

OPTIMA HEALTH VANTAGE

TIERED SUMMARY OF BENEFITS

Optima Health
Effective July 1, 2020 or October 1, 2020

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. For details about Pre-Authorization, Covered Services, and Non-Covered Services please read Your entire Evidence of Coverage document carefully. **Except for Emergency Services You must use In-Network Plan Providers for Your Covered Services. This Plan has tiered Copayment or Coinsurance amounts listed for some In-Network benefits. For tiered benefits You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals or other Facilities.**²

DEDUCTIBLE³

\$150 per Person per Contract Year
 \$300 per Family per Contract Year

MAXIMUM OUT OF POCKET LIMIT⁴

\$1,500 per Person Per Contract Year
 \$3,000 per Family Per Contract Year

PHYSICIAN SERVICES

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery⁵.**

Physician Office Visits	In-Network Benefits Copayments/%Coinsurance ²
Primary Care Physician (PCP) Office Visit	Tier 1 Physician: You Pay \$5 Tier 2 Physician: You Pay \$25
Virtual Consults Must be furnished by approved Optima Health providers.	Covered at 100%
Specialist Office Visit	Tier 1 Physician: You Pay \$10 Tier 2 Physician: You Pay \$40
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of \$250 per dose. This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 20%
Preventive Care ^{9,10}	In-Network Benefits Copayments/%Coinsurance ²
Routine Annual Physical Exam Well Baby Exams Annual GYN Exams and Pap Smears ¹⁰ PSA Tests Colorectal Cancer Tests Routine Adult and Childhood Immunizations Screening Colonoscopy Screening Mammograms Women's Preventive Services	No Charge

OUTPATIENT THERAPY AND REHABILITATION SERVICES

You Pay a Copayment or Coinsurance amount for each visit for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit.

Short Term Therapy Services ⁶	In-Network Benefits Copayments/%Coinsurance ²
Physical Therapy Occupational Therapy Pre-Authorization is required.⁵ Physical and Occupational Therapy are limited to a maximum combined benefit for all places of service of 30 visits per contract year. ⁶	You Pay \$25
Speech Therapy Pre-Authorization is required.⁵ Speech Therapy is limited to a maximum benefit for all places of service of 30 visits per contract year. ⁶	You Pay \$25
Short Term Rehabilitation Services ⁶	In-Network Benefits Copayments/%Coinsurance ²
Cardiac Rehabilitation Pulmonary Rehabilitation Vascular Rehabilitation Vestibular Rehabilitation Pre-Authorization is required.⁵ Services are limited to a maximum combined benefit for all places of service of 30 visits per contract year. ⁶	Covered at 100%
Other Outpatient Therapy Services	In-Network Benefits Copayments/%Coinsurance ²
IV Infusion Therapy Respiratory/Inhalation Therapy	You Pay \$40
Chemotherapy and Chemotherapy Drugs Radiation Therapy Pre-Authorization is required for Chemotherapy and Chemotherapy Drugs, Radiation Therapy.⁵	You Pay \$40
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. 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. Does not apply to Chemotherapy Drugs.	You Pay \$100
OUTPATIENT DIALYSIS SERVICES	
	In-Network Benefits Copayments/%Coinsurance ²
Dialysis Services	Covered at 100%
OUTPATIENT SURGERY	
	In-Network Benefits Copayments/%Coinsurance ²
Outpatient Surgery Pre-Authorization is required.⁵ Copayment or Coinsurance applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	You Pay \$125

OUTPATIENT DIAGNOSTIC PROCEDURES

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

Outpatient Diagnostic Procedures	In-Network Benefits Copayments/%Coinsurance ²
Diagnostic Procedures	After Deductible You Pay 20%
X-Ray Ultrasound Doppler Studies	After Deductible You Pay 20%
Lab Work	After Deductible You Pay 20%

OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES

Outpatient Advanced Imaging and Testing Procedures	In-Network Benefits Copayments/%Coinsurance ²
Magnetic Resonance Imaging (MRI) Magnetic Resonance Angiography (MRA) Positron Emission Tomography (PET Scans) Computerized Axial Tomography (CT Scans) Computerized Axial Tomography Angiogram (CTA Scans) Sleep Studies Magnetic Resonance Spectroscopy (MRS) Single Photon Emission Computed Tomography (SPECT) Nuclear Cardiology Pre-Authorization is required for all procedures except MRS, SPECT and Nuclear Cardiology.⁵ Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	After Deductible You Pay 20%

MATERNITY CARE

Maternity Care	In-Network Benefits Copayments/%Coinsurance ²
Maternity Care^{7, 9, 10} Pre-Authorization is required for prenatal services.⁵ Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	You Pay \$150 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services

INPATIENT SERVICES

Inpatient Services	In-Network Benefits Copayments/%Coinsurance ²
Inpatient Hospital Services Pre-Authorization is required.⁵	You Pay \$300
Transplants Pre-Authorization is required.⁵ Transplants are covered at contracted facilities only.	You Pay \$300
Skilled Nursing Facilities/Services⁶ Pre-Authorization is required.⁵ Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days per contract year that in the Plan's judgment requires Skilled Nursing Services ⁶	Covered at 100%

AMBULANCE SERVICES

Ambulance Services	In-Network Benefits Copayments/%Coinsurance ²
Ambulance Services⁸ Pre-Authorization is required for non-emergent transportation only.⁵ Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	After Deductible You Pay 20%

EMERGENCY SERVICES	
	In-Network Benefits Copayments/%Coinsurance²
Emergency Services^{2,8} Pre-Authorization is <u>not</u> required. Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility. Emergency care will be provided whether the provider is In-Network or Out-of-Network.	You Pay \$150
URGENT CARE CENTER SERVICES	
	In-Network Benefits Copayments/%Coinsurance²
Urgent Care Center Services⁸ Pre-Authorization is <u>not</u> required. Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay an Emergency Services Copayment or Coinsurance.	You Pay \$40
MENTAL/BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER SERVICES	
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Pre-Authorization is required for Inpatient Services, partial hospitalization services, intensive outpatient program (IOP), electro-convulsive therapy, and Transcranial Magnetic Stimulation (TMS). ⁵	
Mental/Behavioral Health/Substance Use Disorder	In-Network Benefits Copayments/%Coinsurance²
Inpatient Services Pre-Authorization is required⁵	You Pay \$300
Outpatient Office Visits	You Pay \$10
Virtual Consults Must be furnished by approved Optima Health providers.	Covered at 100%
Other Outpatient Visits (Includes Hospital Outpatient and Freestanding Outpatient Centers)	You Pay \$125
Employee Assistance Visits)⁶ Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174	No Charge for up to 4 visits from Optima Employee Assistance Providers per presenting issue as determined by treatment protocols. ⁶
DIABETES TREATMENT	
Coverage includes benefits for equipment, supplies and 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. Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating Eye Med Provider at the applicable office visit Copayment or Coinsurance amount.	
	In-Network Benefits Copayments/%Coinsurance²
Insulin Pumps Pre-Authorization is required.⁵	No Charge
Pump Infusion Sets and Supplies Pre-Authorization is required.⁵	After Deductible You Pay 20%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution.	Covered under the Plan's Prescription Drug Benefit.
Insulin, Needles, and Syringes	Covered under the Plan's Prescription Drug Benefit
Outpatient Self-Management Training and Education and Nutritional Therapy	No Charge

OTHER COVERED SERVICES

Other Services	In-Network Benefits Copayments/%Coinsurance ²
<p>Prosthetic Limbs and Components Pre-Authorization is required.⁵ Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components.</p> <p>Definitions: "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.</p> <p>"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.</p> <p>"Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.</p>	<p>After Deductible You Pay 20%</p>
<p>Autism Spectrum Disorder Pre-Authorization is required.⁵ Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder.</p> <p>"Autism Spectrum Disorder" means any pervasive develop 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.</p> <p>"Diagnosis of Autism Spectrum Disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder.</p> <p>"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) <u>Applied Behavioral Analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.</u></p> <p>"Applied Behavioral 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. <u>Coverage for Applied Behavioral Analysis under this benefit is limited to an annual maximum benefit of \$35,000 per child.</u>⁶</p>	<p>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.</p> <p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>
<p>Clinical Trials Pre-Authorization is required.⁵ Coverage of routine patient costs for phase I, II and III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>

