covered under the Plan's benefit for Early Intervention Services.

**Enteral or Parenteral Feeding** - Supplements and/or supplies are excluded from Coverage unless they are used as the sole source of nutrition. Over the counter supplements are excluded from Coverage.

**Exercise Equipment** - is excluded from Coverage, including, but not limited to bicycles, treadmills, stairclimbers, and pool or health club memberships.

**Experimental/Investigational Treatment and Procedures** - are excluded from Coverage. Any drug, device, medical treatment or procedure may be considered experimental or investigative if:

- 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 Food and Drug Administration (FDA); or
- The drug, device, medical treatment or procedure is currently under study in a Phase I, 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 service is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment.

**Eye Examination** - or any corrective or protective eyewear required by an employer as a condition of employment is excluded from Coverage.

**Eye Glasses** - or contact lenses or the fitting thereof are excluded from Coverage, except for the first pair of lenses (including contact lens, or placement of intraocular lens or eyeglass lens only.) following cataract surgery.

**Eye Movement Desensitization and Reprocessing Therapy** - is excluded from Coverage.

**Eye Corrective Surgery** - is excluded from Coverage, including, but not limited to, Radial Keratotomy, PRK and LASIK.

## F

**Food Allergy Testing** - is excluded from Coverage.

**Foot Care** – The following are excluded from Coverage except for those Members with Diabetes or severe vascular problems:

- Routine foot care such as the removal of corns or calluses and the trimming of nails, except for an operation which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions;
- Treatment and services related to flat-feet, fallen arches, routine bunionectomy or chronic foot strain;
- Foot Orthotics of any kind, including but not limited to, customized or non-customized shoes, boots, and inserts.

## G

### **Genetic Testing and Counseling** –

- Genetic testing and counseling are excluded from Coverage except for amniocentesis, HLAB 27, infant chromosomal analysis.
- BRAC1 and BRAC2, and FAP or AFAP are covered for colorectal cancer when Pre-Authorized by the Plan.

**GIFT programs (Gamete Intrafallopian Transfer)** - are excluded from Coverage.

**Growth Hormones** - are covered only under the Plan's Outpatient Prescription Drug Rider.

## H

**Hearing Aids** - are excluded from Coverage, including but not limited to, fittings, molds and/or supplies, such as batteries, unless covered under a Rider.

**Heart** - Artificial and/or mechanical heart devices, placement and other related expenses are excluded from Coverage.

**Home Births** – are excluded from Coverage.

**Home Health** - Home Health Care Skilled Services are limited or excluded as follows:

- Services or supplies which are not specified in Home Health Care Plans are excluded from Coverage;
- Services for any Member who is not home-bound as determined by the Plan are excluded from Coverage;
- Custodial Care is excluded from Coverage;
- Transportation services are excluded from Coverage.

**Hypnotherapy** - is excluded from Coverage.

## I

**IGE** - IGE immunoassays for quantitative Invitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST is excluded from Coverage.

**Immunizations** - as related to foreign travel and/or employment are excluded from Coverage.

**Implants** - Breast implants, except after mastectomy to produce symmetry, are excluded from Coverage.

**Incarceration** - Services and treatments required or performed while the Member is incarcerated in a Local, State, Federal or Community Correctional Facility are excluded from Coverage.

**Infertility** - All services, tests, medications, and treatments in connection with the diagnosis or treatment of Infertility, and all services, tests, medications, and treatments that aid in or diagnose potential problems with conception are excluded from Coverage unless covered under a Rider, including, but not limited to:

- In-Vitro Fertilization programs, Artificial insemination or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;

- GIFT programs;
- Reproductive material storage;
- Treatment related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage, or sperm washing;
- Infertility Services needed due to a reversal of sterilization;
- Services to reverse voluntary sterilization;
- Semen analysis;
- Sims-Huhner test (smear);
- Drugs used to treat infertility.

## J

## K

**Keloids** – the treatment of keloids as a result of body piercing or pierced ears is excluded from Coverage.

## L

**Laboratory Services** - Laboratory services received from Non-Plan Providers or laboratories are covered under out-of-network benefits only.

**Laser Therapy** - for Vitiligo or psoriasis is excluded from Coverage.

**Lung Cancer Screening Helical CT Scans** - are excluded from Coverage.

## M

**Magnetic Resonance Spectroscopy** - is excluded from Coverage.

**Massage Therapy** - is excluded from Coverage.

**Maternity Services** –

- Home Births – are excluded from Coverage.
- Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post-partum care for a Dependent child is excluded from Coverage unless covered under a Rider.

**Maximum Benefit** - Amounts in excess of a benefit limit as stated in the Schedule of Benefits of this Certificate of Insurance are excluded from Coverage.