OTHER COVERED SERVICES

Other Services	In-Network Benefits Copayments/%Coinsurance ²
<p>Durable Medical Equipment (DME) and Supplies Orthopedic Devices and Prosthetic Appliances Pre-Authorization is required for single items over \$750.⁵ Pre-Authorization is required for all rental items.⁵ Pre-Authorization is required for repair and replacement.⁵ Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.</p>	<p>After Deductible You Pay 20%</p>
<p>Early Intervention Services Pre-Authorization is required.⁵ Covered for Dependent children from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.</p>
<p>Home Health Care Skilled Services⁶ Pre-Authorization is required.⁵ Services are covered up to a maximum of 100 visits per contract year for Members who are home bound and in the Plan's judgment require Home Health Skilled Services.⁶ You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.</p>	<p>Covered at 100%</p>
<p>Hospice Care Pre-Authorization is required.⁵</p>	<p>No Charge</p>
<p>Telemedicine Services Telemedicine means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.</p>
<p>Out of Area Dependent Program Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits listed on the Plan Face Sheet or Schedule of Benefits when Covered Services are received from Optima Health providers that participate in the Out of Area Program. The Plan will require eligible out of area Dependents to complete an annual certification form prior to being eligible for the program. All Pre-Authorization requirements apply depending on the type and place of service. Except for Emergency Services any Covered Services received outside of the service area from Out of Network Non-Plan Providers that are not included in the Out of Area Dependent Program will not be covered.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>

OTHER COVERED SERVICES

Other Services	In-Network Benefits Copayments/%Coinsurance²
<p>Infertility Services⁶ Includes the following services to diagnose and treat underlying medical conditions resulting in infertility: Endometrial biopsies (Limited to 2 per lifetime) Semen analysis (Limited to 2 per lifetime) Hysterosalpingography (Limited to 2 per lifetime) Sims-Huhner test (smear) (Limited to 4 per lifetime) Diagnostic laparoscopy (Limited to 1 per lifetime) Excluded are Artificial Insemination (AI), In-Vitro Fertilization (IVF) and all other types of artificial or surgical means of conception and drugs used in connection with these procedures.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service.</p>

RIDERS

Riders	In-Network Benefits Copayments/%Coinsurance ²
<p>Vision Care and Materials Rider⁶ Optima Health contracts with EyeMed Vision Services to administer this benefit. You are eligible to receive a routine eye examination, refraction, and materials including lenses and frames, or contact lenses once every 12 months from a Participating EyeMed Provider.</p> <p>To contact EyeMed about participating Providers call 1-888-610-2268.</p>	<p>Examinations</p> <p>You Pay \$15 Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost. For eye examinations from Out-of-Network Non-Plan Providers Member's will be reimbursed \$50 for an eye examination only.</p> <p>Materials</p> <p>You Pay \$20 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.</p> <p>Cost sharing amounts You pay for Covered Services under this rider will not count toward Your Deductible or Maximum Out of Pocket Limit. Unless services are considered an Essential Health Benefit (EHB) for children.</p>
<p>Hearing Aid Rider⁶ Pre-Authorization is required.⁵ Covered Services include the following up to the annual maximum benefit of \$1,200:</p> <ul style="list-style-type: none"> • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) <p>Replacement is covered only every 48 months from date of acquisition. Batteries are not covered. Supplies are not covered.</p>	<p>You Pay \$40 per visit</p> <p>Cost sharing amounts You pay for this rider will not count toward Your Deductible or Maximum Out of Pocket Limit.</p>
<p>Chiropractic Care Rider⁶ Pre-Authorization is required by ASH for all Chiropractic services. Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit. Pre-Authorization is required by ASH for all chiropractic care services To use this benefit call ASH's Member Services at 1-800-678-9133. Representatives are available from 8 AM to 9 PM Monday-Friday. Maximum number of visits 30 per contract year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per contract year when medically necessary.</p>	<p>You Pay \$35</p>
<p>Morbid Obesity Rider Pre-Authorization is required.⁵ Covered Services include the treatment of morbid obesity through gastric bypass surgery or other methods recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.</p>	<p>The Member will be responsible for all applicable In-Network Copayments, Coinsurances, and any Deductibles depending on the type and place of service.</p>

DENTAL SERVICES SCHEDULE OF BENEFITS: CHOICE PPO

This Schedule includes Your Covered Dental Benefits and cost sharing amounts under the Rider. You must meet all Deductibles listed below. After You meet Your Deductible You pay the applicable Coinsurance for Your Covered Service. Coverage is limited to the Maximum Benefits stated below.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT

	In-Network Benefits	Out-of-Network Benefits
Deductibles Combined In-Network and Out-of-Network per Member per Benefit Year.	\$50 per Person \$150 per Family	\$50 per Person \$150 per Family
Annual and Lifetime Maximum Benefits Combined In-Network and Out-of-Network per Member per Benefit Year for Annual Maximum.	Class II and Class III Services: Annual \$2,000 per Person Class IV Orthodontia Services Lifetime \$2,000 per Person	Class II and Class III Services: Annual \$2,000 per Person Class IV Orthodontia Services Lifetime \$2,000 per Person

Out-of-Network Allowance

If the course of treatment will exceed \$300 pre review is requested. Members may receive Covered Services from Participating Dentists or Non-Participating Dentists. Unlike Participating Dentists that have agreed to accept negotiated fees for services, Non-Participating Dentists have no contract with Dominion National or Dominion National's leased dental networks. As such, Non-Participating Dentists set their own fees and Dominion National only reimburses the Member based on the established Participating Dentist's fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the Non-Participating Dentist's fee is higher than Dominion National's Participating Dentist's fee schedule, the Member will be billed the remaining balance to cover the Non-Participating Dentist's fee.

DENTAL SERVICES

Class I Diagnostic and Preventive Services	In-Network Benefits Copayments/Coinsurance	Out-of-Network Benefits Copayments/Coinsurances
<ol style="list-style-type: none"> 1. Two evaluations per Benefit Year including a maximum of one comprehensive evaluation per 36 months 2. One emergency or problem focused exam (D0140) per Benefit Year 3. Two prophylaxis (cleaning, scaling and polishing teeth) per Benefit Year (one additional cleaning is covered during pregnancy and for diabetic patients) 4. One topical fluoride per Benefit Year, to age 16 5. Bitewing x-rays, 2 per Benefit Year 6. Periapical x-rays 7. One diagnostic x-ray, full or panoramic per 60 months 8. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service) 9. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars) 	Covered at 100%	Covered at 100%

Class II Basic Services	In-Network Benefits Copayments/Coinsurance	Out-of-Network Benefits Copayments/Coinsurances
<ol style="list-style-type: none"> 1. Simple extraction of teeth 2. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months 3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin) 4. Antibiotic injections administered by a dentist 5. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment) 6. Oral surgery, including postoperative care for: <ol style="list-style-type: none"> a. Removal of teeth, including impacted teeth b. Extraction of tooth root c. Alveolectomy, alveoplasty, and frenectomy d. Excision of periocoronary gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy e. Reimplantation or transplantation of a natural tooth f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst 7. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: <ol style="list-style-type: none"> a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage) b. Pulpotomy c. Apicoectomy d. Retrograde fillings, per root per lifetime 8. Periodontic services, limited to: <ol style="list-style-type: none"> a. Two periodontal cleanings following surgery per Benefit Year (D4341 is not considered surgery) b. One root scaling and planing per quadrant of mouth per 24 months from age 21 c. Occlusal adjustment performed with covered surgery d. Gingivectomy and gingival curettage e. Osseous surgery including flap entry and closure f. One pedicle or free soft tissue graft per site per lifetime g. One appliance (night guards) per 5 years within 6 months of osseous surgery h. One full mouth debridement per lifetime 	<p>After Deductible Covered at 80%</p>	<p>After Deductible Covered at 80%</p>