**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 excluded from Coverage.

**Medical Equipment and Supplies** -

- Any disposable or convenience medical equipment, appliances, devices, and/or supplies are excluded from Coverage, including but not limited to: exercise equipment, air conditioners,

purifiers, humidifiers and dehumidifiers, whirlpool baths, hypoallergenic pillows or bed linens, telephones, handrails, ramps, elevators and stair glides, orthotics, changes made to vehicles, residences or places of business, adaptive feeding devices, adaptive bed devices, water filters or purification devices and other similar equipment and supplies.

- Disposable Medical Supplies are excluded from Coverage, including, but not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.

**Membership Fees** - to health and/or athletic clubs are excluded from Coverage.

**Mental Health and Substance Abuse Services** - The following mental health and substance abuse services are excluded from Coverage:

- Medically Necessary Treatments - Any services, supplies or treatments not specifically listed as Covered as well as services and any other procedures determined not to be Medically Necessary are excluded from Coverage.
- The Plan only covers psychiatric confinement in a Plan Hospital.
- All services, other than emergency services that have not been authorized are excluded from Coverage.
- Non-medical ancillary services are not covered including but not limited to vocational rehabilitation services, employment counseling, expressive therapies, and health education are excluded from Coverage.
- Psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings are excluded from Coverage.
- Court ordered examinations or care unless medically necessary are excluded from Coverage.
- Services delivered while detained under a Temporary Detention Order (TDO) are excluded from coverage.
- Psychiatric treatment for sexual dysfunction or sexual therapy, mental retardation or learning disabilities is excluded from Coverage.
- Psychoanalysis to complete degree or residency requirements is excluded from Coverage.
- Pastoral counseling or relationship counseling is excluded from Coverage.
- Psychological testing for educational purposes is excluded from Coverage.
- Residential level of care or treatment is excluded from Coverage.

- Other non-covered services listed in this manual that could be deemed mental health services are excluded from Coverage.
- Sex Change Operations and any medical treatment of gender identity disorders are excluded from Coverage.

**Mobile Cardiac Outpatient Telemetry** - (MCOT) is excluded from coverage.

**Morbid Obesity** - Coverage for the treatment of morbid obesity through gastric bypass surgery or other such methods, surgeries, services or drugs are excluded from Coverage unless covered under a Rider.

**Motorized or Power Operated Vehicles** - are excluded from Coverage, including, but not limited to, any adaptations to motorized or power operated vehicles and/or chair lifts.

## **N**

**Neuro-cognitive therapy** - Following a neurological event or to restore cognitive deficits neuro-cognitive therapy is excluded from Coverage.

**Neuropsychological Testing** - are excluded from Coverage, including, but not limited to, psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings, or not authorized by the Plan.

**Newborn Coverage** - for the newborn or other child of a Dependent child is excluded from Coverage.

## **O**

**Obstetrical Care** -

- Home births are excluded from Coverage.
- Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post-partum care for a Dependent child is excluded from Coverage unless covered under a Rider.

**Oral Surgery**

- Dental implants, and any preparation work for implants or dentures are excluded from Coverage
- Extraction of wisdom teeth is excluded from Coverage unless covered under a rider.
- Oral surgery, which is part of an orthodontic treatment program, is excluded from Coverage.
- Orthodontic treatment prior to Orthognathic surgery is excluded from Coverage.

**Orthoptics** - or vision/visual training and any associated supplemental testing are excluded from Coverage.

**Out Of Network Medical and Laboratory Services** - any services other than Emergency Services received from Non-Plan Providers, whether referred or directed by a Plan Provider, will be processed under the Plan's out of network benefit unless Pre-authorized by the Plan.

## P

**Paternity Testing** – is excluded from Coverage.

**Penile implants** - are excluded from Coverage.

**Personal comfort items** - are excluded from Coverage, which include, but are not limited to, telephones, televisions, extra meal trays and personal hygiene items including, but not limited to, underpads, diapers, icebags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs.

**PET Scans** - Positron Emission Tomography (PET) Scans are excluded from Coverage unless authorized by the Plan.

### **Physician Examinations** -

- Physicals for employment, insurance or recreational activities are excluded from Coverage.
- Executive physicals are excluded from Coverage.
- School physicals are excluded from Coverage, except when a Member has not had a health assessment with his or her physician during the calendar year.
- A second opinion from a Non-Plan Provider will be covered under the Plan's Out-of-Network benefits.
- Services or supplies not prescribed, performed, or directed by a provider licensed to do so.

**Physician's clerical charges** - are excluded from Coverage. This includes, but is not limited to, charges for no show appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records, or the generation of correspondence to other parties.