Class III Major Services	In-Network Benefits Copayments/Coinsurance	Out-of-Network Benefits Copayments/Coinsurances
<ol style="list-style-type: none"> 1. One study model per 36 months 2. Crown build-up for non-vital teeth 3. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter 4. One repair of dentures or fixed bridgework per 24 months 5. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery or implant placement procedures 6. Restoration services, limited to: <ol style="list-style-type: none"> a. Gold or porcelain inlays, onlays, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced (will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage) c. Stainless steel crowns up to age 14 (one per tooth per lifetime) d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally 7. Prosthetic services, limited to: <ol style="list-style-type: none"> a. Initial placement of dentures or fixed bridgework (including acid etch metal bridges) b. Replacement of dentures or fixed bridgework that cannot be repaired after 7 years from the date of last placement c. Addition of teeth to existing partial denture d. One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement) 8. Implants and related services 	After Deductible Covered at 50%	After Deductible Covered at 50%
Class IV Orthodontia Services	In-Network Benefits Copayments/Coinsurance	Out-of-Network Benefits Copayments/Coinsurances
Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy	Covered at 50%	Covered at 50%

Plan Exclusions:

The following are not Covered Dental Services under this Rider.

1. Treatment required for conditions resulting while on active duty as a Member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
2. Services which are covered under Medicare, worker's compensation or employer's liability laws.
3. Services and treatment provided without charge or for which there would be no charge in the absence of insurance.
4. Services not listed as covered.
5. Hospitalization for any dental procedure.
6. Services and treatment for which Member is eligible for coverage under his or her hospital, medical/surgical or major medical plan.
7. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
8. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
9. Replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
11. Services for increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
12. Oral hygiene instructions; plaque control; completion of a claim form; acid etch; broken appointments; prescription or take-home fluoride; or diagnostic photographs.
13. Dispensing of drugs.
14. Diagnosis or treatment of temporomandibular joint (TMJ) syndromes, problems and/or occlusal disharmony.
15. Procedures that in the opinion of Dominion National are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, anodontia, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

All benefits are subject to the terms and conditions in the *Evidence of Coverage (EOC)*. Words that are capitalized are defined terms listed in the Definitions section of the EOC.

Children are covered up to the end of the year in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your benefits. This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your EOC for details about how to file a complaint or an appeal.

Under certain circumstances Your coverage can be terminated. However, Your Coverage can only be rescinded for fraud or intentional misrepresentation of material fact. Please look in Your EOC in the section on When Your Coverage will end.

For Optima Health plans that require that You choose a Primary Care Provider (PCP) You have the right to choose any PCP who participates in our network and who is available to accept You or Your family members. For children, You may choose a pediatrician as the PCP.

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.
2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

Tiered Benefits and Cost Sharing.

This Plan has tiered Copayment or Coinsurance amounts listed for some In-Network benefits. For tiered benefits You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals or other Facilities or providers. When you use Tier 2 Physicians, Hospitals or other Facilities or other providers Your out of pocket costs will be higher. You can access Tier 1 or Tier 2 Primary Care Physicians (PCP) or Specialist providers without a referral.

Tier 1 Physician, Facility or other provider means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 1 cost sharing amounts listed on the Plan Face Sheet Schedule of Benefits. Tier 1 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 1 Physicians, Facilities, and other providers and their locations is available to each enrollee during enrollment and anytime upon request.

Tier 2 Physician, Facility, or other provider means an In-Network Plan Provider or Plan Facility under contract with Optima providing professional and Hospital services to Members at the Tier 2 cost sharing amounts listed on the Plan Face Sheet Schedule of Benefits. Tier 2 Physicians or Facilities include Primary Care Physicians (PCPs), Specialists, Hospitals and other inpatient and outpatient facilities and other providers. A list of Tier 2 Physicians and Facilities and other providers and their locations is available to each enrollee during enrollment and anytime upon request.

Services or treatment You receive from Out-of-Network Non-Plan Providers will not be Covered under the Plan except in the following situations:

- If during treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits;
- You have received advance approval from Us to use an Out-of-Network Non-Plan Provider; and We have authorized the service to be Covered under Your In-Network Benefits;
- Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket amounts.

3. **Deductible** means the dollar amount You must pay out of pocket each contract year for Covered Services before the Plan begins to pay for Your benefits. If You have individual coverage You must satisfy the individual member coverage Deductible before coverage begins. If You have family coverage You and Your family must satisfy the family coverage Deductible. This Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. Amounts You are required to pay for preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. Amounts applied to the Deductible will apply toward the Plan's Maximum Out of Pocket Limit. The Deductible does not apply to Preventive Care Visits and Screenings. Cost sharing amounts You pay for some Covered Services will not count toward Your Deductible. Deductibles will not be reimbursed under the Plan. Any part of the contract year Deductible that is satisfied in the last three months of a contract year can be carried forward to the next contract year.

4. **Maximum Out of Pocket Limit** means the total dollar amount You and Your family pay out of pocket for most Covered Services during a contract year. Deductibles, Copayments and Coinsurance amounts that You pay for most Covered Services will count toward Your Maximum Out of Pocket Limit. If You have individual coverage once You meet the individual Maximum Out-of-Pocket Amount Optima Health will cover most Plan benefits with no out-of-pocket costs for the remainder of Your Plan year. If You have Family coverage and one covered family member meets the individual maximum Optima Health will cover most Plan benefits with no out-of-pocket costs for that family member. Once You and Your family have met the entire family Maximum Out-of-Pocket Amount Optima Health will cover most Covered Services with no out-of-pocket costs for the remainder of Your Plan year for the entire family. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayment or Coinsurance amounts and any other charges for the following will not count toward Your Maximum Out of Pocket Limit:**
 1. Amounts You pay for services or charges not covered under Your Plan;
 2. Amounts You pay for services after a benefit limit has been reached;
 3. Balance billing amounts from Non-Plan Providers;
 4. Premium amounts;
 5. Ancillary charges which result from Your request for a brand name outpatient prescription drug when a generic drug is available;
 6. Except for Emergency Services, amounts You pay for Out-of-Network Services;
 7. Cost Sharing amounts including Copayments, Coinsurance, and Deductibles for the following:
 - i. Amounts You pay for Vision care unless services are considered an Essential Health Benefit (EHB) for children;
 - ii. Amounts You pay for any benefits covered under a plan rider including riders for Vision Care and Materials unless services are considered an Essential Health Benefit (EHB) for children, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction unless services are considered an Essential Health Benefit (EHB) for children

5. This benefit requires Pre-Authorization before You receive services. We have instructions and procedures in place for providers to obtain Pre-Authorization through Medical Care Services. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.

6. Coverage for this benefit or service is limited as stated. Unless otherwise noted benefit limits are combined for all places of service. The Plan will not cover any additional services after the limits have been reached. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your Maximum Out of Pocket Maximum Limit.

7. 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 You are 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 You would have paid on a per visit or per procedure basis.

8. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical

screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. 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 You received care from a Plan Provider.

9. Recommended Preventive Care listed below will be covered with no Member cost-sharing when received from In-Network Plan Providers. However, You may still have to pay Your office visit cost sharing including any Copayments, Coinsurance, and Deductibles listed on the Face Sheet of Your Evidence of Coverage in certain circumstances:
- You will pay office visit cost sharing if Your preventive care item or service is billed separately, or is tracked as individual encounter data separately from the office visit.
 - You should not pay office visit cost sharing if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit, and the primary purpose of the office visit is the delivery of the preventive item or service.
 - You will pay office visit cost sharing if an item or service is not billed separately, or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.
 - You will pay all charges for any preventive care or office visits You receive from Out-of-Network Non-Plan Providers.