**Prescription Drugs** - outpatient prescription drugs are excluded from Coverage unless covered under a Rider.

**Prescription Drug Rider Exclusions** - Any drugs not specifically listed as covered in the Prescription Drug Rider are excluded from Coverage. All other drugs and over-the-counter medications, even if written on a prescription blank, are excluded from Coverage unless they are listed on the Plan's list of covered Preferred and Standard drugs. For a full listing of excluded

outpatient prescription drugs, please reference your Plan's Prescription Drug Rider exclusions.

**Private Duty Nursing** - is excluded from Coverage.

## Q

## R

**RAST Testing** - IGE immunoassays for quantitative Invitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST is excluded from Coverage.

**Reconstructive surgery** - is excluded from Coverage unless such 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.

**Remedial Education and/or Programs** - are excluded from Coverage, including services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities or for mental retardation or for autism disabilities.

**Routine Disposable Medical Supplies** - are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.

## S

**Saliva Tests** - are excluded from Coverage.

**Second Opinions** – A second opinion from a Non-Plan Provider will be covered under the Plan's Out-of-Network benefits.

**Services** – the following services are excluded from Coverage:

- Services for which a charge is not normally made;
- Services or supplies not prescribed, performed or directed by a provider licensed to do so;
- Services if they are for dates of service before the Member's effective date under the Plan or after the Member's Coverage under the Plan ends;

- Telephone consultations, charges for missed appointments, charges for completing forms, or charges associated with copying medical records.
- Services not specifically listed or described as covered under this Plan.
- Non-medically necessary complications of non-covered services including medical, mental health, and surgical services related to the complication.
- Treatment and services, other than Emergency Services, received outside of the United States of America are covered under out of network benefits only.

**Sex Change Operations** - and any treatment of gender identity disorders are excluded from Coverage.

**Smoking Cessation** - including the drugs and treatment associated with smoking cessation are excluded from Coverage.

**Spinal Manipulation (For Optima Equity PPO plans only)** - is excluded from Coverage.

**Sterilization** - Reversal of voluntary sterilization and infertility services required because of such reversal are excluded from Coverage.

**Supplies** - Disposable medical supplies are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diaper, any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.

## T

**Therapies** - Physical, speech and occupational therapies will be limited in Coverage and only covered to the extent of restoration to the pre-trauma or pre-illness level.

- Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status;
- Therapies for developmental delay or abnormal speech pathology are excluded from Coverage except as covered through Early Intervention Services;
- Therapies which are primarily educational in nature, including but not limited to, special education or lessons in sign language are excluded from Coverage;
- Therapies performed to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering) are excluded from Coverage;
- Physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal, except for children under age 3 who

qualify for early intervention services, are excluded from Coverage.

- Group speech therapy; group or individual exercise classes or personal training sessions; or recreational therapy. This includes but is not limited to sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.
- Restorative therapies to maintain chronic level of care are excluded from Coverage;
- Therapies which are available in a school program or similar programs available through state and local funding are excluded from Coverage;
- Recreation therapies including art, dance, music, exercise, equine, or sleep therapies are excluded from Coverage;
- Driver evaluations as part of occupational therapy are excluded from Coverage;
- Driver Training is excluded from Coverage;
- Functional capacity testing to return to work is excluded from Coverage;
- Work hardening programs are excluded from Coverage.

**Transplant Services** - Any organ or tissue transplant services not specifically listed as covered by the Plan are excluded from Coverage, including, but not limited to:

- Services received from non-contracted providers unless Pre-authorized by the Plan;
- Services and supplies associated with screenings, searches and registries;
- Organ and tissue transplants that are considered experimental or investigative are excluded from Coverage;
- Organ and tissue transplants that are not medically necessary are excluded from Coverage.
- Any transplant not specifically listed as covered.

**Travel and Transportation** - expenses are excluded from Coverage except for Medically Necessary transport and ambulance services which must be approved and authorized by the Plan.

## U

**Urea Breath Testing** - is excluded from Coverage unless authorized by the Plan.

## V

**Vaccines** - are excluded from Coverage unless authorized by the Plan.

**Virtual Colonoscopy** - is excluded from Coverage unless authorized by the Plan.

**Vision Materials** - Any vision supplies or materials not specifically listed as covered are excluded from Coverage.

**Vitiligo** – treatments by laser, light or other methods is excluded from Coverage.

**W**

**Wigs** - or cranial prostheses as a result of hair loss for any reason are excluded from Coverage.

**Wisdom Teeth** - extraction of wisdom teeth are excluded from Coverage unless covered under a rider.

**X**

**Y**

**Z**



4417 Corporation Lane • Virginia Beach, VA 23462  
[www.optimahealth.com](http://www.optimahealth.com)