Where no frequency or limits are indicated the Plan will use its normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Some services may be administered under Your prescription drug benefit under the Plan. Services covered under the Plan's outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. **Please use the following link for a complete list of covered preventive care services: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>**

1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:
 - **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
 - **Contraceptive Methods and Counseling including:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
 - **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
 - **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
 - **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.

- **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
 - **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
 - **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.
10. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your EOC in the Utilization Management Section for more information on Pre-Authorization.

Optima Vantage \$15/30/45/55
Outpatient Prescription Drug Summary of Benefits

This Summary of Benefits describes Your outpatient prescription drug coverage. All drugs must be United States Food, Drug Administration (FDA) approved, and you must have a prescription. You will need to pay Your Copayment or Coinsurance when you fill your prescription at the pharmacy. If Your Plan has a separate pharmacy 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 listed in Your coverage documents. Optima Health's Pharmacy and Therapeutics Committee places covered drugs into the following Tiers. You will pay Your Copayment or Coinsurance depending on which Tier Your Drug is in.

- **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 than 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.
- **Specialty Drugs (Tier 4)** includes those drugs classified by the Plan as Specialty Drugs. Tier 4 also includes covered compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or on-going medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional. Specialty Drugs include the following:
 - Medications that treat certain patient populations including those with rare diseases;
 - Medications that require close medical and pharmacy management and monitoring;
 - Medications that require special handling and/or storage;
 - Medications derived from biotechnology and/or blood derived drugs or small molecules; and
 - Medications that can be delivered via injection, infusion, inhalation, or oral administration.

Specialty Drugs are only available through the Optima Health specialty mail order pharmacy. Proprium Pharmacy at 1-855-553-3568. Specialty Drugs will be delivered to Your home address from Our Specialty mail order pharmacy. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Pharmacy Member Services at the number on Your Optima Health ID Card. You can also log onto optimahealth.com for a list of Specialty Drugs.

A compound prescription medication is used to meet the needs of a specific individual and must have at least one ingredient requiring a Physician's authorization by State or Federal Law. Compound prescriptions can usually be filled at Your local pharmacy.

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

Underwritten by Optima Health Plan

\$10/45/75/20% \$150 Deductible 4 Tier Open Formulary

Optima Vantage \$15/30/45/55
Outpatient Prescription Drug Summary of Benefits

Maximum Out-of-Pocket Limit	Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are not Covered, do not count toward the Plan's Maximum Out of Pocket Limit and must continue to be paid after the Maximum Out of Pocket Limit has been met.
Insulin, syringes, and needles	Covered at the cost sharing listed below for the applicable Tier.
Diabetic Testing Supplies covered including blood glucose monitors, test strips, lancets, lancet devices, and control solution	Covered at 100% Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. Pre-Authorization is required for talking blood glucose meters.
Copayments and Coinsurances.	
<p>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.</p> <p>ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider are covered with no Member cost sharing. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/</p>	
Selected Generic (Tier 1)	You Pay \$15 Copayment
Selected Brand & Other Generic (Tier 2)	You Pay \$30 Copayment
Non-Selected Brand (Tier 3)	You Pay \$45 Copayment
Specialty Drugs (Tier 4)	You Pay \$55 Copayment
Mail Order Pharmacy Benefit Copayments and Coinsurances	
<p>Some Outpatient prescription drugs are available through the Plan's Mail Order Provider. This does not include Tier 4 Specialty Drugs. You may call OptumRx Home Delivery at 866-244-9113 to find out if a drug is available. If Your drug is available You may purchase up to a 90-day supply for 2 Copayments or the applicable Coinsurance amount. If available under mail order benefits Prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider are covered with no Member cost sharing.</p>	
Selected Generic (Tier 1)	You Pay \$30 Copayment
Selected Brand & Other Generic (Tier 2)	You Pay \$60 Copayment
Non-Selected Brand (Tier 3)	You Pay \$90 Copayment
Specialty Drugs (Tier 4)	No 90 day mail order benefits are available for Tier 4 Specialty Drugs.

LIMITATIONS AND OTHER COVERAGE TERMS.

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

1. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.
2. 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 Health's Allowable Charge.
3. 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.

Underwritten by Optima Health Plan

\$10/45/75/20% \$150 Deductible 4 Tier Open Formulary

Optima Vantage \$15/30/45/55
Outpatient Prescription Drug Summary of Benefits

4. Prescriptions may be filled at a Plan pharmacy or at a non-participating pharmacy if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies.
5. 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.
6. 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 Limit.
7. 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. However, 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.
8. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. You can call Member Services at the number on Your ID card to verify that your prescription drug has been pre-authorized.
9. Unless required by law, certain Prescription Drugs may not be Covered under the Plan if You could use a "clinically equivalent drug." "Clinically equivalent drug" means a drug that for most individuals will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered by the Plan please call the Member Services number on the back of Your Optima identification card. If You or Your doctor believes You need to use a different Prescription Drug, please have Your doctor contact Us. If We agree that it is Medically Necessary and appropriate we will cover the other Prescription Drug instead of the "clinically equivalent drug."
10. At its' sole discretion Optima Health's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in or if a particular drug is included on the Plan's formulary. 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 or Your Plan's formulary. 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.
11. Insulin, syringes, needles, blood glucose monitors, test strips, lancets, lancet devices, and control solution are covered under the Plan's prescription drug benefit. Insulin pumps, pump infusion sets and supplies, and 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 non-insulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, are covered under the Plan's medical benefit. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under the Plan.
12. 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.
13. 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.
14. 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.
15. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
16. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to two 90 day courses of treatment per year when prescribed by a health care provider.

PRESCRIPTION DRUG COVERAGE EXCLUSIONS.

Underwritten by Optima Health Plan

\$10/45/75/20% \$150 Deductible 4 Tier Open Formulary

Optima Vantage \$15/30/45/55
Outpatient Prescription Drug Summary of Benefits

The following is a list of exclusions that apply to Your drug benefit.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications with no approved FDA indications are excluded from Coverage.
3. 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.
4. 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.
5. 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.
6. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage under this rider.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage under this rider.
9. 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.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. 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.
13. 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.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded from Coverage
18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country
20. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage
22. Medical foods are excluded from Coverage.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following Standard reference compendia are not Covered Services:
 - a. American Hospital Formulary Service Drug Information;
 - b. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
 - c. Elsevier Gold Standard's Clinical Pharmacology.
24. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed illness or when included under ACA Recommended Preventive Care.
25. Non-Sedating antihistamines are excluded from Coverage.
26. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage.
27. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
28. Prescriptions written by a licensed dentist are excluded from Coverage, except for the prevention of infection or pain in conjunction with a Covered dental procedure.
29. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription
30. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
31. Infertility drugs are excluded from Coverage.
32. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.

Underwritten by Optima Health Plan

\$10/45/75/20% \$150 Deductible 4 Tier Open Formulary

Optima Vantage \$15/30/45/55
Outpatient Prescription Drug Summary of Benefits

Synchronization of Medication. For prescription drugs Covered under the Plan We will permit and apply a prorated daily cost sharing rate to prescriptions that are dispensed by an In-Network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the Member, and the Member requests or agrees to a partial supply for the purpose of synchronizing the Member's medications. Proration will not occur more frequently than annually.

The Plan will not deny Coverage for the dispensing of a medication by an In-Network pharmacy on the basis that the dispensing is for a partial supply if the prescribing provider or the pharmacist determines the fill or refill is in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the Member's medications.

Underwritten by Optima Health Plan

\$10/45/75/20% \$150 Deductible 4 Tier Open Formulary